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**Diane M. Billings**

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*Lippincott's Q&A Review for*

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*Lippincott's Q&A Review for*

# NCLEX-RN<sup>®</sup>

TENTH EDITION

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**Diane M. Billings, EdD, RN, FAAN**  
Chancellor's Professor Emeritus  
Indiana University School of Nursing

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**Acquisitions Editor**

Bill Lamsback

**Art Director**

Brett MacNaughton

**Editorial Product Manager**

Annette Ferran

**Production Manager**

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**Design Coordinator**

Joan Wendt

**Manufacturing Manager**

Beth J. Welsh

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## Contributors

**Desiree Hensel, PhD, RNC-NIC, CNE**  
Assistant Professor  
Indiana University School of Nursing  
Bloomington, Indiana

**Margie A. Hull, MEd, APRN-BC, CNS, CDE**  
Diabetes CNS, CDE  
Wishard Health Services  
Indianapolis, Indiana

**Lesley Milgrom, RN, MSN**  
Clinical Assistant Professor  
Indiana University School of Nursing  
Indianapolis, Indiana

**Lee Schwecke, BSN, MSN, EdD**  
Associate Professor Emeritus  
Indiana University School of Nursing  
Staff Nurse, Psychiatric Pavilion  
Community Hospital North  
Indianapolis, Indiana

**Sharon Vinten, MSN, RN, WHNP, CNE**  
Staff Nurse  
Carolina's Health Care System  
Charlotte, North Carolina

**Sandra Wood, MSN, APRN BC**  
Clinical Assistant Professor Emerita  
Indiana University School of Nursing  
Indianapolis, Indiana

---

## Contributors to the Previous Edition

Karen Bawel-Brinkley, RN, MS, MSN, PhD  
Carol Bostrom, RN, MSN, APRN, BC  
Judith A. Halstead, RN, DNS  
Margie Hull, MEd, MSN, APRN-BC, CDE-RN  
Colleen M. O'Leary-Kelley, PhD, RN  
Virginia Richardson, RN, DNS, CPNP  
Pat Twedt, RN, MS  
Gayle Roux, PhD, RN, NP-C  
Lee W. Schwecke, RN, MSN, EdD  
Evelyn Stephenson, MSN, RNC  
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Mary Ann Wehmer, RN, MSN, CNOR  
Sandra Wood, MSN, APRN, BC



# Reviewers

## OB AND PEDS REVIEWERS

---

**Samantha H. Bishop, MN, RN, CPNP**

Assistant Professor of Nursing  
Division of Nursing and Health Sciences  
Gordon College  
Barnesville, Georgia

**Sally Boyster, MSN, CNE**

Coordinator/Professor Women's & Children's Nursing  
Rose State College  
Midwest City, Oklahoma

**Stephanie C. Butkus, MSN, RN, CPNP**

Assistant Professor  
Kettering College of Medical Arts  
Kettering, Ohio

**Darlene Nebel Cantu, RNC-NIC, C-EFM, BSN, MSN**

Assistant Professor  
San Antonio College  
San Antonio, Texas  
Online faculty in Masters Nursing Program  
University Of Phoenix  
Online faculty in RN to BSN Nursing Program  
Chamberlain College of Nursing

**Cynthia Chatham, BSN, MSN, DSN**

Associate Professor  
University of Southern Mississippi Gulf Coast  
Campus  
Long Beach, Mississippi

**Kim Cooper, MSN**

Nursing Department Program Chair  
Ivy Tech Community College  
Terre Haute, Indiana

**Elizabeth Di Fabio, MSN, BSN**

Nursing Instructor  
Anoka-Ramsey Community College  
Coon Rapids, Minnesota

**L. Sue Gabriel, EdD, MFS, MSN, RN, SANE-A, CFN**

Associate Professor  
Bryan LGH College of Health Sciences, School of  
Nursing  
Lincoln, Nebraska

**Rochelle Kuhn, RN, MS, CRNP**

Pediatric Nursing Instructor  
Frankford Hospital School of Nursing  
Philadelphia, Pennsylvania

**Lucy Megginson, MSN, RN, PhD student**

Assistant Professor of Nursing  
Georgia Highlands College  
Rome, Georgia

**Linda Strong, MSN, RN, CPNP, CNE**

Assistant Professor, Pediatric Nursing  
Cuyahoga Community College  
Cleveland, Ohio

## PSYCH REVIEWERS

---

**Lois Angelo, MSN, APRN**

Assistant Professor of Nursing  
Massachusetts College of Pharmacy and Health  
Sciences  
Boston, Massachusetts

**Harlene Caroline, BSN, MS, PhD(c)**

Professor  
Curry College  
Milton, Massachusetts

**Edith Claros, RN, APRN-BC, PhD(c)**

Assistant Professor of Nursing  
Massachusetts College of Pharmacy School of  
Nursing  
Worcester, Massachusetts

**Brandy Mechling, RN, MSN, CNS, PhD student**

Lecturer  
University of North Carolina at Wilmington  
Wilmington, North Carolina

**Mitzi Grace Mitchell, BScN, BA, MHSc, MN, DNS, PhD(c),  
RN, GNC(c)**

Lecturer  
York University  
Toronto, Ontario, Canada



Veronica Garcia Walker, MSN, BSN, RN  
UT Clinical Faculty  
The University of Texas at Austin  
Austin, Texas

### **MED-SURG REVIEWERS**

---

Marlys Bohn, BSN, MS, PhD  
Department Head, Nursing Student Services  
South Dakota State University  
Brookings, South Dakota

Deborah A. Green, MSN, RN, BC  
Clinical Education Coordinator  
Clarian North Medical Center  
Carmel, Indiana

Susan A. Lisko, DNP, RN, MSN, BSN  
Assistant Professor of Nursing  
Youngstown State University  
Youngtown, Ohio

Gina Maiocco, PhD, RN, CCNS  
Assistant Professor/Coordinator Fast Track Program  
West Virginia University  
Morgantown, West Virginia

Lisa Peden, BSN, MSN  
Associate Professor of Nursing  
Dalton State College  
Dalton, Georgia

Wendy J. Waldspurger Robb, PhD, RN, CNE  
Director of the Graduate Nursing Program  
Assistant Professor  
Cedar Crest College  
Allentown, Pennsylvania

Tami J. Rogers, DVM, MSN, BSN  
Professor of Nursing  
Valencia Community College  
Orlando, Florida

JoAnn Evanko Thistlethwaite, RN, MNEd, ABD  
Assistant Professor Medical Surgical Nursing  
Indiana University of Pennsylvania  
Indiana, Pennsylvania

Susan K. Tucker, RN, BSN, MSN, DNP  
Division Director of Nursing  
Gadsen State Community College  
Gadsen, AL

Donna Williams, DNP, RN  
Nurse Faculty  
Itawamba Community College  
Fulton, MS

Judith Young, CCRN, BSN, MSN  
Clinical Assistant Professor  
Indiana University School of Nursing  
Indianapolis, Indiana



# Preface

## Introduction to the Q&A Review for NCLEX-RN®

This exam review book, the accompanying CD-ROM, and the online study resources have been developed to help you prepare for the National Council Licensing Examination for Registered Nurses (NCLEX-RN®). You will also find this book helpful for review when preparing for course exams, final exams, NCLEX-RN assessment exams, or other standardized or competency exams.

### Study resources

This review book includes multiple resources that you can use in any combination to meet your own study and test preparation plans:

- More than 5,800 test questions using 8 different formats of question types including the new audio, video, and graphic option questions.
- A CD-ROM with more than 1,300 questions with rationales for correct and incorrect answers that provides you with ample opportunity to experience test-taking using computer-administered questions and allows you to customize tests for specific review and practice
- Questions written for all clinical areas of nursing (childbearing family and their neonate; nursing care of infants, children, and adolescents; nursing care of adults with medical and surgical health problems; and nursing care of clients with psychiatric disorders and mental health problems)
- Questions organized by health problems to facilitate review for course-specific exams
- Questions coded by client needs to assure practice in *all* areas of the NCLEX-RN test plan
- Questions coded by cognitive level to guide study and test-taking at higher levels of the cognitive domain
- Questions emphasizing integrative processes on the NCLEX-RN test plan
- Questions with teaching feedback and rationales for both correct and incorrect answers
- Questions using *all* types of question formats used on the licensing exam (multiple choice, multiple response, hot-spot, fill-in-the blank, drag-and-drop/ordered response, chart/exhibit, as well as graphic, audio, and video inclusion questions)
- Questions primarily written at higher levels of the cognitive domain (analysis, synthesis, evaluation, and creation)
- Questions emphasizing clinical decision making, clinical judgment, and management of care
- Questions to provide practice for calculating drug dosages, intravenous drip rates, intake and output, and other questions requiring calculation and reporting of a numerical response to the question
- Questions emphasizing current nursing practice in the areas of client safety, managing care quality, home care, health promotion, care of the older adult, cancer nursing, end-of-life care, perioperative care, community health nursing, and emergency and disaster nursing
- Questions about managing care quality and safety at the end of each chapter
- An entire chapter that explains the various test question formats and strategies for answering each type of test item and at each level of the cognitive domain
- Six comprehensive tests of 180 questions each designed to resemble the testing format of the NCLEX-RN
- A description of the current NCLEX-RN test plan
- A study plan and checklist to guide systematic preparation for the licensing examination
- Information about developing study skills, taking tests, and managing test anxiety
- Tips for studying from students who have successfully passed the NCLEX-RN exam
- Addresses, telephone numbers, and websites for the National Council of State Boards of Nursing, Inc., and each state board of nursing
- Online resources for students, including tips for test-taking and downloadable NCLEX questions for your handheld media device

## Organization of the book

The review book is organized in three sections. Each section is designed to build on the previous section.

The first section of the book provides information about the licensing exam and how to prepare for and take high-stakes examinations. A full chapter is devoted to explaining the various types of test question formats and cognitive levels of questions used on the licensing exam; the chapter also provides examples of all types and levels of questions and strategies for answering them.

In the second section of the book, there are four major units—nursing care of the childbearing family and their neonate; nursing care of infants, children, and adolescents; nursing care of adults with medical and surgical health problems; and nursing care of clients with psychiatric disorders and mental health problems. Within each unit, chapter tests are grouped according to health problems and include questions that are matched to the NCLEX-RN test plan. At the end of each chapter there is a section of questions about managing client safety and quality care. These questions are essential to test your understanding of important concepts about patient safety and quality. Because the test questions in this section are organized around health problems, this section is ideal for use when preparing for teacher-made or commercially-prepared tests that focus on specific content in your curriculum.

The third section of the book contains six comprehensive exams written to simulate the NCLEX-RN by placing test items in random order of content area. Each test presents a variety of situations commonly encountered in nursing practice, and includes test questions from all components of the NCLEX-RN test plan and all types of questions used on the licensing exam (except video and audio questions, which are found only on the CD).

## The CD-ROM

Additionally, this review package includes a CD-ROM with more than 1,300 questions. The CD-ROM will allow you to practice with audio and video questions, so be sure to use this feature of this Q&A Review Book.

The CD-ROM can be used in several ways. For example, you may take a test in the four content areas, arrange a test to present questions in random order, or select questions for particular review and practice. The program also enables you to print out test results to gauge your progress. The CD-ROM simulates the actual NCLEX-RN exam by formatting questions on a computer screen and requiring you to use the keyboard and mouse to enter answers to the questions. It also features a pop-up calculator for use

in answering questions that require you to calculate drug doses and drip rates for intravenous infusions.

## Using This Review Package for Preparing for Nursing Exams

We suggest that you begin your review by using the practice exams in the book to identify areas of strength and areas in which you need further study. Each exam contains specific questions written in the style of the NCLEX-RN. Answers include rationales for both correct and incorrect answer options to reinforce learning. You may wish to score the results of each practice test and identify areas in which you need further review. To evaluate your results after completing each exam, divide the number of your correct responses by the total number of questions in the test and multiply by 100. For example, if you answered 72 of 90 items correctly, you would divide 72 by 90 and multiply by 100, for a result of 80%. If you answered more than 75% of the items in an area correctly, you are most likely prepared to answer questions in that area on the NCLEX-RN. If you answered fewer than 75% of the questions correctly, you need to determine why. Did you answer incorrectly because of lack of content knowledge or because you did not read carefully? Use this information to guide your study.

After reviewing the specific content areas in the practice exams, take the comprehensive exams. These exams more realistically reflect the NCLEX-RN because each test presents a variety of situations commonly encountered in nursing practice and across all clinical disciplines. Underlying knowledge, skills, and abilities related to the basic sciences, fundamentals of nursing, pharmacology and other therapeutic measures, communicable diseases, legal and ethical considerations, and nutrition are included in items as needed to plan nursing care for individual clients or groups of clients. The comprehensive exams also include test items related to client safety and care quality.

Next, use the CD-ROM to simulate taking computerized adaptive tests. Note how the questions are presented on the computer screen, and practice answering questions without using a pencil. Use the diagnostic features of the CD-ROM to identify areas for further study and develop your own customized test for focused review.

And don't forget to check the online resources available at <http://thepoint.lww.com/Billings10e>. The study tips will provide you with a foundation to begin your exam preparation. The downloadable NCLEX questions can be put on your iPhone, allowing you to practice anytime and anywhere.



## Acknowledgments

This book has been developed with the expertise of a team of nationally recognized test item writers. Thanks to Desiree Hensel, Margie Hull, Leslie Milgrom, Lee Schwecke, Sharon Vinten, and Sandy Wood for developing questions to prepare students for test-taking success. Thanks also to the editorial staff at Lippincott Williams & Wilkins: Elizabeth Nieginski for launching this book and Bill Lamsback for guiding it to completion. Particular thanks goes

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**Diane M. Billings**, EdD, RN, FAAN  
*Chancellor's Professor Emeritus*  
Indiana University School of Nursing



## About the Author

Diane Billings, EdD, RN, FAAN, award-winning author and nursing educator, offers more than 35 years' experience teaching nursing from the associate through the graduate levels, with a special focus on the NCLEX-RN examination.

Dr. Billings' NCLEX experience includes developing and teaching NCLEX review courses, integrating computer-based licensing exam review programs into nursing curricula, and designing NCLEX test questions. A nationally recognized test-item writer, her NCLEX preparation books have helped thousands of students pass the NCLEX-RN exam.

The Chancellor's Professor of Nursing at Indiana University since 2002, Dr. Billings is the recipient of the National League for Nursing's Award for Outstanding Leadership in Nursing Education, the President's Award for Distinguished Teaching at Indiana University, and the Founders Award for Excellence in Teaching from Sigma Theta Tau, International. In addition to her best-selling NCLEX books, her book *Teaching In Nursing: A Guide for Faculty* won the 1998 AJN Book of the Year Award. She is a fellow in the American Academy of Nursing.

# Contents

## Part 1 ■ Introduction to the NCLEX-RN® Licensing Examination and Preparation for Test-Taking 1

### CHAPTER 1

The NCLEX-RN® Licensing Examination . . . . . 2

### CHAPTER 2

NCLEX-RN® Test Questions and Strategies for  
Answering Them . . . . . 10

### CHAPTER 3

How to Prepare for and Take the NCLEX-RN® and  
Other Nursing Exams . . . . . 22

## Part 2 ■ Practice Tests 29

### CHAPTER 1

The Nursing Care of the Childbearing Family . . . . 30

- Test 1: Antepartal Care 30
- Test 2: Complications of Pregnancy 61
- Test 3: The Birth Experience 87
- Test 4: Postpartal Care 119
- Test 5: The Neonatal Client 150

### CHAPTER 2

The Nursing Care of Children . . . . . 180

- Test 1: Health Promotion 180
- Test 2: The Child with Respiratory Health  
Problems 196
- Test 3: The Child with Cardiovascular and Hematologic  
Health Problems 213
- Test 4: The Child with Health Problems of the Upper  
Gastrointestinal Tract 227
- Test 5: The Child with Health Problems Involving  
Ingestion, Nutrition, or Diet 251
- Test 6: The Child with Health Problems of the Urinary  
System 262
- Test 7: The Child with Neurologic Health  
Problems 277
- Test 8: The Child with Musculoskeletal Health  
Problems 296
- Test 9: The Child with Dermatologic and Endocrine  
Health Problems 312

### CHAPTER 3

The Nursing Care of Adults with Medical and  
Surgical Health Problems . . . . . 321

- Test 1: The Client with Cardiac Health  
Problems 321
- Test 2: The Client with Vascular Disease 345
- Test 3: The Client with Hematologic Health  
Problems 369
- Test 4: The Client with Respiratory Health  
Problems 396
- Test 5: The Client with Upper Gastrointestinal Tract  
Health Problems 428
- Test 6: The Client with Lower Gastrointestinal Tract  
Health Problems 443
- Test 7: The Client with Biliary Tract Disorders 461
- Test 8: The Client with Endocrine Health  
Problems 477
- Test 9: The Client with Urinary Tract Health  
Problems 501
- Test 10: The Client with Reproductive Health  
Problems 522
- Test 11: The Client with Neurologic Health  
Problems 549
- Test 12: The Client with Musculoskeletal Health  
Problems 573
- Test 13: The Client with Cancer 603
- Test 14: The Client Having Surgery 640
- Test 15: The Client with Health Problems of the Eyes,  
Ears, Nose, and Throat 667
- Test 16: The Client with Health Problems of the  
Integumentary System 680
- Test 17: Responding to Emergencies, Mass Casualties,  
and Disasters 691

### CHAPTER 4

The Nursing Care of Clients with Psychiatric  
Disorders and Mental Health Problems . . . . . 698

- Test 1: Mood Disorders 698
- Test 2: Schizophrenia, Other Psychoses, and Cognitive  
Disorders 731
- Test 3: Personality Disorders, Substance-Related  
Disorders, Anxiety Disorders, and Anxiety-Related  
Disorders 761
- Test 4: Stress, Crisis, Anger, and Violence 798
- Test 5: Mental Health Problems of Children,  
Adolescents, and Families 820

**Part 3 ■ Postreview Tests 837**

Comprehensive Test 1	838
Comprehensive Test 2	876
Comprehensive Test 3	912
Comprehensive Test 4	947
Comprehensive Test 5	984
Comprehensive Test 6	1021

**Appendices 1063**

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PART

1

**Introduction to  
the NCLEX-RN®  
Licensing  
Examination and  
Preparation for  
Test-Taking**

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# 1

## The NCLEX-RN® Licensing Examination

### Overview

The National Council Licensure Examination for Registered Nurses (NCLEX-RNs®) is administered to graduates of nursing schools to test the knowledge, abilities, and skills necessary for entry-level safe and effective nursing practice. The examination is developed by the National Council of State Boards of Nursing, Inc. (NCSBN), an organization with representation from all state boards of nursing.<sup>1</sup> The same examination is used in all 50 states, the District of Columbia, and United States possessions. The exam is also administered at international test centers worldwide.<sup>1</sup> Students who have graduated from baccalaureate, diploma, and associate-degree programs in nursing must pass this examination to meet licensing requirements in the United States.

### The Test Plan

The NCSBN prepares the test plan used to develop the licensing examination. The test plan is based on an analysis of current nursing practice and the skills, abilities, and processes nurses use to provide nursing care.

#### Practice Analysis: The Foundation of the Test Plan

The NCLEX-RN test plan is based on the results of a practice analysis conducted every 3 years of the entry-level performance of newly licensed registered nurses and on expert judgment provided by members of the National Council's Examination Committee as well as a Job Analysis Panel of Experts.<sup>1, 2, 5</sup> The job analysis asks newly graduated nurses to rank the nursing activities that they perform on a regular basis. The questions used on the test plan, therefore, include those activities that nurses commonly perform. For example, the 2008 RN practice analysis revealed that nursing practice commonly involved activities such as preparing and administering medications, using rights of medication administration; ensuring proper identification of client when providing care; applying

principles of infection control (e.g., hand hygiene, room assignment, isolation, aseptic/sterile technique, universal/standard precautions); performing emergency care procedures (e.g., cardiopulmonary resuscitation, abdominal thrust maneuver, respiratory support, automated, external defibrillator); recognizing signs and symptoms of complications and intervening appropriately when providing client care; reviewing pertinent data prior to medication administration (e.g., vital signs, lab results, allergies, potential interactions).

Less commonly performed activities included providing care and/or support for a client with non-substance related dependencies; assisting client and staff to access resources regarding genetic issues; incorporating alternative/complementary therapies into client plan of care (e.g., music therapy, relaxation therapy), and performing post-mortem care.

The National Council of State Boards of Nursing also used the findings from the Practice Analysis activity statements to generate knowledge statements, the knowledge needed by newly licensed nurses to provide safe care.<sup>5</sup> The findings of this second report are used to inform item development for the NCLEX-RN examination.

#### Test Item Writers

Nurse clinicians and nurse educators nominated by the Council of State Boards of Nursing to serve as item writers write the test questions on the NCLEX-RN exam. Because the item writers come from a variety of geographical areas and practice settings, the test items reflect nursing practice in all parts of the country.

#### Test Plan Details

Test plans, or test blueprints, are developed to indicate the components and the relative weights of the components that will be tested on an exam. Because exams test both content (knowledge) and process (critical thinking, synthesis of information, clinical decision-making), test plans usually have two or three dimensions. The test plan for the NCLEX-RN addresses two components of nursing

**TABLE 1.1**  
**Test Plan Structure**

The framework of Client Needs was selected for the NCLEX-RN® examination because it provides a universal structure for defining nursing actions and competencies across all settings for all clients.

#### Client Needs

Four major categories of Client Needs organize the content of the NCLEX-RN Test Plan. Two of the four categories are further divided into a total of six subcategories that define the content contained within the two Client Needs categories. These categories and subcategories are:

- A. Safe, Effective Care Environment**
  - 1. Management of Care
  - 2. Safety and Infection Control
- B. Health Promotion and Maintenance**
- C. Psychosocial Integrity**
- D. Physiological Integrity**
  - 1. Basic Care and Comfort
  - 2. Pharmacological and Parenteral Therapies
  - 3. Reduction of Risk Potential
  - 4. Physiological Adaptation

#### Integrated Concepts and Processes

The following concepts and processes fundamental to the practice of nursing are integrated throughout the four major categories of Client Needs:

- **Nursing Process**
- **Caring**
- **Communication and Documentation**
- **Teaching/Learning**

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care: (1) client needs categories and (2) integrated processes, such as the nursing process, caring, communication and documentation, and teaching/learning. (See Table 1.1.) Representative items test knowledge of these components as they relate to specific health care situations in all of the four major areas of client needs. The questions developed for the test plan are written to test nursing knowledge and the ability to apply nursing knowledge to client situations.

#### Client Needs

The health needs of clients are grouped under four broad categories: (1) safe, effective care environment; (2) health promotion and maintenance; (3) psychosocial integrity; and (4) physiologic integrity. Two of these categories include subcategories of related and specified needs. (See Table 1.2.) The percentage of test items in each subcategory on the NCLEX-RN examination is shown in Figure 1.1.

Understanding the category of client needs is key (🔑) to recognizing the types of questions that are found on the licensing exam and the relative emphasis given to the category based on the percentage of questions from that category on the exam.

#### Integrated Processes

The NCLEX-RN test plan also is organized according to four integrated processes. These include the nursing process, caring, communication and documentation, and teaching/learning. (See Table 1.1 and Figure 1.1.)

#### The Nursing Process

The NCLEX-RN test plan includes questions from all steps of the nursing process. The five phases of the nursing process are: (1) assessment, (2) analysis, (3) planning, (4) implementation, and (5) evaluation.

**Assessment.** Assessment involves establishing a database. The nurse gathers objective and subjective information about the client, and then verifies the data and communicates information gained from the assessment.

**Analysis.** Analysis involves identifying actual or potential health care needs or problems based on assessment data. The nurse interprets the data, collects additional data as indicated, and identifies and communicates the client's nursing diagnoses. The nurse also determines the congruency between the client's needs and the ability of the health care team members to meet those needs.

**Planning.** Planning involves setting outcomes and goals for meeting the client's needs and designing strategies to attain them. The nurse determines the goals of care, develops and modifies the plan, collaborates with other health team members for delivery of the client's care, and formulates expected outcomes of nursing interventions.

**Implementation.** Implementation involves initiating and completing actions necessary to accomplish the defined goals. The nurse organizes and manages the client's care; performs or assists the client in performing activities of daily living; counsels and teaches the client, significant others, and health care team members; and provides care to attain the established client goals. The nurse also provides care to optimize the achievement of the client's health care goals; supervises, coordinates, and evaluates delivery of the client's care as provided by nursing staff; and records and exchanges information.

**Evaluation.** Evaluation determines goal achievement. The nurse compares actual with expected outcomes of therapy, evaluates compliance with prescribed or proscribed therapy, and records and describes the client's response to therapy or care. The nurse also modifies the plan, as indicated, and reorders priorities.

TABLE 1.2

**Categories and Subcategories of Client Needs****A. Safe, Effective Care Environment**

1. *Management of Care*—Providing and directing nursing care that enhances the care delivery setting to protect clients, family/significant others and health care personnel. Related content includes but is not limited to:

- Advance Directives
- Advocacy
- Case Management
- Client Rights
- Collaboration with Multidisciplinary Team
- Concepts of Management
- Confidentiality/Information Security
- Consultation
- Continuity of Care
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Information Technology
- Legal Rights and Responsibilities
- Performance Improvement (Quality Improvement)
- Referrals
- Supervision

2. *Safety and Infection Control*—Protecting clients, family/significant others and health care personnel from health and environmental hazards. Related content includes but is not limited to:

- Accident/Injury Prevention
- Emergency Response Plan
- Ergonomic Principles
- Error Prevention
- Handling Hazardous and Infectious Materials
- Home Safety
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Safe Use of Equipment
- Security Plan
- Standard Precautions/Transmission-Based Precautions/Surgical Asepsis
- Use of Restraints/Safety Devices

**B. Health Promotion and Maintenance**

The nurse provides and directs nursing care of the client and family/significant others that incorporates the knowledge of expected growth and development principles, prevention and/or early detection of health problems, and strategies to achieve optimal health. Related content includes but is not limited to:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Health and Wellness
- Health Promotion/Disease Prevention
- Health Screening
- High Risk Behaviors
- Lifestyle Choices
- Principles of Teaching/Learning
- Self-Care
- Techniques of Physical Assessment

**C. Psychosocial Integrity**

The nurse provides and directs nursing care that promotes and supports the emotional, mental, and social well-being of the client and family/significant others experiencing stressful events, as well as clients with acute and chronic mental illness. Related content includes but is not limited to:

- Abuse/Neglect
- Behavioral Interventions
- Chemical and Other Dependencies
- Coping Mechanisms

- Crisis Intervention
- Cultural Diversity
- End of Life Care
- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment

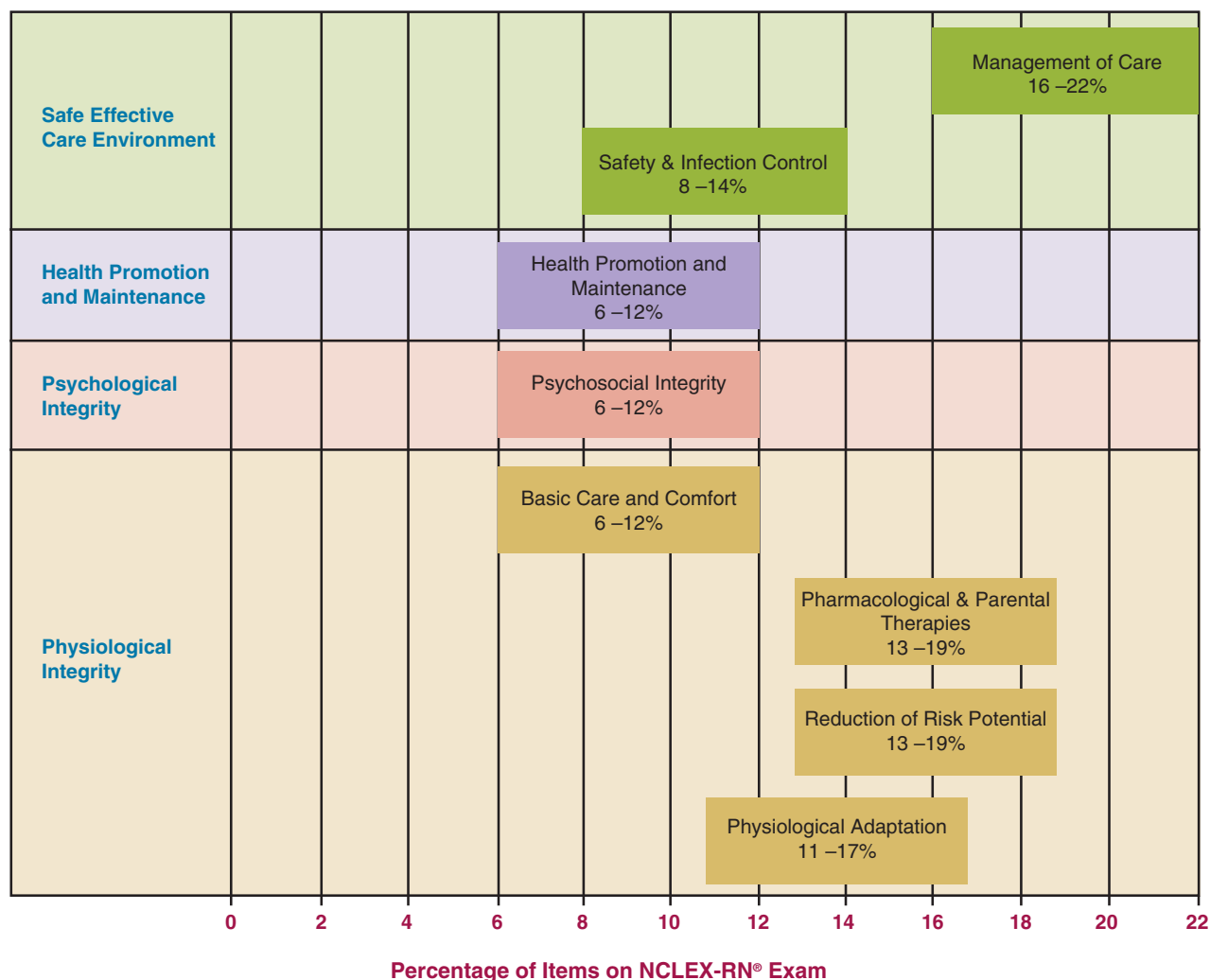
#### **D. Physiological Integrity**

The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential, and managing health alterations.

1. *Basic Care and Comfort*—Providing comfort and assistance in the performance of activities of daily living. Related content includes but is not limited to:
  - Assistive Devices
  - Elimination
  - Mobility/Immobility
  - Non-Pharmacological Comfort Interventions
  - Nutrition and Oral Hydration
  - Personal Hygiene
  - Rest and Sleep
2. *Pharmacological and Parenteral Therapies*—Providing care related to the administration of medications and parenteral therapies. Related content includes but is not limited to:
  - Adverse Effects/Contraindications/Side Effects/Interactions
  - Blood and Blood Products
  - Central Venous Access Devices
  - Dosage Calculation
  - Expected Actions/Outcomes
  - Medication Administration
  - Parenteral/Intravenous Therapies
  - Pharmacologic Agents/Actions
  - Pharmacological Pain Management
  - Total Parenteral Nutrition
3. *Reduction of Risk Potential*—Reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments, or procedures. Related content includes but is not limited to:
  - Changes/Abnormalities in Vital Signs
  - Diagnostic Tests
  - Laboratory Values
  - Potential for Alterations in Body Systems
  - Potential for Complications of Diagnostic Tests/Treatments/Procedures
  - Potential for Complications from Surgical Procedures and Health Alterations
  - System Specific Assessments
  - Therapeutic Procedures
4. *Physiological Adaptation*—Managing and providing care for clients with acute, chronic, or life-threatening physical health conditions. Related content includes but is not limited to:
  - Alterations in Body Systems
  - Fluid and Electrolyte Imbalances
  - Hemodynamics
  - Illness Management
  - Medical Emergencies
  - Pathophysiology
  - Unexpected Response to Therapies

**FIGURE 1.1**  
**Test Plan and Distribution of Content**

**Client Needs Categories**



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The five phases of the nursing process are equally important. Therefore, each is represented by an equal number of items on the NCLEX-RN and all are integrated throughout the exam. In this book, you will have opportunities to respond to questions involving all five steps of the nursing process.

### Caring

The caring process refers to interaction between the nurse, client, and family in a way that conveys mutual respect and trust. The nurse offers encouragement and hope to clients and their families while providing nursing care. Questions about the caring process are threaded throughout the licensing exam

to test the candidate's attitudes and values for caring for and about clients. In this book, you will have the opportunity to respond to questions that test your ability to apply the caring process in a variety of situations.

### Communication and Documentation

Another element of the licensing exam test plan evaluates the nurse's ability to communicate with clients, families, and health team members. The test also includes questions about documenting nursing care according to standards of nursing practice. In this book, you will be presented with questions that ask you to determine the most effective way to

communicate with clients, families, and other health professionals. You will also have the opportunity to respond to questions that require you to select the appropriate information to document or chart.

### Teaching/Learning

An important aspect of nursing care is to teach clients and their families about managing their own health status. Nurses also teach other members of the health care team. Questions in this book are designed to assist you in answering questions about the teaching and learning process for a variety of clients and health care team members.

## Exam Administration

### Computer Adaptive Testing

The NCLEX-RN is administered using computer adaptive testing (CAT) procedures. CAT uses the memory and speed of the computer to administer a test individualized for each candidate. When the examination begins, the computer randomly selects a question of medium difficulty. The next question is based on the candidate's response to the previous question. If the question is answered correctly, an item of similar or greater difficulty is generated; if it is answered incorrectly, a less-difficult item is selected. Thus, the test is adapted for each candidate. Once competence has been determined, the exam is completed at a passing level.

CAT has several advantages. For example, an exam can be given in less time because candidates potentially have to answer fewer questions. CAT exams also can be administered frequently, allowing a graduate of a nursing program to take the exam following graduation, receive the results quickly, and enter the work force as a registered nurse in less time than is possible with paper-and-pencil exams. Study results also show that, because CAT is self-paced, candidates undergo less stress.

Each NCLEX-RN test is generated from a large pool of questions (a test item bank) based on the NCLEX-RN test plan. The test item bank includes all types of questions, but an individual candidate may or may not receive each type of question, depending on the questions generated from the item bank for each candidate. The exams for all candidates are derived from the same large pool of test items. They contain comparable questions for each component of the test plan. Although the questions are not exactly the same, they test the same knowledge, skills, and abilities from the test plan. All candidates must meet the requirements of the test plan and achieve the same passing score. Each candidate, therefore, has the same opportunity to demonstrate competence. Although one candidate may answer fewer questions, all candidates have the opportunity

to answer a sufficient number of questions to demonstrate competence until the stability of passing or failing is established or the time limit expires.

All candidates must answer at least 75 test questions; the maximum number of questions is 265. Each exam also includes 15 “pretest” questions that are being tested for use on subsequent exams. Candidates cannot differentiate “pretest” items from operational items on the exam.

Six hours are available to each candidate for completing the test. This time includes an opportunity to review the online candidate tutorial about the test and to take rest breaks. Although some candidates may finish in a shorter time, others will use the entire 6 hours. The amount of time used during testing is not an indication of passing or failing the examination, but rather, reflects the time required to establish competence for each candidate.

### Scheduling the Examination

The first step you must take to schedule your NCLEX-RN exam is to apply to the state board of nursing in the state in which you plan to take the examination. After receiving confirmation from the state board of nursing that you have met their requirements, you will then receive an Authorization to Test (ATT). Registration for the exam with Pearson VUE ([pearsonvue.com/nclex](http://pearsonvue.com/nclex)) can be done by mail or online, and confirmation of registration should occur within several days, or immediately if done online. ATT is valid for a specified period of time; check with your state board of nursing for their specific requirements. After receiving the ATT, you can schedule an appointment to take the exam. Check for current information at the NCSBN web site ([www.ncsbn.org](http://www.ncsbn.org)) and the web site of your state board of nursing. (See the appendix for State and Territorial Boards of Nursing.) Scheduling to take the examination at an international test center requires additional steps and fees; consult the web site of the NCSBN for current information.

### Test Center Locations

The Council of State Boards of Nursing contracts with vendors in each state to serve as exam sites. Your school of nursing can inform you of the nearest location. You can also contact your state board of nursing for information. (See the appendix for State and Territorial Boards of Nursing for the address.) You can also find updated information from the NCSBN at its web site ([www.ncsbn.org](http://www.ncsbn.org)).

### Computer Use and Screen Design

Test questions are presented on the computer screen (monitor); you select your answer and use

the keyboard or a mouse to enter your answer. The CD-ROM included with this book simulates the NCLEX-RN and provides you with an opportunity to practice taking computer-generated examinations. At every testing site, written directions are provided at each computer exam station. There are also tutorials and practice questions on the computer that you can complete to be sure you understand how to use the computer before you begin the exam.

The computer used at the testing site has a drop-down clock that indicates elapsed time for taking the exam. This clock can be turned “off” or “on” depending on your preference. Some test-takers wish to watch the time as they take the test; others wish to monitor their time periodically. When the exam ends, there will be a message on the screen that indicates “Examination is ended.”

The computer used at the testing site also has a drop-down calculator. The calculator can be used to answer test items requiring calculation. You can use the mouse to drag the calculator to a position on the screen where it is most helpful to you.

### Exam Security

Each testing site maintains a high level of security for the exam and for the candidate. The exam is administered on a secured file server and uses password security and host site authentication. All exam sites use proctors and video/audio monitoring. Candidates are required to undergo identification verification, which includes showing a valid and recent photo ID (driver’s license or passport—passport required at international test centers) with signature (the name must match exactly the name on the Authorization to Test), fingerprint testing, or providing a digital signature. Some sites are also using a palm vein reader and/or other biometric tests. Check with your state board of nursing and the NCSBN for details about exam security in the jurisdiction in which you are taking the exam.

### Exam Confidentiality

The NCSBN takes significant steps to protect exam confidentiality. You will not be allowed to bring anything into the exam area, including cellular telephones, watches, handheld electronic devices or paper, or pen/pencil into the exam. While taking the exam, you are not allowed to give or receive test-taking assistance and you cannot review study materials during a break from the exam; a proctor will be monitoring these areas. Additionally, you will be asked to sign a confidentiality agreement that you will not share information about the test or the test items with others.

### Special Accommodations

Special accommodations for ADA candidates can be made with authorization from the individual state board of nursing and the NCSBN. To be eligible for special accommodations, the candidate must have a professionally recognized diagnosis and documentation with recent test results and evaluations. If approved, the accommodations will be noted on the ATT and implemented at the testing center. Check with your state board of nursing for additional information.

### The Test Center

Although each test center is configured differently, each center will have a small waiting area, a registration area, and a proctored testing area; lockers are provided for valuables. Since the waiting area is small, you should advise your friends and/or family to return to the test center when you have completed the exam.

You should arrive at the test center 30 minutes before you are scheduled to take the test. You should bring your Authorization to Test (ATT) and two forms of identification with you, one of which has photo identification. Leave all unnecessary items in your car or with friends or family. When you register at the test center, the test center staff will obtain your fingerprint and digital signature, and as available, a palm vein reading. At this time you will also lock any valuables and electronic devices in a locker. No watches, pencils, or cell phones will be allowed in the test taking area.

### Taking the Exam

Once you have entered the testing area and have settled comfortably at the desk, the proctor will turn the computer on. You may request ear plugs if the noise of other test-takers using the computers in the area is distracting. Each test area has an erasable note board with a marking pen which may be used to make notes or perform math calculations. Before the actual exam begins, there will be an online tutorial that gives you information about the exam and provides an opportunity to practice using the keyboard, mouse, and calculator. Previous computer experience is not necessary to take the NCLEX-RN exam.

You will begin the exam after completing the tutorial. The test questions are presented on the computer screen. You should answer each question; the next question will not appear until you have submitted an answer to the question on the screen. There is no penalty for guessing, but you should make a reasonable attempt to answer the question correctly.



As you progress through the test, pace yourself. You should answer the questions at a comfortable speed, not spending too much time on any one question. There is a clock on the computer which can be turned off or on. Some students prefer to turn the clock on periodically rather than watching the time on the clock and feeling rushed. The clock will appear during the last 5 minutes of the test. You may take a break as needed. The proctor will escort you to the restroom; biometric identification (fingerprint, palm vein reading) will be obtained on your return to the computer desk.

Once you have answered a sufficient number of questions to determine if you have passed or failed the test, or if the allotted time (6 hours) has ended, the exam will end. You will be asked to take a survey about the test experience following the exam, and when you are finished you can raise your hand to indicate to the proctor that you are finished. The proctor then will collect all items at the desk and escort you to the exit.

### Results Reporting

Computerized testing allows timely reporting of examination results. The results of the examination are first reviewed at the testing site and then forwarded to the state board of nursing within 8 hours. Results are reported to the candidate within 2 weeks. Some jurisdictions have “quick results” services; for a fee, the candidate can obtain “unofficial” results by internet or a 900 number telephone call.

The exam can be retaken within 45 days. Check with your state board of nursing for details. (See the appendix for a listing of state boards of nursing.)

### When to Take the NCLEX-RN®

Recent research indicates that candidates should take the exam within 6 months of graduating.<sup>5</sup> You should, therefore, plan your own schedule to be prepared to take the NCLEX-RN exam as soon after graduation as is possible. Suggestions for

developing a study plan are discussed in Chapter 2 of this book.

### Additional Information

For further information about the NCLEX-RN, the test plan, test questions, or exam format, visit the NCSBN web site at [www.ncsbn.org](http://www.ncsbn.org) or write to the NCSBN. For information about the dates, requirements, and specifics of writing the examination in your state, contact your state board of nursing. The addresses and telephone numbers of the NCSBN and each state board of nursing are provided in the appendix. Information can also be obtained from the vendor who has contracted to provide the testing center for the NCLEX-RN exam. The current vendor is PearsonVue, and information can be found at their web site ([www.pearsonvue.com/nclex](http://www.pearsonvue.com/nclex)).

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# 2

## NCLEX-RN® Test Questions and Strategies for Answering Them

The test questions used on the NCLEX-RN exam are written to test the knowledge, skills, and abilities essential to provide safe client care. Understanding the types of questions, the cognitive level of the questions, as well as the thinking processes used to answer the questions is essential for test success. This chapter provides information about the test items used on the NCLEX-RN exam and offers strategies for answering questions for various types of test items and levels of the cognitive domain.

### Types of Test Items

The NCLEX-RN examination uses eight types, or formats, of test items.<sup>1</sup> These include multiple-choice items and seven alternate item formats: multiple-response, fill-in-the-blank (calculation), hot-spot, chart/exhibit, drag-and-drop/ordered-response, graphic options, and audio. Video inclusion items are being evaluated for use by the National Council of State Boards of Nursing<sup>2</sup> and are included on the CD that accompanies this book as an additional way for you to develop your critical thinking and test taking skills.

Although each type of item tests your understanding of nursing content and is developed using the same test development process, each type of test item requires you to respond in a different way. Because alternate item formats test knowledge, skills, and abilities in a variety of ways, there are increased opportunities for you to demonstrate your competence.<sup>3</sup> All test item types are scored as either correct or incorrect; no partial credit is awarded for any question type ([www.ncsbn.org](http://www.ncsbn.org)).

All eight types of test items and video inclusion test questions are used in this review book and CD-ROM to give you the opportunity to learn how to answer each type of question. You can also find examples of these types of questions on the NCSBN web site ([www.ncsbn.org](http://www.ncsbn.org)), in the candidate tutorial that precedes each licensing exam at the PearsonVue web site ([www.pearsonvue.com/nclex](http://www.pearsonvue.com/nclex)), and in the candidates' bulletin that you will receive prior to taking the licensing exam.

### Multiple-Choice Item

Multiple-choice items include a scenario/situation, a question, and four answers, only *one* of which is correct. (See Figure 2.1) The scenario provides information about the client or care management situation. The question (stem) poses the problem to solve. The question may be written as a direct question, such as “What should the nurse do **first**?” or as an incomplete sentence, such as “The nurse should...” The answers (options) are possible responses to the stem. Each stem has one correct option and three incorrect options. The options may be written as complete sentences or may complete the sentence stem stated in the question. Multiple-choice items are the most common type of test item used on the licensing exam.

FIGURE 2.1

### Sample Multiple-Choice Item

**112.** While caring for a 24-year-old primigravid client scheduled for emergency surgery because of a probable ectopic pregnancy, the nurse should:

- 1. Prepare to witness an informed consent for surgery.
- 2. Assess the client for massive external bleeding.
- 3. Explain that the fallopian tube can be salvaged.
- 4. Monitor the client for uterine contractions.



### Strategies for Answering Multiple Choice Questions

- Read the scenario and relate the question and answers to the data provided in the scenario. Pay particular attention to information about the client's age, family status, health status, ethnicity, or point in the care plan (e.g., early admission versus preparation for discharge).
- Answer the question before looking at the possible answers.

- Choose the answer that best matches the answer you first thought was correct.
- Recognize that only ONE answer is correct.
- Double check your answer to be sure you have responded to the question; note particularly key words such as **first, except, not, most, last**; be sure that you are basing your answer on best nursing practice, not experience with one client or in a particular clinical agency.

### Multiple-Response Item

Multiple-response items are similar to multiple-choice items, except that they include four or more answers and have *one or more* correct answer(s). (See Figure 2.2.) These questions will ask you to identify all of the answers that are correct (“Select all that apply.”). At least one of the answers will be incorrect, and thus you will not ever check all of the answers to a multiple-response question. Multiple-response questions will be scored as being either correct or incorrect; no partial credit is given for selecting some of the correct responses.

**FIGURE 2.2**

#### Sample Multiple-Response Item

- 74.** A primigravid client at 32 weeks’ gestation is enrolled in a breast-feeding class. Which of the following statements indicate that the client understands the breast-feeding education? Select all that apply.
- 1. “My milk supply will be adequate since I have increased a whole bra size during pregnancy.”
  - 2. “I can hold my baby several different ways during feedings.”
  - 3. “If my infant latches on properly, I won’t develop mastitis.”
  - 4. “If I breast-feed, my uterus will return to prepregnancy size more quickly.”
  - 5. “Breast milk can be expressed and stored at room temperature since it is natural.”
  - 6. “I need to feed my baby when I see feeding cues and not wait until she is crying.”

When using the text pages in this book to answer the multiple-response questions, you can make check marks in the boxes located in front of the answers. When using the CD that accompanies this textbook and on the actual NCLEX-RN exam you will place your cursor on the box in front of the answer you wish to select and click on the box; a check mark will appear indicating that you wish to select that answer. To change an answer you can use the mouse to remove the check mark from that box.

### Strategies for Answering Multiple-Response Questions

- Read the question carefully and determine what it is you are to select, for example all possible side effects of a particular drug; all intended outcomes of a particular nursing intervention; all of the elements of a teaching plan for a client with a particular health problem; all instructions a nurse should give to a client who is being discharged.
- Consider how the answers are “clustered” and how the correct answers are related.
- Be sure you have selected ALL of the possible correct answers.
- Double check your answer by reviewing the answers you did NOT check and be sure they are incorrect and should not be included in the answer.

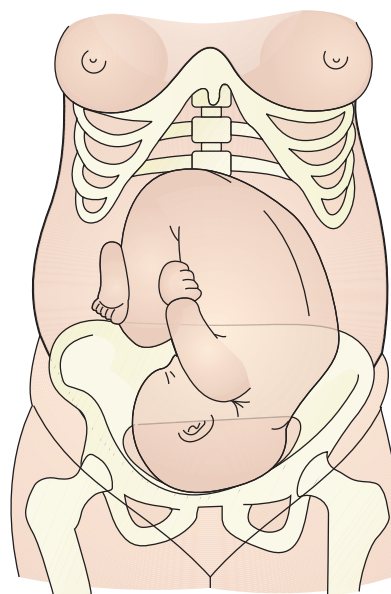
### Hot-Spot Item

Hot-spot items involve identifying the location of a specific item, such as an appropriate injection site, assessment area, or correct part of a waveform. The question will be phrased, “Identify the location.....” or “Select the area,,,,,,” (See Figure 2.3.)

**FIGURE 2.3**

#### Sample Hot-Spot Item

- 60.** The nurse performed Leopold’s maneuvers and determined that the fetal position is LOA. Identify the area where the nurse would place the Doppler to most easily hear fetal heart sounds.



When answering hot-spot questions in the book, you should place an X on the illustration provided to identify the proper area and then refer to the answer section for that chapter to confirm your response. On the actual NCLEX-RN and on the CD-ROM accompanying this book, you will use the mouse to move your cursor over the area you want to select and then left-click the area. A red “X” will appear over the area you have selected. If you make an error, you can move the cursor to the part of the figure that is the answer you wish to enter.

### Strategies for Answering Hot-Spot Questions

- Read the question carefully, and answer the question first by visualizing an answer; then look at the figure to mark your answer.
- Double check your answer to make sure you have selected the correct “spot” based on evidence for best nursing practice.

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

Fill-in-the-blank items involve calculations, such as determining a drug dose, calculating an I.V. drip rate, or totaling intake-output records. (See Figure 2.4.) These items can be answered with a number. On the NCLEX exam, if you do not enter a number, you will receive an error message that will prompt you to “enter a numeric answer.” When an answer includes a measurement amount such as milliliters (ml), grams (g), or inches, the measurement unit will be stated in the stem of the question and supplied in the answer box, thus you will not include the unit of measure as part of your answer. The question will indicate if you are to round your answer and, if so, to how many decimal places.

**FIGURE 2.4**

#### Sample Fill-in-the-Blank Item

**47.** A client at 28 weeks’ gestation in premature labor was placed on ritodrine (Yutopar). To maintain the pregnancy, the physician orders the client to have 10 mg now, 10 mg in 2 hours, and then 20 mg every 4 hours while contractions persist, not to exceed the maximum daily oral dose of 120 mg. At what time will the client have reached the maximum dose if she begins taking the medication at 10:00 a.m. and follows the physician’s order?

\_\_\_\_\_ a.m.

When answering fill-in-the-blank questions on the text pages of this book you can use paper and pencil, a handheld device with a calculator, or a calculator to determine your answers. However, in the CD that accompanies this book and on the actual NCLEX-RN exam, a drop-down calculator will be available for you to use to calculate your answers. The division sign used is similar to the one used on the Microsoft Calculator (/); be sure to familiarize yourself with the mathematical function keys. To practice calculations required for fill-in-the-blank questions, use the calculator on your computer.

### Strategies for Answering Fill-in-the-Blank Questions

- Determine what calculation the question is asking you to perform (add, subtract, use a formula).
- Use the erasable note board provided at the testing station, the drop-down calculator, or another type of calculator or paper and pencil to perform the appropriate mathematical function.
- To avoid calculation errors, be sure that you do not enter numbers rapidly when you are using the calculator.
- Round the numbers, as directed, to one or two decimal points; round the number after completing the calculation. If rounded numbers are required to answer the question, the decimal point must be included in the answer.
- Place your answer in the appropriate line.
- Double check your answer using a logic test—is this answer plausible? Did I perform the correct mathematical function? Is the answer appropriate for the unit of measure required in the question?

### Chart/Exhibit Item

Chart/exhibit items present data from a chart, graph, or table. Data from a client’s chart will be presented from one or more chart “tabs” such as: prescriptions/orders, history and physical, laboratory results, miscellaneous reports, imaging results, flow sheets, intake and output, medication administration record, progress notes, and vital signs. (See Figure 2.5.) On the actual NCLEX-RN exam, you will be prompted to “Click on the exhibit button below for additional client information.” You will then use the data presented in the scenario and on the chart or exhibit to make a nursing decision. For example, you will click on up to three tabs to locate data and then you will interpret the data, validate if the data are correct or sufficient, and then be asked to respond to a question based on the data.

**FIGURE 2.5**  
**Sample Chart/Exhibit Item**

**80.** A 7-year-old has had an appendectomy on November 12. He has had pain for the last 24 hours. There is an order to administer Tylenol with Codeine every 3 to 4 hours as needed. The nurse is beginning the shift and the child is requesting pain medication. The nurse reviews the chart below for pain history. Based on the information in the chart, what should the nurse do next?

- 1. Administer the Tylenol with Codeine.
- 2. Distract the child by giving him breakfast.
- 3. Instruct the child to take deep breaths and blow his pain away.
- 4. Assess the child again in 1 hour.

Nurses Progress Notes		
Date	Time	Progress Notes
11/12/07	03:00 pm	Tylenol with Codeine given PO. FACES pain scale changed from 5 to 2 within 15 minutes
11/12/07	06:00 pm	Tylenol with Codeine given PO. FACES pain scale changed from 5 to 2
11/12/07	09:30 pm	Tylenol with Codeine given PO. FACES pain scale changed from 5 to 2
11/13/07	01:00 am	Tylenol with Codeine given PO. FACES pain scale changed from 4 to 1
11/13/07	07:00 am	Client rates pain on FACES pain scale as 4

In this book and on the accompanying CD-ROM, chart/exhibit questions show data on 1 or 2 “tabs” and then ask you to use the data to respond to the question. When these types of questions are administered by the computer (as in the NCLEX-RN exam), you may be asked to determine which “tab” to use to locate the information that is required to answer the question and you will click on the tab to open the tab(s) and a “pop-up” window will appear on the computer screen.

### Strategies for Answering Chart/Exhibit Questions

- Read the scenario and question carefully to understand the context for the data to be provided in the chart or exhibit. For example, are you looking for vital signs? Would an elevated pulse or drop in blood pressure be consistent with the context of the question and provide data for making a nursing decision?
- Read the information provided on the chart or exhibit and identify the information that is essential to answer the question.
- Review the chart or exhibit “pop-up box” as many times as needed.
- If necessary, take notes on a scratch pad (one will be provided at the testing center).
- Answer the question only from data provided in the chart or exhibit and from the data presented in the scenario.
- Double check your answer by being sure you have obtained all of the data necessary to answer the question and that the answer is complete and plausible.

### Drag-and-Drop/Ordered-Response Item

Drag-and-drop/ordered-response items require you to place information in a specified order. (See Figure 2.6.) For example, the question might ask you to put steps of a procedure in order, or provide information about several clients, and ask you to determine the order of priority in which each client should receive nursing care. Or the question may ask you the order in which to teach a client about a procedure or self-care process. There may be up to 6 options to arrange in a specific order. The questions will be scored as correct or incorrect; there is no “partial credit” for having part of the answer in the correct order.

When answering drag-and-drop/ordered-response items in the text of this book, you will simply write the answer options in their correct order in the blank spaces provided in the answer column. On the actual licensing exam, you will drag each response from the left-hand column and drop it into the correct order on the right-hand column. You can move the items around until you have them in the correct order and then click “submit” to enter your answer. If you need to change your answer, you can drag the response to another position and reorder the responses. The CD-ROM that accompanies this book functions in much the same way, except that you will click on “Next” to proceed to the next question.

FIGURE 2.6

**Sample Drag-and-Drop/Ordered-Response Item**


**73.** A neonate born at 29 weeks' gestation received nasal continuous positive airway pressure. The neonate is receiving oxygen at 1 L/minute via nasal cannula at a fraction of inspired oxygen ( $F_{IO_2}$ ) of 0.23. The pulse oximetry reading is 70% saturation. In which order of priority from first to last should the nurse take these actions?

1. Increase the  $F_{IO_2}$ .

2. Make sure the pulse oximeter is correlating to the heart rate.

3. Assess the neonate for color.

4. Assess the neonate for respiratory effort.


 **Strategies for Answering Drag/Drop Ordered Response Questions**

- Read the key words in the stem of the question that indicate the order in which you are to place the answers (usually from first to last).
- Test the logic of your answer.
- Be sure all items have been placed.
- Double check your answer by reviewing the correct order for the answers and that you have placed your answers in the order in which you intend to answer the question. One answer out of order will cause the question to be counted as incorrect.

**Graphic Option Item**

Although graphics can be used as a part of the question (See Figure 2.13.), with graphic option items the *answers* to these questions are presented as a graphic. (See Figure 2.7.) Graphic option items use graphics (figures, illustrations, photos) in the answers to the questions. You will need to select the correct answer(s) from the graphic options offered as possible answer(s) to the question.

FIGURE 2.7

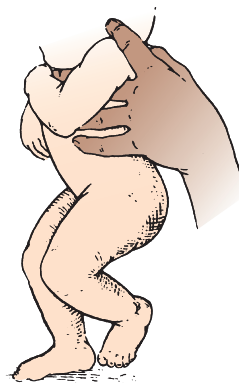
**Sample Graphic Option Item**

**19.** The nurse is to assess a newborn for incurving of the trunk. Which illustration indicates the position in which the nurse should place the newborn?

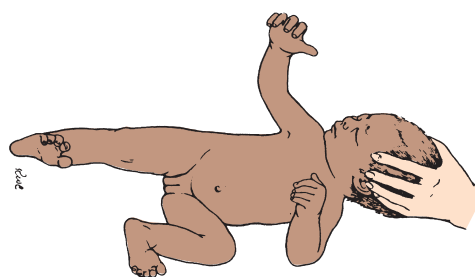
1.



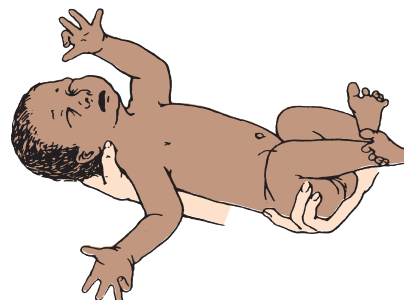
2.



3.



4.



In the text of this book, you can use your pencil to mark the correct answer to a graphic option question. On the CD that accompanies this book and on the actual NCLEX-RN exam you will click on the circle in front of the graphic that represents your answer. To change your answer, click on another circle.

### Strategies for Answering Graphic Option Questions

- Read the question carefully and visualize the answer before looking at the options presented with the test item.
- Look carefully at each graphic option and be certain you understand the differences among the options.
- Select the option that best answers the question.
- Double check your answer by reviewing the question, answering the question based on best nursing practice, and matching the answer to the graphic option.

### Audio Item

Audio items include a short audio clip with data that are essential to answer the question. (See Figure 2.8 for an example of how a question is written; to hear the audio clip use the CD that accompanies this book.) For example, you could be asked to listen to breath sounds, heart sounds, bowel sounds, or verbal interactions. The question will indicate that you should click on the play button to listen to the audio clip. You will be able to play the audio clip as many times as needed to

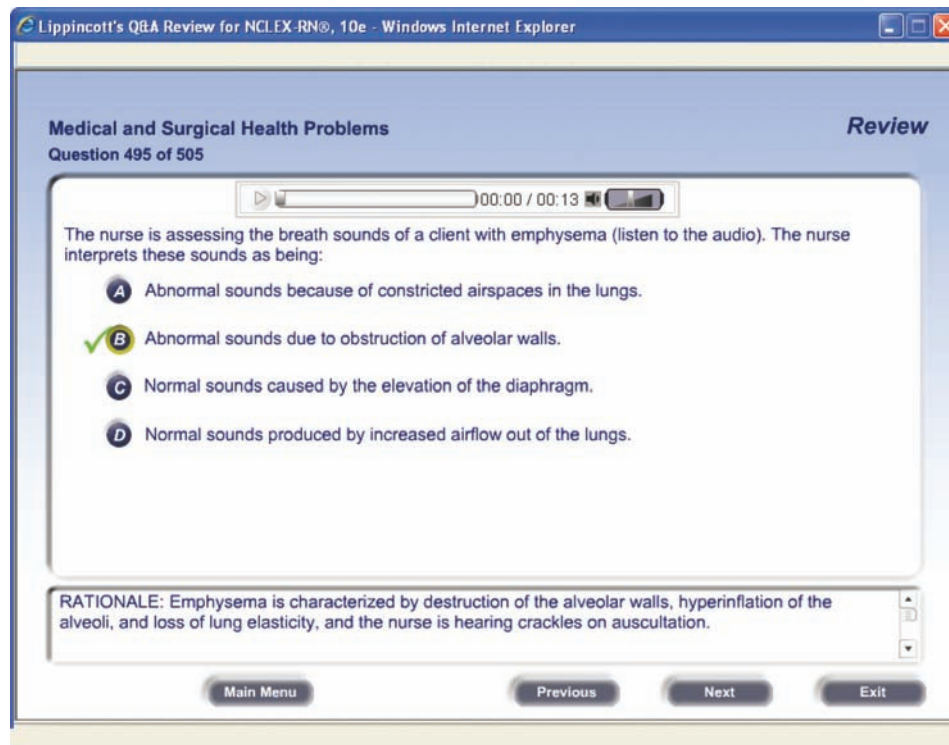
answer the question. The question may ask you to identify the sound on the audio clip, for example type of breath sound, or you may be asked to make a nursing judgment and/or select a nursing action based on your interpretation of the sound.

In this review book, the audio questions are presented on the CD that accompanies this textbook. You will be able to listen to the sounds and choose the correct answer. When taking audio test questions on the actual NCLEX-RN exam you will have headphones to use and you will be able to adjust the volume.

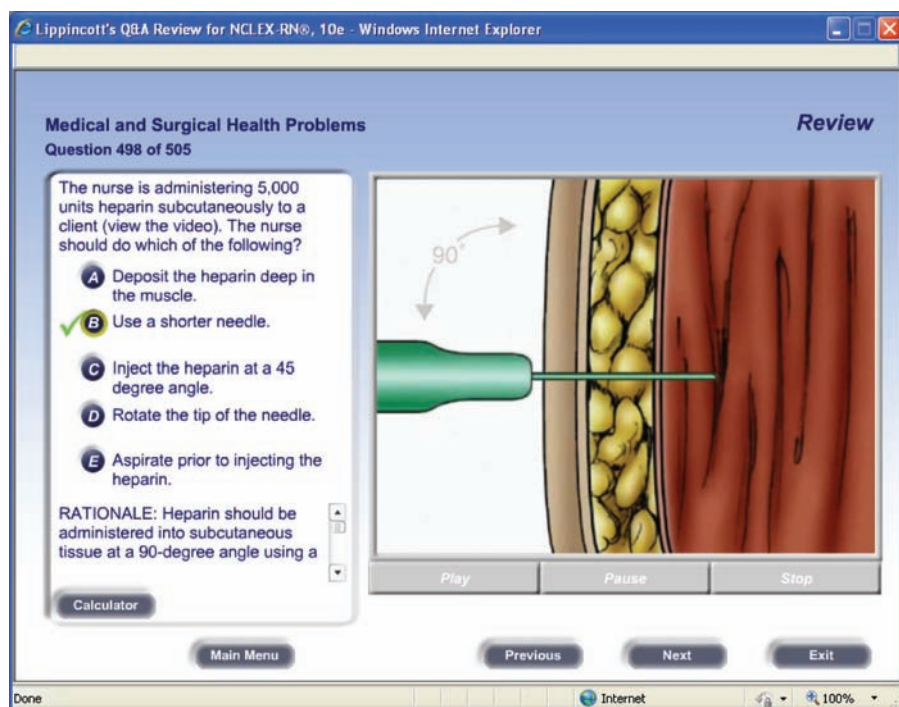
### Strategies for Answering Audio Questions

- Read the test item carefully to understand the clinical context in which the scenario occurs.
- Listen to the audio clip before answering the question; listen to the audio clip as many times as needed to answer the question.
- Relate the sounds in the audio clip to the scenario in the test item; if the question asks you to make a nursing decision or select a nursing action, base your answer on your interpretation of the sound and best nursing practices.
- Double check your answer by reviewing the question and answering the question based on best nursing practice.

**FIGURE 2.8**  
**Sample Audio Item**



**FIGURE 2.9**  
**Sample Video Item**



### Video Item

Video items use video clips to present a clinical situation or to demonstrate a procedure. The question will be based on information you have viewed in the video clip. Video items in this book are *only* found on the CD. (Figure 2.9 shows how video questions are *written*; refer to the CD for an *actual* example of a video item.)

### Strategies for Answering Video Items

- Read the question carefully to understand the clinical context of the question.
- Anticipate what the video clip will show, what you should pay particular attention to when you are watching the clip, and how the question relates to what is being shown in the video clip.
- Play the video clip as often as you need to view the action; look for actions that are correct or not correct.
- Double check your answer by comparing the video clip and the answer options and selecting the option that represents best nursing practices.

### Cognitive Levels of Test Items

The cognitive level of questions refers to the type of mental activity such as critical thinking, and clinical reasoning required to answer the question. The cognitive levels used to write test items for the NCLEX-RN are derived from the original Bloom's taxonomy and the Bloom's revised taxonomy of the cognitive domain.<sup>4,5</sup> (See Table 2.1.) The lowest level of the taxonomy is the *knowledge* (or *remember*) level and involves the ability to remember or recall facts. The next level of the cognitive domain, *comprehension* (or *understand*) requires you to interpret, explain, or understand the knowledge. The *application* (or *apply*) level involves using information that you remember and understand and can apply in new situations. *Analysis* (or *analyze*) requires recognizing and differentiating relationships between parts and using clinical reasoning and critical thinking skills. *Synthesis* (or *synthesize*) refers to the ability to take several pieces of information or clinical data and use them to make a nursing care judgment or decision. The next level



TABLE 2.1

**Levels of the Cognitive Domain**

- Knowledge/Remember:** Recognizing, recalling
- Comprehension/Understand:** Interpreting, exemplifying, classifying, summarizing, inferring, comparing, explaining
- Application/Apply:** Executing, implementing, using knowledge appropriately in new or different situations
- Analysis/Analyze:** Differentiating, organizing, attributing
- Synthesis/Synthesize:** Putting parts together to form a whole; using data from several sources to form a conclusion or make a decision
- Evaluation/Evaluate:** Checking, critiquing, judging against standards or protocols
- Creation/Create:** Generating, planning, producing

of the cognitive domain is *evaluation* (or *evaluate*). Here you must check data, critique information, or judge the outcome of nursing care. The final level of the cognitive domain is *creation* (or *create*). At this level, you must be able to generate new approaches to nursing care or develop a unique nursing care plan based on available information.

Test items can be written to test at all levels of the cognitive domain, but questions that are written for the NCLEX-RN exam are generally written at application levels and above because nursing requires the ability to apply knowledge to clinical situations, analyze data, think critically, prioritize information, make clinical decisions for client care, evaluate outcomes of nursing interventions or health care treatments, and create care plans based on specific client needs. This book presents questions at the application level and higher.

Clinical reasoning refers to the higher order mental activities and critical thinking skills used to solve a problem or make a decision. Nurses use clinical reasoning, critical thinking, critical synthesis, clinical decision making, and make clinical judgments to provide safe client care. Understanding the types of test items written at various levels of the cognitive domain and strategies to answer them is key (🔑) to success on the licensing exam. Examples of questions at higher levels of the cognitive domain are provided here to assist you in further understanding the types of questions used on the licensing exam and the strategies you can use to answer them. A summary of the cognitive levels, with examples of question stems and strategies for answering them, is given in Table 2.2.

**Application Level Item**

Application level items test your ability to apply knowledge to a specific scenario. These questions draw on your ability to know and understand nursing content, and to then apply this information to a specific scenario or situation. (See Figure 2.10.)

FIGURE 2.10

**Sample Application Level Item**

**81.** The nurse is to administer Polycillin (ampicillin) 500 mg orally to a client with a ruptured appendix. The nurse checks the capsule in the client's medication box which is located inside of the client's room. The dosage of the medication is not labeled, but the nurse recognizes the color and shape of the capsule. The nurse should next:

- 1. Administer the medication to maintain blood levels of the drug.
- 2. Ask another registered nurse to verify that the capsule is ampicillin.
- 3. Contact the pharmacy to bring a properly labeled medication.
- 4. Notify the unit manager to report the problem.

**Strategies for Answering Application Level Questions**

- Read the question and consider what information you already know and how that information should be used to answer this particular question.
- Consider how information you can recall should be applied to nursing care for the client that is described in the scenario for the question.
- Apply known formulas (divided dose/drip rate calculation), frameworks (for example Maslow's hierarchy, developmental stages, stages of moral development), and procedural steps (how to administer a particular medication) to answer the question posed in the new clinical situation (scenario).
- Double check your answer by recognizing what information you are applying to answer the question.

**TABLE 2.2**  


### Keys to Answering Test Questions from Various Levels of the Cognitive Domain

Cognitive Level	Descriptions	Examples of Question Stems	Strategies for Answering Questions
Application	<p>Transfer knowledge from classroom to clinical practice.</p> <p>Use a formula or guidelines to perform calculations.</p> <p>Apply knowledge and understanding to new situations.</p>	<p>To assess the breath sounds for a client with heart failure, where should the nurse place the stethoscope?</p> <p>The client is to receive 1,000 ml of fluids in 8 hours. The intravenous administration set delivers 15 drops per minute. The nurse should regulate the infusion to provide how many ml per minute?</p> <p>Which nursing intervention is appropriate for this client?</p>	<p>Use knowledge and understanding of how to auscultate breath sounds to assess a particular client.</p> <p>Apply appropriate formula to calculate an intravenous fluid drip rate.</p>
Analysis	<p>Organize clinical data into relevant parts in order to make a nursing diagnosis, form a conclusion, or make a clinical decision.</p> <p>Review all data to determine if sufficient data are available to make a decision.</p> <p>Analyze data to determine priorities.</p> <p>Distinguish relevant from irrelevant data.</p> <p>Determine what data are needed to plan or implement care.</p>	<p>The nurse should instruct the client about which of the following side effects that may occur when the client takes this drug? Select all that apply.</p> <p>The nurse is teaching a client to use a metered-dose inhaler. In which order should the nurse instruct the client about the steps to take to use the inhaler?</p> <p>Based on the clinical assessment, the nurse should formulate which nursing diagnosis?</p> <p>Which of the following (data) indicates the need for (nursing action)?</p> <p>Which client should the nurse care for <b>first</b>?</p> <p>Which (data) indicate the nurse should assess the client further?</p> <p>Based on these findings, the nurse determines the client is in xxxx stage of development.</p> <p>Which client is at risk for xxx?</p>	<p>Use knowledge and understanding about nursing interventions and apply to the client's particular situation.</p> <p>Apply knowledge and understanding about drug side effects to instruct a particular client</p> <p>Use knowledge and understanding of correct order of a skill or procedure to teach a particular client.</p> <p>Review the client's signs and symptoms to determine an appropriate nursing diagnosis.</p> <p>Analyze data to determine which nursing action to take next.</p> <p>Organize information about a group of clients and determine which client requires nursing care first.</p> <p>Analyze data and determine if additional data are needed.</p> <p>Analyze data/findings and determine appropriate stage (of development).</p> <p>Analyze data about a group of clients with risk factors and determine client's risk.</p>

<p>Synthesis</p>	<p>Assemble information from several sources to determine the best course of action.</p>	<p>After reviewing (data from the client and the chart), the nurse should <b>first</b>?</p> <p>Based on this information (about side effects of medication) and the client's current health status the nurse should instruct the client to xxxx?</p> <p>After assessing the client, the nurse reviews the physician orders. The nurse should do which of the following <b>first</b>?</p> <p>After reviewing the client's rhythm strip, pain medication record, and vital signs chart, the nurse should next?</p> <p>Which of the following indicates the nurse's <b>best</b> response to the child's parent?</p> <p>Which statement indicates the client has understood the nurse's teaching?</p> <p>Which of the following indicate the intended therapeutic effect has occurred?</p> <p>The nurse is observing an unlicensed nursing personnel turn a client. Which of the following indicates the nurse should intervene?</p> <p>The nurse has administered nitroglycerin to a client with chest pain. In 30 seconds the client's chest pain should be?</p> <p>Which should be included in a discharge plan for the client? Select all that apply.</p> <p>Which of the following nursing interventions best meet this client's needs?</p> <p>The nurse is planning care for 6 clients. The staffing for the team includes 1 registered nurse and 1 nursing assistant. Which of the following clients should be assigned to the nursing assistant? Select all that apply.</p> <p>The nurse is gathering information for a "hand off" for transferring the client from one nursing unit to another. The nurse should include which of the following information in the report. Select all that apply.</p>
<p>Evaluation</p>	<p>Make judgments about the effectiveness of nursing care.</p> <p>Use standards of care to determine the extent to which the client has met them.</p> <p>Critique care given by others.</p>	<p>Use information from a variety of appropriate sources such as the client, client responses to medical and nursing interventions, laboratory data, diagnostic tests progress notes to determine appropriate nursing action.</p> <p>Determine if the client understands the instructions based on the criteria established in the teaching plan.</p> <p>Evaluate effectiveness of a nursing intervention, drug, or treatment based on the intended or expected outcome.</p> <p>Evaluate appropriateness of care given by others according to standards of care and knowledge of scope of practice.</p> <p>Judge effectiveness of outcome of a nursing action (administering a drug) based on expected therapeutic effect.</p> <p>Develop a discharge plan.</p>
<p>Creation</p>	<p>Create or develop a unique or individualized plan, report, or protocol based on client needs.</p>	<p>Individualize a standardized care plan for a specific client.</p> <p>Create a care management plan for a group of clients and team of health care professionals.</p> <p>Create a detailed report about the client's health status.</p>

### Analysis Level Items

Questions at this level ask you to analyze data, clusters of symptoms, implementation plans, and then make nursing diagnoses and clinical decisions. These questions can also ask about what additional information should be obtained to make a clinical decision, plan care, or make a nursing diagnosis. (See Figure 2.11.)

**FIGURE 2.11**  
**Sample Analysis Level Item**

- 14.** An 8-month-old infant is seen in the well-child clinic for a routine checkup. The nurse should expect the infant to be able to do which of the following? Select all that apply.
- 1. Say “mama” and “dada” with specific meaning.
  - 2. Feed self with a spoon.
  - 3. Play peek-a-boo.
  - 4. Walk independently.
  - 5. Stack two blocks.
  - 6. Transfer object from hand to hand.

#### Strategies for Answering Analysis Level Questions

- Identify the data presented in the scenario that lead you to draw a conclusion or make a nursing diagnosis.
- Identify how the parts are related and how the nurse should assemble them to make a complete care plan.
- Determine if you have sufficient information to make a decision.
- Review data from all sources possible (client’s vital signs, client’s responses to medication and treatments, chart information, client assignment list, etc.)
- Double check your answer by determining that you have understand all of the components of care and have made the correct nursing decision based on those components.

### Synthesis Level Items

Synthesis level test items ask you to use several pieces of information to make a clinical decision.

The focus here is on obtaining sufficient information to make a clinical decision, rather than analyzing data already available. The information may come from the client/family or members of the health care team. In synthesis level items, you must determine accuracy and usefulness of information for the particular situation, sort relevant data from irrelevant data, and use it to plan or give nursing care. (See Figure 2.12.)

**FIGURE 2.12**  
**Sample Synthesis Level Item**

- 9.** The nurse is reviewing the laboratory report with the client’s lithium level taken that morning prior to administering the 5 p.m. dose of lithium. The lithium level is 1.8 mEq/L. The nurse should:
- 1. Administer the 5 p.m. dose of lithium.
  - 2. Hold the 5 p.m. dose of lithium.
  - 3. Give the client 8 oz (236 ml) of water with the lithium.
  - 4. Give the lithium after the client’s supper.

#### Strategies for Answering Synthesis Level Questions

- Read the question to determine what information is necessary to provide safe client care.
- Determine if you have sufficient and accurate information.
- Interpret all data obtained in context of the question and the client’s needs.
- Make a clinical decision about the relevant nursing action.
- Double check your answer by being sure that the information you have directs you to the correct answer.

### Evaluation Level Items

Evaluation level items ask you to make judgments about care, determine the effectiveness of nursing care, or evaluate the extent to which an intended outcome has been achieved. Evaluation level test items can also ask you to determine if the care given by others (client/family, health care

team, health care provider) is appropriate. (See Figure 2.13.)

**FIGURE 2.13**  
**Sample Evaluation Level Item**

**33.** A 6 month old has had a pyloromyotomy to correct a pyloric stenosis. Three days after surgery, the parents have placed their infant in his own infant seat (see figure). The nurse should do which of the following?



- 1. Reposition the infant to the left side.
- 2. Ask the parents to put the infant back in his crib.
- 3. Remind the parents that the infant cannot use a pacifier now.
- 4. Tell the parents they have positioned their infant correctly.

 **Strategies for Answering Evaluation Level Questions**

- Review the question to determine what is to be evaluated.
- Before looking at possible answers, consider what is the accepted standard of care, ideal level of care, or intended outcome.
- Match the answers with your understanding of the standard of care.
- Double check your answer with the scenario and expected standard of care in that scenario.

**Creation Level Items**


Creation level test items require you to use information obtained from a client, family, or clinical situation and develop a new or unique approach to solving the clinical problem. For example, the

test items may ask you to develop a plan of care, a discharge plan, or an action plan to manage quality improvement. (See Figure 2.14.)

**FIGURE 2.14**  
**Sample Creation Level Item**

**4.** The nurse is conducting a community presentation on the early detection of colon cancer. Which of the following should the nurse encourage members of the audience to report to their health care providers? Select all that apply.

- 1. Fatigue.
- 2. Unexplained weight loss with adequate nutritional intake.
- 3. Rectal bleeding.
- 4. Bowel changes.
- 5. Positive fecal occult blood testing.

 **Strategies for Answering Creation Level Test Questions**

- Read the question to determine what is to be developed or created.
- Consider all of the elements necessary to have a complete plan of care, discharge plan, etc.
- Understand what is and is not appropriate to include in the plan being created and rule out inappropriate aspects of care for the client or situation presented in the scenario.
- Double check your answer by reviewing the appropriateness of each of the elements in the plan you have developed.

**References and Web Links**

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5. Su, W.M., Osiek, P. J., & Starnes, B. (2005). Using the revised Bloom's Taxonomy in the Clinical Laboratory. *Nurse Educator*, 30(3), 117–122.

# 3

## How to Prepare for and Take the NCLEX-RN® and Other Nursing Exams

Studying for the NCLEX-RN or other similar exams requires careful planning and preparation. You can make the best use of your time by developing a systematic approach to study that includes these five steps to test for success:

- Assessing your study needs.
- Developing a study plan.
- Refining your test-taking strategies.
- Rehearsing test anxiety management skills.
- Evaluating progress on a regular basis.

Use these five steps as you take your first test in nursing school. Refine your test-taking strategies as you evaluate your progress at each step of the way, so that when you are ready to take the licensing exam you will be an experienced and successful test-taker. Use the Personal Study Plan in Table 3.1 to help develop your own study plan.

### Assessing Study Needs

The first step toward test success is to determine your strengths and limitations. Even students who have been successful throughout their academic life, and nurses who are excellent caregivers, have areas in which they need improvement. Be honest with yourself as you assess your own study needs. These steps can help you in your assessment:

- Review your success in nursing school. Review your record of achievement in courses in the nursing curriculum. Success on the NCLEX-RN tends to correlate with grades (grade point average) achieved in nursing school. Subjects in which you received high grades, that you found easy to learn, or in which you have had additional clinical practice or work experience are likely to be areas of strength. On the other hand, subjects you found difficult to learn (or in which you did not achieve high grades) should be areas for concentrated review. Also consider content areas that you have not studied for a while. Recent course work will be the most familiar and, therefore, may require the least amount of study. All students, even students who have achieved success in nursing courses, benefit from identifying areas requiring study and spending time

practicing test-taking skills. You also can use the practice exams in this book to identify areas needing further study. Begin with the subjects you find most difficult or in which you have the least confidence.

- Assess your test-taking skills. Using effective test-taking skills contributes to exam success. What have you done in the past to make you confident about taking a test? How do you feel when you are in the exam situation? What has worked in the past to help you be successful? Review these strategies to build on past successes and work on problem areas. Consider additional strategies suggested in the section “Refining Your Test-Taking Strategies,” page 15. You can practice these skills by simulating the testing situation using the practice tests and comprehensive exams in this review book.

- Assess your ability to take tests that require application, analysis, and evaluation. Test questions used on the licensing exam are written at higher levels of the cognitive domain. Many candidates’ experience with taking tests has come from taking “teacher-made” tests—tests developed by the faculty at your school of nursing. These tests are commonly written to test students’ knowledge and understanding of course content and may not include questions that require application, analysis, or evaluation of course material. Additionally, several of the types of alternate-format questions have recently been added to the exam, and nursing faculty may not yet be designing their own test questions using these formats. Finally, some students are able to “second-guess” the teacher and use this ability to their advantage when taking teacher-made classroom tests. However, it is not as easy to anticipate test questions on standardized and licensing exams, and you will need to develop skills that will help you think critically when presented with an unfamiliar situation. As you prepare to take the licensing exam, spend time on questions where you need to “figure out” the best approach to answering the question. You can use the questions in this book and CD-ROM to be sure you understand the difference between questions that require only recall and understanding and those that require you to apply information to provide client care, make clinical judgments, and initiate nursing actions.

**TABLE 3.1**  
**Personal Study Plan**

**Assess Study Needs**

**1. Review your success in nursing school.**

- I did best in these courses:  
\_\_\_\_\_
- I needed to study harder in these courses:  
\_\_\_\_\_
- I took these courses near the beginning of the curriculum:  
\_\_\_\_\_
- I scored best on these practice exams in this book:  
\_\_\_\_\_
- I am not satisfied with my scores on these practice exams in this book:  
\_\_\_\_\_
- I need further study in these content areas:  
\_\_\_\_\_
- I need further study in these areas of the nursing process:  
\_\_\_\_\_
- I need further study in these areas of client needs:  
\_\_\_\_\_

**2. Review your test-taking skills.**

- I can identify the components of a test question.
- I read questions carefully before answering.
- I can make reasonable guesses if I am not certain of the correct answer.

**3. Review your test-anxiety management skills.**

- I can do relaxation and deep-breathing exercises.
- I can visualize success.
- I can give myself positive feedback.
- I can concentrate for extended periods of time.

**4. Review your computer skills.**

- I am able to use a computer to read and answer test questions.

- I have used the CD-ROM accompanying this book.

**Develop a Study Plan**

- I will study in this location:  
\_\_\_\_\_
- I will study at these times and dates:  
\_\_\_\_\_
- I have assembled all of the materials I need to study:  
\_\_\_\_\_
- I will study with a study group:  
\_\_\_\_\_

**Evaluate Progress**

- I have completed the practice tests in this book.
- I have completed the comprehensive tests in this book.
- I need to improve my scores in these areas:  
\_\_\_\_\_
- I am prepared to take the NCLEX-RN examination.

**Strategies for Taking Tests**

- Read the question carefully.
- Anticipate the correct answer.
- Read for key words.
- Base answers on nursing knowledge.
- Identify the components of the test item.

**Strategies for Managing Test Anxiety**

- Mental rehearsal
- Relaxation
- Deep breathing
- Positive self-talk
- Distraction
- Concentration

■ Assess your English language skills. Persons for whom English is an additional language or who do not have well-developed reading and comprehension skills may require additional practice in reading and answering NCLEX-RN-style test questions. If you are one of these persons, plan additional time to practice reading and answering questions, to time yourself when answering questions, and to

validate that you understand the question correctly. If necessary, seek assistance.

■ Assess your ability to take timed tests. Are you always the last one to finish a test? Do you request additional time to complete a test? If so, you will want to practice taking timed tests and doing your best, while completing as many questions as possible. The licensing exam is designed to be completed

in 6 hours; only questions completed within that time frame will be scored. As you use the practice questions and tests in this book and CD-ROM, time yourself and, if needed, determine ways that you can increase your speed without sacrificing accuracy.

- Assess your skills for taking computer-administered exams. Although previous computer experience is not necessary to take the NCLEX-RN, you should familiarize yourself with the differences between taking a paper-and-pencil exam and taking exams administered by the computer. If you have not used a computer before, find a learning resource center at your college, university, library, or hospital where you can become familiar with basic computer keyboard skills. The CD-ROM accompanying this book, which simulates the computerized NCLEX, offers you the opportunity to practice taking computer-administered test questions. Use it to practice reading questions from the computer screen and become acquainted with answering questions in a computerized format. If you are accustomed to underlining key words or making notes in the margins of paper-and-pencil tests, adapt these strategies to reading and answering the questions on the computer screen. Also be sure that you can use a drop down calculator to answer questions requiring the use of math skills.

## Developing a Study Plan

Once you have identified areas of strength and areas needing further study, develop a specific plan and begin to study regularly. Students who study a small amount of content over a longer period of time tend to have higher success rates than students who wait until the last few weeks before the exam and then “cram.” Consider these suggestions:

- Identify a place for study. The area should be quiet and have room for your books and papers. This area might be in your home, at your nursing school, at your workplace, or in a library. Be sure your friends and family understand the importance of not interrupting you when you are studying.
- Establish regular study times. Make appointments with yourself to ensure a commitment to study. Frequent, short study periods (1 or 2 hours) are preferable to sporadic, extended study periods. Plan to finish your studying 1 week before the NCLEX-RN; last-minute cramming tends to increase anxiety.
- Obtain all necessary resources. As you begin to study, it is helpful to have easy access to textbooks, notes, and study guides.
- Make the best use of your time. Make review cards that you can carry with you to study during free moments throughout the day. Some students record review notes and listen to the tapes or Podcasts while driving or exercising.

- Reduce or eliminate stressful situations. Students who are juggling multiple responsibilities (such as working, managing a family, taking courses, planning a wedding, or caring for elderly parents) may find it difficult to find time to study or to concentrate when studying. Managing a variety of stressful situations puts students at risk for failing exams. If possible, reduce the number of stressful situations you are involved in during the time you are preparing to take the NCLEX-RN exam.

- Develop effective study skills. Study skills enable you to acquire, organize, remember, and use the information you need to take the NCLEX-RN. These skills include outlining, summarizing, applying, synthesizing, reviewing, and practicing test-taking strategies. Use these study skills each time you prepare for an exam.

- Use study skills with which you are familiar and that have worked well for you in the past. Recall effective study behaviors that you used in nursing school, such as reviewing highlighted text, outlines, or content maps.

- Study to learn, not to memorize. The NCLEX-RN tests application and analysis of knowledge. When reviewing content, continually ask yourself, “How is this information used in client care?” “What clinical decision-making will be required of this information?” and “What is the role of the nurse in using this information?” Being able to apply information, rather than just being able to list or recognize information, is one of the most important study skills to master.

- Identify your learning and study style preferences. Each student has a preferred way of learning. For example, some students prefer learning material by listening; they are considered *auditory* learners. If this describes your preference, you will benefit from reviewing taped notes or class lectures. Some students learn best in a visual mode. They learn by reading, reviewing slide presentations, or looking at illustrations. For these *visual* learners, reading and looking at images is helpful. *Kinesthetic* learners, those who like to touch and manipulate to learn, benefit from working with models and manikins to reinforce their learning. While you likely have one learning style and study preference, using a variety of styles will enhance the study experience.

- Some students prefer to study alone, whereas others benefit from study groups; know which approach works best for you and develop your study plan accordingly. If you participate in a study group, limit the group. The group should develop norms for working together that focus on understanding and applying nursing content, rather than memorizing facts. Every member must come prepared to contribute.

- Anticipate questions. As you study, formulate questions around the content. Practice giving a



rationale for your answer to these questions. If you work in a study group, have each member contribute questions that the entire group answers.

- Study common, not unique, nursing care situations. The NCLEX-RN tests minimum competence for nursing practice; therefore, focus on common health problems and client needs. Review the *RN Practice Analysis*, published by the National Council of State Boards of Nursing, and the current licensing exam test plan to determine common nursing care activities.<sup>1</sup>

- Simulate test-taking. The comprehensive tests in Part Three of this book and the CD-ROM are designed to simulate the random order in which questions appear in the NCLEX-RN. Use these resources to focus on areas of common concern in nursing care rather than on the traditional content delineation of adult, pediatric, psychiatric, and childbearing clients. Make additional copies of answer sheets, and retake the exams on which you had low scores.

## Refining Your Test-Taking Strategies

Knowing how to take a test is as important as knowing the content being tested. Strategies for taking tests can be learned and used to improve test scores. Here are some suggestions for building a repertoire of effective test-taking strategies:

- Understand the type of test item and the cognitive level and related thinking processes. (See Chapter 2, pages 10 to 21 for more information on question types and cognitive levels found on the NCLEX-RN exam.)

- Understand which integrated process (step of the nursing process, caring, communication, documentation, teaching/learning) is being tested. For example, as you read the question, determine whether the question is asking you to set priorities (planning) or judge outcomes (evaluation).

- Understand client needs. As you read the question, consider the question in the context of client needs. Be sure to understand if the question is asking you to determine what to do “first” or to select the nursing action that is “best.”

- Understand the age of the client noted in the test question. If relevant to answering the question, the age of the client will be specified; consider what information about that age-group will be important to answering the question. If the age of the client is not specified, assume that the client is an adult and base your answers on principles of adult growth and development.

- Read the question carefully. This is one of the most important aspects of effective test taking. Do not rush. Ask yourself, “What is this question asking?” and “What is the expected response?” If necessary, rephrase the question in your own words.

- Do not read meaning into a question that is not intended, and do not make a question more difficult than it is. If you do not understand the question, try to figure it out. If, for example, the question is asking about the fluid balance needs of a client with pheochromocytoma and you do not remember what pheochromocytoma is, then try to answer the question based on your knowledge of principles of fluid balance.

- The exam questions reflect national nursing practice standards and are not written to test knowledge of procedures or practices at specific health care agencies. Thus, it is important to answer the question from the framework of best nursing practice, not unique practices or procedures that are specific to one clinical agency.

- Determine if the question is asking you to set priorities or place steps of a procedure in a particular order. Read the stem of the question carefully and be clear about the priority (first, last) or order (first, last) in which you are to answer the question. Base your answer on commonly used nursing frameworks for setting priorities, such as the nursing process: assess, plan, implement, evaluate; Maslow’s hierarchy of needs; physiological, safety and security; love and belonging, self-esteem; self-actualization; principles of emergency care: breathing, bleeding, circulation; principles of triage: resuscitation, emergent, urgent, less urgent, non-urgent; fire response priorities: rescue, alarm, confine, extinguish; role of the nurse vs. role of the physician, vs. role of the licensed practical nurse (LPN) and unlicensed assistive personnel (UAP); or procedures for delegation: scope of practice, workload, ability, follow up.

- Look for key words that provide clues to the correct answer. For instance, words such as “except,” “not,” and “but” can change the meaning of a question; words such as “first,” “next,” and “most” ask you to establish a priority or use an order or sequence of steps; key words such as “most likely” or “least likely” are asking you to determine a probability of a successful outcome. When the question asks you to “select all that apply”, be sure you are considering each option as having the possibility of being correct, and have ruled out the ones you have not selected as being incorrect.

- Be certain you understand the meaning of all words in the question. If you see a word you do not know, try to figure out its meaning from a familiar base of the word or from the context of the question.

- Attempt to answer the question before you see the answers, and then look for the answer(s) (hot spot and graphics) that is/are similar to the one(s) you generated.

- Eliminate answers that you know are not correct.

- Base answers on nursing knowledge. Remember that the NCLEX-RN is used to test for safe practice and that you have learned the information needed to answer the question.

- If you do not know an answer, make a reasonable guess. Hunches and intuition are often correct. Do not waste time and energy; give yourself permission to not know every question, and move on to the next one. In CAT, you must answer each question before the next item is administered, and because the level of difficulty will be adjusted as you answer each question, it is likely that you will know the answer to one of the next questions.

### Strategies for Managing Test Anxiety

All test takers experience some anxiety. A certain amount of anxiety is motivating, but be prepared to control unwanted anxiety. Anxiety can be managed by both physical and mental activities. Practice anxiety management strategies while you are taking the comprehensive examinations in this book, and use them with *each* exam you take in school or elsewhere. Practicing managing test anxiety when taking “low stakes” tests, such as classroom tests, will make managing test anxiety much easier when you are taking the “high stakes” tests, such as course or program final exams and, of course, the licensing exam. Commonly used anxiety management strategies include:

- *Mental rehearsal*—Mental rehearsal involves reviewing the events and environment during the examination. Anticipate how you will feel, what the setting will be like, how you will take the exam, what the computer screen will look like, and how you will talk to yourself during the exam. Visualize your success. Rehearse what you will do if you have test anxiety.

- *Relaxation exercises*—Relaxation exercises involve tensing and relaxing various muscle groups to relieve the physical effects of anxiety. Practice systematically contracting and relaxing muscle groups from your toes to your neck to release energy for concentration. You can do these exercises during the exam to promote relaxation. Smile! Smiling relaxes tense facial muscles and reminds you to maintain a positive attitude.

- *Deep breathing*—Taking deep breaths by inhaling slowly while counting to 5 and then exhaling slowly while counting to 10 increases oxygen flow to the lungs and brain. Deep breathing also decreases tension and helps manage anxiety by focusing your thoughts on the breathing and away from worries.

- *Positive self-talk*—Talking to yourself in a positive way serves to correct negative thoughts (e.g., “I can’t pass this test” and “I don’t know the answers to any of these questions”) and reinforces a positive self-concept. Replace negative thoughts with positive ones, for example, tell yourself, “I can do this,” “I studied well and am prepared,” or “I can figure this out.” Visualize yourself as a nurse—you have passed the test!

- *Distraction*—Thinking about something else can clear your mind of negative or unwanted thoughts. Think of something fun, something you enjoy. Plan now what you will think about to distract yourself during the exam.

- *Concentration*—During the exam, be prepared to concentrate. Have tunnel vision. Do not worry if others finish the test before you. Remember that everyone has his or her own speed for taking tests and that each test is individualized. Do not rush; you will have plenty of time. Focus; do not let noises from the keyboard next to you divert your attention. Do not become overwhelmed by the testing environment. Use positive self-talk as you begin the exam. Some students become bored during the exam and then become careless as they answer questions toward the end of the exam. Practice taking tests of at least 265 questions and discover how long you can focus your attention on the test questions. Practice taking breaks if you begin to lose your concentration.

### Evaluating Your Progress

The last step of your study plan is to check your progress. Note if your scores on the practice and comprehensive tests improve. Do not spend time on content you have mastered, on areas in which you obtained high scores on the practice exam, or on areas with which you feel confident. Use the results of your evaluation to set priorities for study on areas needing additional review. As noted above, evaluate your study skills, your test taking abilities, and the use of test-anxiety management strategies as you take *each* test throughout your academic program. Doing so now will prepare you to test for success.

### Tips from Students Who Have Passed the NCLEX-RN®

Students who have successfully passed the NCLEX-RN offer these tips for preparing for, and taking, this exam:

- Study regularly several months before taking the exam. Be sure you are well prepared. Accept responsibility for your study plan—being prepared is up to you!

- Practice taking randomly generated test questions. Most students are accustomed to taking teacher-made exams that cover several topics in the same content area. When taking the NCLEX-RN examination, however, each question will come from a different topic or content area, and you will need to be prepared to shift your focus to a different practice area for each question.

- Use practice questions until you can score at least 75% on the exam. Use practice exams with at least 2,000 questions so you test yourself with a wide range of content and types of questions.
- Use a timer to determine how many questions you can answer in a specified amount of time. Use the timer to be sure you are keeping a steady pace, but not rushing through the test.
- Schedule to take the exam when YOU are ready, but as soon after graduation as is feasible.<sup>2</sup> Candidates who take the exam before they are prepared are not as successful. You are in control of when you take the exam!
- Make sure you know the date, time, and place the exam will be given; how to get to the exam site; how long it takes to drive there; and where you can park. It may be helpful to visit the exam site and see the room where the exam will be given.
- Visualize yourself in the room taking the test. Use mental rehearsal to practice anxiety-managing strategies.
- Organize the information you will need to bring to the testing center the night before the exam. You will need to present your Authorization to Test. You will also need to provide required identification.
- Make sure you are physically prepared. Get enough rest before the examination; fatigue can impair concentration. If you work, it may be advisable not to work the day before the exam; if you work on a shift that is different from the time of the

exam, adjust your work schedule several days ahead of time.

- Avoid planning time-consuming activities (e.g., weddings, vacation trips) immediately before the exam.
- Do not use any drugs you usually do not use (including caffeine and nicotine), and do not use alcohol for 2 days before the exam.
- Eat regular meals before the exam. Remember that high-carbohydrate foods provide energy, but excessive sugar and caffeine can cause hyperactivity.
- Dress comfortably, in layers that can be added or removed according to your comfort level.

The authors of this review book and CD-ROM offer our best wishes for success on all of the exams you will be taking throughout your academic career. We are confident that your review and preparation have given you a good foundation for a positive testing experience!

## References

1. National Council of State Boards of Nursing, Inc. Retrieved July 26, 2010, from <https://www.ncsbn.org>
2. National Council of State Boards of Nursing. (2007). *The NCLEX Delay Pass Rate Study*. Retrieved July 7, 2010, from <https://www.ncsbn.org/delaystudy2006.pdf>

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PART

2

# Practice Tests

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# 1

## The Nursing Care of the Childbearing Family

### TEST

### 1

## Antepartal Care

- The Preconception Client
- The Pregnant Client Receiving Prenatal Care
- The Pregnant Client in Childbirth Preparation Classes
- The Pregnant Client with Risk Factors
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Preconception Client

**1.** A client has obtained Plan B (levonorgestrel 0.75 mg, 2 tablets) as emergency contraception. After unprotected intercourse, the client calls the clinic to ask questions about taking the contraceptives. The nurse realizes the client needs further explanation when she makes which of the following responses?

- 1. "I can wait 3 to 4 days after intercourse to start taking these to prevent pregnancy."
- 2. "My boyfriend can buy Plan B from the pharmacy if he is over 18 years old."
- 3. "The birth control works by preventing ovulation or fertilization of the egg."
- 4. "I may feel nauseated and have breast tenderness or a headache after using the contraceptive."

**2.** An antenatal G 2, T 1, P 0, Ab 0, L 1 client is discussing her postpartum plans for birth control with her health care provider. In analyzing the available choices, which of the following factors has the **greatest** impact on her birth control options?

- 1. Satisfaction with prior methods.
- 2. Preference of sexual partner.
- 3. Breast- or bottle-feeding plan.
- 4. History of clotting disease.

**3.** After the nurse instructs a 20-year-old nulligravid client on how to perform a breast self-examination, which of the following client statements indicates that the teaching has been successful?

- 1. "I should perform breast self-examination on the day my menstrual flow begins."
- 2. "It's important that I perform breast self-examination on the same day each month."
- 3. "If I notice that one of my breasts is much smaller than the other, I shouldn't worry."
- 4. "If there is discharge from my nipples, I should call my health care provider."

**4.** Assessment of a 16-year-old nulligravid client who visits the clinic and asks for information on contraceptives reveals a menstrual cycle of 28 days. The nurse formulates a nursing diagnosis of *Deficient knowledge* related to ovulation and fertility management. Which of the following would be important to include in the teaching plan for the client?

- 1. The ovum survives for 96 hours after ovulation, making conception possible during this time.
- 2. The basal body temperature falls at least 0.2° F after ovulation has occurred.
- 3. Ovulation usually occurs on day 14, plus or minus 2 days, before the onset of the next menstrual cycle.
- 4. Most women can tell they have ovulated because of severe pain and thick, scant cervical mucus.

**5.** Which of the following instructions about activities during menstruation would the nurse include when counseling an adolescent who has just begun to menstruate?

- 1. Take a mild analgesic if needed for menstrual pain.
- 2. Avoid cold foods if menstrual pain persists.
- 3. Stop exercise while menstruating.
- 4. Avoid sexual intercourse while menstruating.

**6.** After conducting a class for female adolescents about human reproduction, which of the following statements indicates that the school nurse's teaching has been effective?

- 1. "Under ideal conditions, sperm can reach the ovum in 15 to 30 minutes, resulting in pregnancy."
- 2. "I won't become pregnant if I abstain from intercourse during the last 14 days of my menstrual cycle."
- 3. "Sperm from a healthy male usually remain viable in the female reproductive tract for 96 hours."
- 4. "After an ovum is fertilized by a sperm, the ovum then contains 21 pairs of chromosomes."

**7.** A 20-year-old nulligravid client expresses a desire to learn more about the symptothermal method of family planning. Which of the following would the nurse include in the teaching plan?

- 1. This method has a 50% failure rate during the first year of use.
- 2. Couples must abstain from coitus for 5 days after the menses.
- 3. Cervical mucus is carefully monitored for changes.
- 4. The male partner uses condoms for significant effectiveness.

**8.** Before advising a 24-year-old client desiring oral contraceptives for family planning, the nurse would assess the client for signs and symptoms of which of the following?

- 1. Anemia.
- 2. Hypertension.
- 3. Dysmenorrhea.
- 4. Acne vulgaris.

**9.** After instructing a 20-year-old nulligravid client about adverse effects of oral contraceptives, the nurse determines that further instruction is needed when the client states which of the following as an adverse effect?

- 1. Weight gain.
- 2. Nausea.
- 3. Headache.
- 4. Ovarian cancer.

**10.** A 22-year-old nulligravid client tells the nurse that she and her husband have been considering using condoms for family planning. Which of the following instructions should the nurse include about the use of condoms as a method for family planning?

- 1. Using a spermicide with the condom offers added protection against pregnancy.
- 2. Natural skin condoms protect against sexually transmitted diseases.
- 3. The typical failure rate for couples using condoms is about 25%.
- 4. Condom users commonly report penile gland sensitivity.

**11.** Which of the following would the nurse include in the teaching plan for a 32-year-old female client requesting information about using a diaphragm for family planning?

- 1. Douching with an acidic solution after intercourse is recommended.
- 2. Diaphragms should not be used if the client develops acute cervicitis.
- 3. The diaphragm should be washed in a weak solution of bleach and water.
- 4. The diaphragm should be left in place for 2 hours after intercourse.

**12.** After being examined and fitted for a diaphragm, a 24-year-old client receives instructions about its use. Which of the following client statements indicates a need for further teaching?

- 1. "I can continue to use the diaphragm for about 2 to 3 years if I keep it protected in the case."
- 2. "If I get pregnant, I will have to be refitted for another diaphragm after the delivery."
- 3. "Before inserting the diaphragm I should coat the rim with contraceptive jelly."
- 4. "If I gain or lose 20 lb, I can still use the same diaphragm."

**13.** A 22-year-old client tells the nurse that she and her husband are trying to conceive a baby. When teaching the client about reducing the incidence of neural tube defects, the nurse would emphasize the need for increasing the intake of which of the following foods? Select all that apply.

- 1. Leafy green vegetables.
- 2. Strawberries.
- 3. Beans.
- 4. Milk.
- 5. Sunflower seeds.
- 6. Lentils.

**14.** A couple is inquiring about vasectomy as a permanent method of contraception. Which teaching statement would the nurse include in the teaching plan?

- 1. "Another method of contraception is needed until the sperm count is 0."
- 2. "Vasectomy is easily reversed if children are desired in the future."
- 3. "Vasectomy is contraindicated in males with prior history of cardiac disease."
- 4. "Vasectomy requires only a yearly follow-up once the procedure is completed."

**15.** A 39-year-old multigravid client asks the nurse for information about female sterilization with a tubal ligation. Which of the following client statements indicates effective teaching?

- 1. "My fallopian tubes will be tied off through a small abdominal incision."
- 2. "Reversal of a tubal ligation is easily done, with a pregnancy success rate of 80%."
- 3. "After this procedure, I must abstain from intercourse for at least 3 weeks."
- 4. "Both of my ovaries will be removed during the tubal ligation procedure."

**16.** A 23-year-old nulliparous client visiting the clinic for a routine examination tells the nurse that she desires to use the basal body temperature method for family planning. The nurse should instruct the client to do which of the following?

- 1. Check the cervical mucus to see if it is thick and sparse.
- 2. Take her temperature at the same time every morning before getting out of bed.
- 3. Document ovulation when her temperature decreases at least 1° F.
- 4. Avoid coitus for 10 days after a slight rise in temperature.

**17.** A couple visiting the infertility clinic for the first time states that they have been trying to conceive for the past 2 years without success. After a history and physical examination of both partners, the nurse determines that an appropriate outcome for the couple would be to accomplish which of the following by the end of this visit?

- 1. Choose an appropriate infertility treatment method.
- 2. Acknowledge that only 50% of infertile couples achieve a pregnancy.
- 3. Discuss alternative methods of having a family, such as adoption.
- 4. Describe each of the potential causes and possible treatment modalities.

**18.** A client is scheduled to have in vitro fertilization (IVF) as an infertility treatment. Which of the following client statements about IVF indicates that the client understands this procedure?

- 1. "IVF requires supplemental estrogen to enhance the implantation process."
- 2. "The pregnancy rate with IVF is higher than that with gamete intrafallopian transfer."
- 3. "IVF involves bypassing the blocked or absent fallopian tubes."
- 4. "Both ova and sperm are instilled into the open end of a fallopian tube."

**19.** A 20-year-old primigravid client tells the nurse that her mother had a friend who died from hemorrhage about 10 years ago during a vaginal delivery. Which of the following responses would be most helpful?

- 1. "Today's modern technology has resulted in a low maternal mortality rate."
- 2. "Don't concern yourself with things that happened in the past."
- 3. "In the United States, mothers seldom die in childbirth."
- 4. "What is it that concerns you about pregnancy, labor, and delivery?"

**20.** A 19-year-old nulligravid client visiting the clinic for a routine examination asks the nurse about cervical mucus changes that occur during the menstrual cycle. Which of the following statements would the nurse expect to include in the client's teaching plan?

- 1. About midway through the menstrual cycle, cervical mucus is thick and sticky.
- 2. During ovulation, the cervix remains dry without any mucus production.
- 3. As ovulation approaches, cervical mucus is abundant and clear.
- 4. Cervical mucus disappears immediately after ovulation, resuming with menses.

**21.** When instructing a client about the proper use of condoms for pregnancy prevention, which of the following instructions would be included to ensure maximum effectiveness?

- 1. Place the condom over the erect penis before coitus.
- 2. Withdraw the condom after coitus when the penis is flaccid.
- 3. Ensure that the condom is pulled tightly over the penis before coitus.
- 4. Obtain a prescription for a condom with non-oxydol 9.



**22.** A multigravid client will be using medroxy-progesterone acetate (Depo-Provera) as a family planning method. After the nurse instructs the client about this method, which of the following client statements indicates effective teaching?

- 1. "This method of family planning requires monthly injections."
- 2. "I should have my first injection during my menstrual cycle."
- 3. "One possible adverse effect is absence of a menstrual period."
- 4. "This drug will be given by subcutaneous injections."

**23.** Which of the following instructions should the nurse include in the teaching plan for a 30-year-old multiparous client who will be using an intrauterine device (IUD) for family planning?

- 1. Amenorrhea is a common adverse effect of IUDs.
- 2. The client needs to use additional protection for conception.
- 3. IUDs are more costly than other forms of contraception.
- 4. Severe cramping may occur when the IUD is inserted.

**24.** After counseling a 35-year-old client about breast self-examination and mammography, the nurse determines that the client has understood the instructions when the client states which of the following?

- 1. "I should have a mammogram every year once I'm 40."
- 2. "I should schedule a mammography examination during my menstrual period."
- 3. "Mammography screening is inexpensive."
- 4. "Mammography is an extremely painful procedure."

**25.** After instructing a 40-year-old woman about osteoporosis after menopause, the nurse determines that the client needs further instruction when the client states which of the following?

- 1. "One cup of yogurt is the equivalent of one glass of milk."
- 2. "Women who do not eat dairy products should consider calcium supplements."
- 3. "African American women are at the greatest risk for osteoporosis."
- 4. "Estrogen therapy at menopause can reduce the risk of osteoporosis."

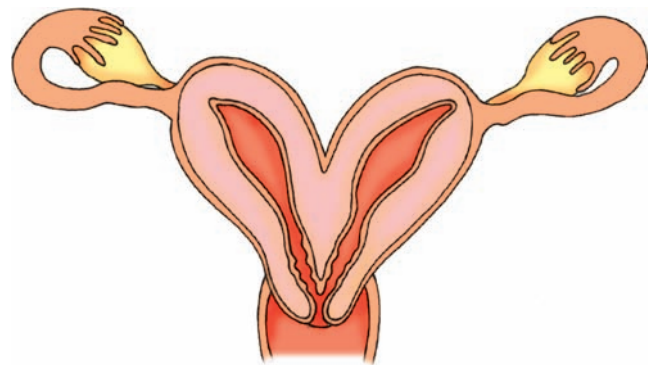
**26.** When developing a teaching plan for an 18 year old client who asks about treatments for sexually transmitted diseases, the nurse should explain that?

- 1. Acyclovir (Zovirax) can be used to cure herpes genitalis.
- 2. *Chlamydia trachomatis* infections are usually treated with penicillin.
- 3. Ceftriaxone sodium (Rocephin) may be used to treat *Neisseria gonorrhoeae* infections.
- 4. Metronidazole (Flagyl) is used to treat condylomata acuminata.

**27.** A couple is visiting the clinic because they have been unable to conceive a baby after 3 years of frequent coitus. After discussing the various causes of male infertility, the nurse determines that the male partner needs further instruction when he states which of the following as a cause?

- 1. Seminal fluid with an alkaline pH.
- 2. Frequent exposure to heat sources.
- 3. Abnormal hormonal stimulation.
- 4. Immunologic factors.

**28.** A 24-year-old woman is being assessed for a malformation of the uterus. The figure below indicates which of the following uterine malformations?



- 1. Septate uterus.
- 2. Bicornate uterus.
- 3. Double uterus.
- 4. Uterus didelphys.

### The Pregnant Client Receiving Prenatal Care

**29.** A primagravid client at 16 weeks' gestation has had an amniocentesis and has received teaching concerning signs and symptoms to report. Which statement indicates that the client needs further teaching?

- 1. "I need to call if I start to leak fluid from my vagina."
- 2. "If I start bleeding, I will need to call back."
- 3. "If my baby does not move, I need to call my health care provider."
- 4. "If I start running a fever, I should let the office know."

**30.** During a visit to the prenatal clinic, a pregnant client at 32 weeks' gestation complains of heartburn. The client needs further instruction when she says she must do what?

- 1. Avoid highly seasoned foods.
- 2. Avoid laying down right after eating.
- 3. Eat small, frequent meals.
- 4. Consume liquids only between meals.

**31.** The nurse is teaching a new prenatal client about her iron deficiency anemia during pregnancy. Which statement indicates that the client needs further instruction about her anemia?

- 1. "I will need to take iron supplements now."
- 2. "I may have anemia because my family is of Asian descent."
- 3. "I am considered anemic if my hemoglobin is below 11 g/dL."
- 4. "The workload on my heart is increased when there is not enough oxygen in my system."

**32.** Following a positive pregnancy test, a client begins discussing the changes that will occur in the next several months with the nurse. The nurse should include which of the following information about changes the client can anticipate in the first trimester?

- 1. Differentiating the self from the fetus.
- 2. Enjoying the role of nurturer.
- 3. Preparing for the reality of parenthood.
- 4. Experiencing ambivalence about pregnancy.

**33.** An antenatal primagravid client has just been informed that she is carrying twins. The plan of care includes educating the client concerning factors that put her at risk for problems during the pregnancy. The nurse realizes the client needs further instruction when she indicates carrying twins puts her at risk for which of the following?

- 1. Preterm labor.
- 2. Twin-to-twin transfusion.
- 3. Anemia.
- 4. Group B *Streptococcus*.

**34.** A 30-year-old multigravid client has missed three periods and now visits the prenatal clinic because she assumes she is pregnant. She is experiencing enlargement of her abdomen, a positive pregnancy test, and changes in the pigmentation on her face and abdomen. These assessment findings reflect this woman is experiencing a cluster of which signs of pregnancy?

- 1. Positive.
- 2. Probable.
- 3. Presumptive.
- 4. Diagnostic.

**35.** An antenatal client receives education concerning medications that are safe to use during pregnancy. The nurse evaluates the client's understanding of the instructions and determines that she needs further information when she states which of the following?

- 1. "If I am constipated, Milk of Magnesia is okay but mineral oil is not."
- 2. "If I have heartburn, it is safe to use Tums, Roloids, Mylanta, and Maalox."
- 3. "I can take Tylenol if I have a headache."
- 4. "If I need to have a bowel movement, Ex-Lax is preferred."

**36.** When preparing a 20-year-old client who reports missing one menstrual period and suspects that she is pregnant for a radioimmunoassay pregnancy test, the nurse should tell the client which of the following about this test?

- 1. It has a high degree of accuracy within 1 week after ovulation.
- 2. It is identical in nature to an over-the-counter home pregnancy test.
- 3. A positive result is considered a presumptive sign of pregnancy.
- 4. A urine sample is needed to obtain quicker results.

**37.** After instructing a female client about the radioimmunoassay pregnancy test, the nurse determines that the client understands the instructions when the client states that which of the following hormones is evaluated by this test?

- 1. Prolactin.
- 2. Follicle-stimulating hormone.
- 3. Luteinizing hormone.
- 4. Human chorionic gonadotropin (hCG).

**38.** Using Nägele's rule for a client whose last normal menstrual period began on May 10, the nurse determines that the client's estimated date of delivery would be which of the following?

- 1. January 13.
- 2. January 17.
- 3. February 13.
- 4. February 17.

**39.** After instructing a primigravid client about the functions of the placenta, the nurse determines that the client needs additional teaching when she says that which of the following hormones is produced by the placenta?

- 1. Estrogen.
- 2. Progesterone.
- 3. Human chorionic gonadotropin (hCG).
- 4. Testosterone.

**40.** The nurse assesses a woman at 24 weeks' gestation and is unable to find the fetal heart beat. The fetal heart beat was heard at the client's last visit 4 weeks ago. According to priority, the nurse should do the following tasks in which order?

1. Call the health care provider.

2. Explain that the fetal heart beat could not be found at this time.

3. Obtain different equipment and recheck.

4. Ask client if baby is or has been moving.

**41.** A primiparous client at 10 weeks' gestation questions the nurse about the need for an ultrasound. She states "I don't have health insurance and I can't afford it. I feel fine, so why should I have the test?" The nurse should incorporate which statements as the underlying reason for performing the ultrasound now? Select all that apply.

- 1. "We must view the gross anatomy of the fetus."
- 2. "We need to determine gestational age."
- 3. "We want to view the heart beating to determine that the fetus is viable."
- 4. "We must determine fetal position."
- 5. "We must determine that there is a sufficient nutrient supply for the fetus."

**42.** A 20-year-old married client with a positive pregnancy test states, "Is it really true? I can't believe I'm going to have a baby!" Which of the following responses by the nurse would be **most** appropriate at this time?

- 1. "Would you like some booklets on the pregnancy experience?"
- 2. "Yes it is true. How does that make you feel?"
- 3. "You should be delighted that you are pregnant."
- 4. "Weren't you and your husband trying to have a baby?"

**43.** A newly diagnosed pregnant client tells the nurse, "If I'm going to have all of these discomforts, I'm not sure I want to be pregnant!" The nurse interprets the client's statement as an indication of which of the following?

- 1. Fear of pregnancy outcome.
- 2. Rejection of the pregnancy.
- 3. Normal ambivalence.
- 4. Inability to care for the newborn.

**44.** A client, approximately 11 weeks pregnant, and her husband are seen in the antepartal clinic. The client's husband tells the nurse that he has been experiencing nausea and vomiting and fatigue along with his wife. The nurse interprets these findings as suggesting that the client's husband is experiencing which of the following?

- 1. Ptyalism.
- 2. Mittelschmerz.
- 3. Couvade syndrome.
- 4. Pica.

**45.** A primigravid client asks the nurse if she can continue to have a glass of wine with dinner during her pregnancy. Which of the following would be the nurse's **best** response?

- 1. "The effects of alcohol on a fetus during pregnancy are unknown."
- 2. "You should limit your consumption to beer and wine."
- 3. "You should abstain from drinking alcoholic beverages."
- 4. "You may have 1 drink or 2 oz of alcohol per day."

**46.** Examination of a primigravid client complaining of increased vaginal secretions since becoming pregnant reveals clear, highly acidic vaginal secretions. The client denies any perineal itching or burning. The nurse interprets these findings as a response related to which of the following?

- 1. A decrease in vaginal glycogen stores.
- 2. Development of a sexually transmitted disease.
- 3. Prevention of expulsion of the cervical mucus plug.
- 4. Control of the growth of pathologic bacteria.

**47.** When measuring the fundal height of a primigravid client at 20 weeks' gestation, the nurse will locate the fundal height at which of the following points?

- 1. Halfway between the client's symphysis pubis and umbilicus.
- 2. At about the level of the client's umbilicus.
- 3. Between the client's umbilicus and xiphoid process.
- 4. Near the client's xiphoid process and compressing the diaphragm.

**48.** A primigravida at 8 weeks' gestation tells the nurse that she wants an amniocentesis because there is a history of Hemophilia A in her family. The nurse informs the client that she will need to wait until she is 15 weeks gestation for the amniocentesis. Which of the following provides the most appropriate rationale for the nurse's statement regarding amniocentesis at 15 weeks' gestation?

- 1. Fetal development needs to be complete before testing.
- 2. The volume of amniotic fluid needed for testing will be available by 15 weeks.
- 3. Cells indicating Hemophilia A are not produced until 15 weeks' gestation.
- 4. Fetal anomalies are associated with amniocentesis prior to 15 weeks' gestation.

**49.** After instructing a primigravid client about desired weight gain during pregnancy, the nurse determines that the teaching has been successful when the client states which of the following?

- 1. "A total weight gain of approximately 20 lb (9 kg) is recommended."
- 2. "A weight gain of 6.6 lb (3 kg) in the second and third trimesters is considered normal."
- 3. "A weight gain of about 12 lb (5.5 kg) every trimester is recommended."
- 4. "Although it varies, a gain of 25 to 35 lb (11.4 to 14.5 kg) is about average."

**50.** When developing a teaching plan for a client who is 8 weeks pregnant, which of the following foods would the nurse suggest to meet the client's need for increased folic acid?

- 1. Spinach.
- 2. Bananas.
- 3. Seafood.
- 4. Yogurt.

**51.** The nurse instructs a primigravid client about the importance of sufficient vitamin A in her diet. The nurse knows that the instructions have been effective when the client indicates that she should include which of the following in her diet?

- 1. Buttermilk and cheese.
- 2. Strawberries and cantaloupe.
- 3. Egg yolks and squash.
- 4. Oranges and tomatoes.

**52.** The nurse is discussing dietary concerns with pregnant teens. Which of the following choices are convenient for teens yet nutritious for both the mother and fetus? Select all that apply.

- 1. Milkshake or yogurt with fresh fruit or granola bar.
- 2. Chicken nuggets with tater tots.
- 3. Cheese pizza with spinach and mushroom topping.
- 4. Peanut butter with crackers and a juice drink.
- 5. Buttery light popcorn with diet cola.
- 6. Cheeseburger with tomato, lettuce, pickle, ketchup, and baked potato.

**53.** An antenatal client is discussing her anemia with the nurse in the prenatal clinic. After a discussion about sources of iron to be incorporated into her daily meals, the nurse knows the client needs further instruction when she responds with which of the following?

- 1. "I can meet two goals when I drink milk, lots of iron and meeting my calcium needs at the same time."
- 2. "Drinking coffee, tea, and sodas decrease the absorption of iron."
- 3. "I can increase the absorption of iron by drinking orange juice when I eat."
- 4. Cream of wheat and molasses are excellent sources of iron."

**54.** The nurse instructs a primigravid client to increase her intake of foods high in magnesium because of its role with which of the following?

- 1. Prevention of demineralization of the mother's bones.
- 2. Synthesis of proteins, nucleic acids, and fats.
- 3. Amino acid metabolism.
- 4. Synthesis of neural pathways in the fetus.

**55.** When caring for a primigravid client at 9 weeks' gestation who immigrated to the United States from Vietnam 1 year ago, the nurse would assess the client's diet for a deficiency of which of the following?

- 1. Calcium.
- 2. Vitamin E.
- 3. Vitamin C.
- 4. Iodine.

**56.** Which of the following statements by a primigravid client scheduled for chorionic villi sampling indicates effective teaching about the procedure?

- 1. "A fiberoptic fetoscope will be inserted through a small incision into my uterus."
- 2. "I can't have anything to eat or drink after midnight on the day of the procedure."
- 3. "The procedure involves the insertion of a thin catheter into my uterus."
- 4. "I need to drink 32 to 40 oz of fluid 1 to 2 hours before the procedure."

**57.** A 34-year-old multiparous client at 16 weeks' gestation who received regular prenatal care for all of her previous pregnancies tells the nurse that she has already felt the baby move. The nurse interprets this as which of the following?

- 1. The possibility that the client is carrying twins.
- 2. Unusual because most multiparous clients do not experience quickening until 30 weeks' gestation.
- 3. Evidence that the client's estimated date of delivery is probably off by a few weeks.
- 4. Normal because multiparous clients can experience quickening between 14 and 20 weeks' gestation.

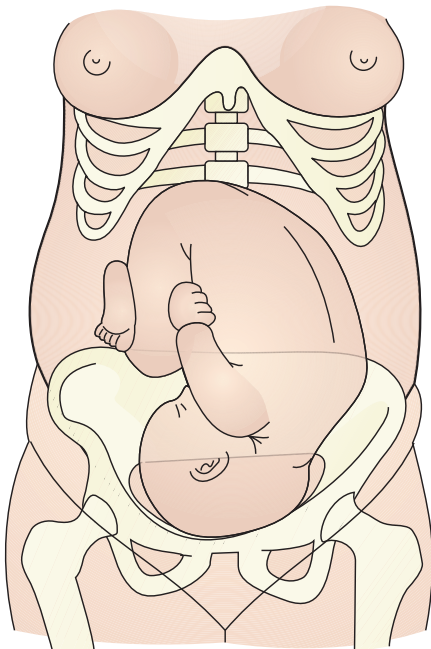
**58.** Which diagnostic test would be the most important to have for a primigravid client in the second trimester of her pregnancy?

- 1. Culdocentesis to detect abnormalities.
- 2. Chorionic villus sampling.
- 3. Ultrasound testing.
- 4.  $\alpha$ -fetoprotein (AFP) testing.

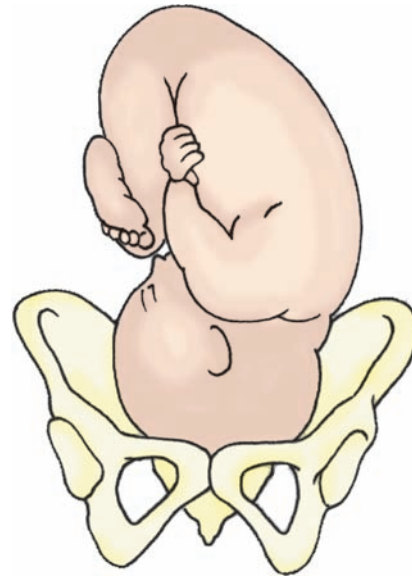
**59.** When performing Leopold's maneuvers, which of the following would the nurse ask the client to do to ensure optimal comfort and accuracy?

- 1. Breathe deeply for 1 minute.
- 2. Empty her bladder.
- 3. Drink a full glass of water.
- 4. Lie on her left side.

**60.** The nurse performed Leopold's maneuvers and determined that the fetal position is LOA. Identify the area where the nurse would place the Doppler to most easily hear fetal heart sounds.



**61.** The nurse is assessing fetal position for a 32-year-old client in her eighth month of pregnancy. As shown below, the fetal position can be described as which of the following?



- 1. Left occipital transverse.
- 2. Left occipital anterior.
- 3. Right occipital transverse.
- 4. Right occipital anterior.

**62.** Which of the following statements by the nurse would be *most* appropriate when responding to a primigravid client who asks, "What should I do about this brown discoloration across my nose and cheeks?"

- 1. "This usually disappears after delivery."
- 2. "It is a sign of skin melanoma."
- 3. "The discoloration is due to dilated capillaries."
- 4. "It will fade if you use a prescribed cream."

**63.** A 36-year-old primigravid client at 22 weeks' gestation without any complications to date is being seen in the clinic for a routine visit. The nurse should assess the client's fundal height to:

- 1. Determine the level of uterine activity.
- 2. Identify the need for increased weight gain.
- 3. Assess the location of the placenta.
- 4. Estimate the fetal gestational age.

**64.** After the nurse reviews the physician's explanation of amniocentesis with a multigravid client, which of the following indicates that the client understands a serious risk of the procedure?

- 1. Premature rupture of the membranes.
- 2. Possible premature labor.
- 3. Fetal limb malformations.
- 4. Fetal organ malformations.

**65.** A primigravid client at 28 weeks' gestation tells the nurse that she and her husband wish to drive to visit relatives who live several hundred miles away. Which of the following recommendations by the nurse would be best?

- 1. "Try to avoid traveling anywhere in the car during your third trimester."
- 2. "Limit the time you spend in the car to a maximum of 4 to 5 hours."
- 3. "Taking the trip is okay if you stop every 1 to 2 hours and walk."
- 4. "Avoid wearing your seat belt in the car to prevent injury to the fetus."

**66.** The nurse is teaching a woman who is 18 weeks pregnant about seat belt safety. Identify the area that indicates that the client understands where the lap portion of the seat belt should be placed.



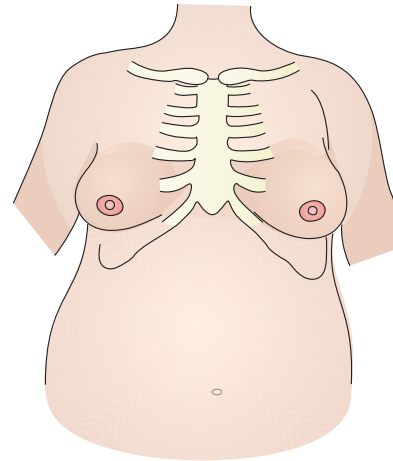
**67.** Which of the following recommendations would be *most* helpful to suggest to a primigravid client at 37 weeks' gestation who is complaining of leg cramps?

- 1. Change positions frequently throughout the day.
- 2. Alternately flex and extend the legs.
- 3. Straighten the knee and flex the toes toward the chin.
- 4. Lie prone in bed with the legs elevated.

**68.** Which of the following recommendations would be the *most* appropriate preventive measure to suggest to a primigravid client at 30 weeks' gestation who is experiencing occasional heartburn?

- 1. Eat smaller and more frequent meals during the day.
- 2. Take a pinch of baking soda with water before meals.
- 3. Decrease fluid intake to four glasses daily.
- 4. Drink several cups of regular tea throughout the day.

**69.** A nurse is eating lunch at a restaurant when she sees a pregnant woman showing signs of airway obstruction. When the nurse asks the woman if she needs help, the woman nods her head yes. Indicate the area where the nurse's fist should be placed to effectively administer thrusts to clear the foreign body from the airway.



**70.** When performing Leopold's maneuvers on a primigravid client at 22 weeks' gestation, the nurse performs the first maneuver to do which of the following?

- 1. Locate the fetal back and spine.
- 2. Determine what is in the fundus.
- 3. Determine whether the fetal head is at the pelvic inlet.
- 4. Identify the degree of fetal descent and flexion.

**71.** A primigravid adolescent client at approximately 15 weeks' gestation who is visiting the prenatal clinic with her mother is to undergo alphafetoprotein (AFP) screening. When developing the teaching plan for this client, the nurse should include which of the following?

- 1. Ultrasonography usually accompanies AFP testing.
- 2. Results are usually very accurate until 20 weeks' gestation.
- 3. A clean-catch midstream urine specimen is needed.
- 4. Increased levels of AFP are associated with neural tube defects.

**72.** Which of the following statements best identifies the rationale for why the nurse reinforces the need for continued prenatal care throughout the pregnancy with an adolescent primigravid client?

- 1. Pregnant adolescents are at high risk for pregnancy-induced hypertension.
- 2. Gestational diabetes during pregnancy commonly develops in adolescents.
- 3. Adolescents need additional instruction related to common discomforts.
- 4. The father of the baby is rarely involved in the pregnancy.

**73.** Which of the following would be included in the teaching plan about pregnancy-related breast changes for a primigravid client?

- 1. Growth of the milk ducts is greatest during the first 8 weeks of gestation.
- 2. Enlargement of the breasts indicates adequate levels of progesterone.
- 3. Colostrum is usually secreted by about the 16th week of gestation.
- 4. Darkening of the areola occurs during the last month of pregnancy.

**74.** A primigravid client at 32 weeks' gestation is enrolled in a breast-feeding class. Which of the following statements indicate that the client understands the breast-feeding education? Select all that apply.

- 1. "My milk supply will be adequate since I have increased a whole bra size during pregnancy."
- 2. "I can hold my baby several different ways during feedings."
- 3. "If my infant latches on properly, I won't develop mastitis."
- 4. "If I breast-feed, my uterus will return to prepregnancy size more quickly."
- 5. "Breast milk can be expressed and stored at room temperature since it is natural."
- 6. "I need to feed my baby when I see feeding cues and not wait until she is crying."

**75.** When planning a class for primigravid clients about the common discomforts of pregnancy, which of the following physiologic changes of pregnancy should the nurse include in the teaching plan?

- 1. The temperature decreases slightly early in pregnancy.
- 2. Cardiac output increases by 25% to 50% during pregnancy.
- 3. The circulating fibrinogen level decreases as much as 50% during pregnancy.
- 4. The anterior pituitary gland secretes oxytocin late in pregnancy.

**76.** When teaching a primigravid client at 24 weeks' gestation about the diagnostic tests to determine fetal well-being, which of the following should the nurse include?

- 1. A fetal biophysical profile involves assessments of breathing movements, body movements, tone, amniotic fluid volume, and fetal heart rate reactivity.
- 2. A reactive nonstress test is an ominous sign and requires further evaluation with fetal echocardiography.
- 3. Contraction stress testing, performed on most pregnant women, can be initiated as early as 16 weeks' gestation.
- 4. Percutaneous umbilical blood sampling uses a needle inserted through the vagina to obtain a sample.

**77.** When teaching a primigravid client how to do Kegel exercises, the nurse explains that the expected outcome of these exercises is to:

- 1. Prevent vulvar edema.
- 2. Alleviate lower back discomfort.
- 3. Strengthen the perineal muscles.
- 4. Strengthen the abdominal muscles.

**78.** During a routine clinic visit, a 25-year-old multigravid client who initiated prenatal care at 10 weeks' gestation and is now in her third trimester states, "I've been having strange dreams about the baby. Last week I dreamed he was covered with hair." The nurse should tell the mother:

- 1. "Dreams like the ones that you describe are very unusual. Please tell me more about them."
- 2. "Commonly when a mother has these dreams, she is trying to cope with becoming a parent."
- 3. "Dreams about the baby late in pregnancy usually mean that labor is about to begin soon."
- 4. "It's not uncommon to have dreams about the baby, particularly in the third trimester."

**79.** A primigravid client at 36 weeks' gestation tells the nurse that she has been experiencing insomnia for the past 2 weeks. Which of the following suggestions would be *most* helpful?

- 1. Practice relaxation techniques before bedtime.
- 2. Drink a cup of hot chocolate before bedtime.
- 3. Drink a small glass of wine with dinner.
- 4. Exercise for 30 minutes just before bedtime.

**80.** Which of the following client statements indicates a need for additional teaching about self-care during pregnancy?

- 1. "I should use nonskid pads when I take a shower or bath."
- 2. "I should avoid using soap on my nipples to prevent drying."
- 3. "I should sit in a hot tub for 20 minutes to relax after working."
- 4. "I should avoid douching even if my vaginal secretions increase."

**81.** To obtain the obstetric conjugate measurement, the nurse would do which of the following?

- 1. Add 1.5 cm to the transverse diameter.
- 2. First measure the angle of the pubic arch.
- 3. Subtract 1.5 to 2 cm from the diagonal conjugate.
- 4. Measure the diameter of the pelvic inlet.

### The Pregnant Client in Childbirth Preparation Classes

**82.** The nurse is developing a teaching plan for a client entering the third trimester of her pregnancy. The nurse should include which of the following in the plan? Select all that apply.

- 1. Differentiating the fetus from the self.
- 2. Ambivalence concerning pregnancy.
- 3. Experimenting with mothering roles.
- 4. Realignment of roles and tasks.
- 5. Trying various caregiver roles.
- 6. Concern about labor and delivery.

**83.** A new antenatal G 6, P 4, Ab 1 client attends her first prenatal visit with her husband. The nurse is assessing this couple's psychological response to their pregnancy. Which of the following requires the **most** immediate follow up?

- 1. The couple are concerned with financial changes this pregnancy causes.
- 2. The couple expresses ambivalence about the current pregnancy.
- 3. The father of the baby states that the pregnancy has changed the mother's focus.
- 4. The father of the baby is irritated that the mother is not like she was before pregnancy.

**84.** When preparing a prenatal class about endocrine changes that normally occur during pregnancy, the nurse should include information about which of the following subjects?

- 1. Human placental lactogen maintains the corpus luteum.
- 2. Progesterone is responsible for hyperpigmentation and vascular skin changes.
- 3. Estrogen relaxes smooth muscle in the respiratory tract.
- 4. The thyroid enlarges with an increase in basal metabolic rate.

**85.** When developing a series of parent classes on fetal development, which of the following should the nurse include as being developed by the end of the third month (9 to 12 weeks)?

- 1. External genitalia.
- 2. Myelinization of nerves.
- 3. Brown fat stores.
- 4. Air ducts and alveoli.

**86.** A primigravid client attending parenthood classes tells the nurse that there is a history of twins in her family. What should the nurse tell the client?

- 1. Monozygotic twins result from fertilization of two ova by different sperm.
- 2. Monozygotic twins occur by chance regardless of race or heredity.
- 3. Dizygotic twins are usually of the same sex.
- 4. Dizygotic twins occur more often in primigravid than in multigravid clients.

**87.** During a 2-hour childbirth preparation class focusing on the labor and delivery process for primigravid clients, the nurse is describing the maneuvers that the fetus goes through during the labor process when the head is the presenting part. In which order do these maneuvers occur?

1. Engagement

2. Flexion

3. Descent

4. Internal rotation

**88.** A primigravid client in a Preparation for Parenting class asks how much blood is lost during an uncomplicated delivery. The nurse should tell the woman:

- 1. "The maximum blood loss considered within normal limits is 500 mL."
- 2. "The minimum blood loss considered within normal limits is 1,000 mL."
- 3. "Blood loss during a delivery is rarely estimated unless there is a hemorrhage."
- 4. "It would be very unusual if you lost more than 100 mL of blood during the delivery."

**89.** Which of the following statements by a primigravid client about the amniotic fluid and sac indicates the need for *further* teaching?

- 1. "The amniotic fluid helps to dilate the cervix once labor begins."
- 2. "Fetal nutrients are provided by the amniotic fluid."
- 3. "Amniotic fluid provides a cushion against impact of the maternal abdomen."
- 4. "The fetus is kept at a stable temperature by the amniotic fluid and sac."

**90.** During a childbirth preparation class, a primigravid client at 36 weeks' gestation tells the nurse, "My lower back has really been bothering me lately." Which of the following exercises suggested by the nurse would be most helpful?

- 1. Pelvic rocking.
- 2. Deep breathing.
- 3. Tailor sitting.
- 4. Squatting.



**91.** A client is experiencing pain during the first stage of labor. What should the nurse instruct the client to do to manage her pain? Select all that apply.

- 1. Walk in the hospital room.
- 2. Use slow chest breathing.
- 3. Request pain medication on a regular basis.
- 4. Lightly massage her abdomen.
- 5. Sip ice water.

**92.** During a Preparation for Parenting class, one of the participants asks the nurse, “How will I know if I am really in labor?” The nurse should tell the participant which of the following about true labor contractions?

- 1. “Walking around helps to decrease true contractions.”
- 2. “True labor contractions may disappear with ambulation, rest, or sleep.”
- 3. “The duration and frequency of true labor contractions remain the same.”
- 4. “True labor contractions are felt first in the lower back, then the abdomen.”

**93.** After instructing participants in a childbirth education class about methods for coping with discomforts in the first stage of labor, the nurse determines that one of the pregnant clients needs further instruction when she says that she has been practicing which of the following?

- 1. Biofeedback.
- 2. Effleurage.
- 3. Guided imagery.
- 4. Pelvic tilt exercises.

**94.** After a Preparation for Parenting class session, a pregnant client tells the nurse that she has had some yellow-gray frothy vaginal discharge and local itching. The nurse’s best action is to advise the client to do which of the following?

- 1. Use an over-the-counter cream for yeast infections.
- 2. Schedule an appointment at the clinic for an examination.
- 3. Administer a vinegar douche under low pressure.
- 4. Prepare for preterm labor and delivery.

**95.** The topic of physiologic changes that occur during pregnancy is to be included in a parenting class for primigravid clients who are in their first half of pregnancy. Which of the following would be important for the nurse to include in the teaching plan?

- 1. Decreased plasma volume.
- 2. Increased risk for urinary tract infections.
- 3. Increased peripheral vascular resistance.
- 4. Increased hemoglobin levels.

**96.** The nurse is obtaining information to support the need for improved prenatal care services in the community. Which of the following information is most important to include?

- 1. The maternal mortality rate.
- 2. The infant mortality rate.
- 3. The perinatal mortality rate.
- 4. The neonatal mortality rate.

### The Pregnant Client with Risk Factors

**97.** A multigravid client at 32 weeks’ gestation has experienced hemolytic disease of the newborn in a previous pregnancy. The nurse should prepare the client for frequent antibody titer evaluations obtained from which of the following?

- 1. Placental blood.
- 2. Amniotic fluid.
- 3. Fetal blood.
- 4. Maternal blood.

**98.** A client with a past medical history of ventricular septal defect repaired in infancy is seen at the prenatal clinic. She is complaining of dyspnea with exertion and being very tired. Her vital signs are 98, 80, 20, BP 116/72. She has + 2 pedal edema and clear breath sounds. As the nurse plans this client’s care, which of the following is her cardiac classification according to the New York Heart Association Cardiac Disease classification?

- 1. Class I.
- 2. Class II.
- 3. Class III.
- 4. Class IV.

**99.** A primigravid client has completed her first prenatal visit and blood work. Her laboratory test for the hepatitis B surface antigen (HBsAg) is positive. The nurse can advise the client that the plan of care for this newborn will include? Select all that apply.

- 1. Hepatitis B immune globulin at birth.
- 2. Series of three hepatitis B vaccinations per recommended schedule.
- 3. Hepatitis B screening when born.
- 4. Isolation of infant during hospitalization.
- 5. Universal precautions for mother and infant.
- 6. Contraindication for breast-feeding because the mother is HBsAg positive.

**100.** A woman who has had asthma since she was a child and it is under control when the client takes her medication correctly and consistently is now pregnant for the first time. Which of the following client statements concerning asthma during pregnancy indicates the need for further instruction?

- 1. "I need to continue taking my asthma medication as prescribed."
- 2. "It is my goal to prevent or limit asthma attacks."
- 3. "During an asthma attack, oxygen needs continue to be high for mother and fetus."
- 4. "Bronchodilators should be used only when necessary because of the risk they present to the fetus."

**101.** A woman at 22 weeks' gestation has right upper quadrant pain radiating to her back. She rates the pain as 9 on a scale of 1 to 10 and says that it has occurred 2 times in the last week for about 4 hours at a time. She does not associate the pain with food. Which of the following nursing measures is the highest priority for this client?

- 1. Educate the client concerning changes occurring in the gallbladder as a result of pregnancy.
- 2. Refer the client to her health care provider for evaluation and treatment of the pain.
- 3. Discuss nutritional strategies to decrease the possibility of heartburn.
- 4. Support the client's use of acetaminophen (Tylenol) to relieve pain.

**102.** A client in the triage area who is at 19 weeks' gestation states that she has not felt her baby move in the past week and no fetal heart tones are found. While evaluating this client, the nurse identifies her as being at the highest risk for developing which problem?

- 1. Abruptio placentae.
- 2. Placenta previa.
- 3. Disseminated intravascular coagulation.
- 4. Threatened abortion.

**103.** A 40-year-old client at 8 weeks' gestation has a 3-year-old child with Down syndrome. The nurse is discussing amniocentesis and chorionic villus sampling as genetic screening methods for the expected baby. The nurse is confident that the teaching has been understood when the client states which of the following?

- 1. "Each test identifies a different part of the infant's genetic makeup."
- 2. "Chorionic villus sampling can be performed earlier in pregnancy."
- 3. "The test results take the same length of time to be completed."
- 4. "Amniocentesis is a more dangerous procedure for the fetus."

**104.** After conducting a presentation to a group of adolescent parents on the topic of adolescent pregnancy, the nurse determines that one of the parents needs further instruction when the parent says that adolescents are at greater risk for which of the following?

- 1. Denial of the pregnancy.
- 2. Low-birth-weight infant.
- 3. Cephalopelvic disproportion.
- 4. Congenital anomalies.

**105.** A dilatation and curettage (D&C) is scheduled for a primigravid client admitted to the hospital at 10 weeks' gestation with abdominal cramping, bright red vaginal spotting, and passage of some of the products of conception. The nurse should assess the client further for the expression of which of the following feelings?

- 1. Ambivalence.
- 2. Anxiety.
- 3. Fear.
- 4. Guilt.

**106.** When providing care to the client who has undergone a dilatation and curettage (D&C) after a spontaneous abortion, the nurse administers hydroxyzine (Vistaril) as ordered. Which of the following is an expected outcome?

- 1. Absence of nausea.
- 2. Minimized pain.
- 3. Decreased uterine cramping.
- 4. Improved uterine contractility.

**107.** On entering the room of a client who has undergone a dilatation and curettage (D&C) for a spontaneous abortion, the nurse finds the client crying. Which of the following comments by the nurse would be **most** appropriate?

- 1. "Are you having a great deal of uterine pain?"
- 2. "Commonly spontaneous abortion means a defective embryo."
- 3. "I'm truly sorry you lost your baby."
- 4. "You should try to get pregnant again as soon as possible."

**108.** Rho(D) immune globulin (RhoGAM) is ordered for a client before she is discharged after a spontaneous abortion. The nurse instructs the client that this drug is used to prevent which of the following?

- 1. Development of a future Rh-positive fetus.
- 2. An antibody response to Rh-negative blood.
- 3. A future pregnancy resulting in abortion.
- 4. Development of Rh-positive antibodies.

**109.** A multigravid client who stands for long periods while working in a factory visits the prenatal clinic at 35 weeks' gestation, stating, "The varicose veins in my legs have really been bothering me lately." Which of the following instructions would be helpful?

- 1. Perform slow contraction and relaxation of the feet and ankles twice daily.
- 2. Take frequent rest periods with the legs elevated above the hips.
- 3. Avoid support hose that reach above the leg varicosities.
- 4. Take a leave of absence from your job to avoid prolonged standing.

**110.** A multigravid client at 36 weeks' gestation has been diagnosed with condylomata acuminata. Which of the following should the nurse include when teaching the client about the disorder and current therapies?

- 1. Cryotherapy may be used to remove the warts.
- 2. Podophyllin solution may be used to decrease the size of the warts.
- 3. A 25% trichloroacetic acid solution can eradicate the disorder.
- 4. Condylomata acuminata has been associated with ovarian cancer.

**111.** A primigravid client at 8 weeks' gestation tells the nurse that since having had sexual relations with a new partner 2 weeks ago, she has noticed flu-like symptoms, enlarged lymph nodes, and clusters of vesicles on her vagina. The nurse refers the client to a physician because the nurse suspects which of the following sexually transmitted diseases?

- 1. Gonorrhea.
- 2. *Chlamydia trachomatis* infection.
- 3. Syphilis.
- 4. Herpes genitalis.

**112.** While caring for a 24-year-old primigravid client scheduled for emergency surgery because of a probable ectopic pregnancy, the nurse should:

- 1. Prepare to witness an informed consent for surgery.
- 2. Assess the client for massive external bleeding.
- 3. Explain that the fallopian tube can be salvaged.
- 4. Monitor the client for uterine contractions.

**113.** A 30-year-old G 4, P 3 client at 30 weeks' gestation is admitted to the hospital for evaluation. The client has experienced two neonatal deaths because of hemolytic disease of the newborn. An amniocentesis is to be performed to evaluate bilirubin density. The nurse should obtain a specimen container that is which of the following?

- 1. Dark.
- 2. Clear.
- 3. Green.
- 4. Amber.

## Managing Care Quality and Safety

**114.** The nurse is reviewing results for clients who are having antenatal testing. The assessment data from which client warrants prompt notification of the health care provider and a further plan of care?

- 1. Primigravida who reports fetal movement 6 times in 2 hours.
- 2. Multigravida who had a positive oxytocin challenge test.
- 3. Primigravida whose infant has a biophysical profile of 9.
- 4. Multigravida whose infant has a reactive non-stress test.

**115.** A client asks the nurse why taking folic acid is so important before and during pregnancy. The nurse should instruct the client that:

- 1. "Folic acid is important in preventing neural tube defects in newborns and preventing anemia in mothers."
- 2. "Eating foods with moderate amounts of folic acid helps regulate blood glucose levels."
- 3. "Folic acid consumption helps with the absorption of iron during pregnancy."
- 4. "Folic acid is needed to promote blood clotting and collagen formation in the newborn."

**116.** A nurse is assigned to the obstetrical triage area. When beginning the assignment, the nurse is given a report about four clients waiting to be seen. Place the clients in the order in which the nurse should see them.

1. A primigravid client at 10 weeks' gestation complaining of not feeling well with nausea and vomiting, urinary frequency, and fatigue.

2. A multiparous client at 32 weeks' gestation asking for assistance with finding a new physician.

3. A single mother at 4 months postpartum fearful of shaking her baby when he cries.

4. An antenatal client at 16 weeks' gestation who has occasional sharp pain on her left side radiating from her symphysis to her fundus.

**117.** The health care provider at a prenatal clinic has ordered multivitamins for a woman who is 3 months' pregnant. The client calls the nurse to report that she has gone to the pharmacy to fill her prescription but is unable to buy it as it costs too much. The nurse should refer the client to:

- 1. The charge nurse.
- 2. The hospital finance office.
- 3. Her hospital social worker.
- 4. Her insurance company.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Preconception Client

**1. 1.** Plan B is a series of contraceptive pills similar in composition to birth control pills that have been used for the past 30 years. Plan B is the brand name for levonorgestrel 0.75 mg. Pills are most effective if taken immediately after unprotected intercourse and then again 12 hours later. Males can purchase this contraceptive as long as they are over 18 years of age. Common side effects include nausea, breast tenderness, vertigo, and stomach pain.

🔑 CN: Physiological adaptation;  
CL: Evaluate

**2. 3.** Birth control plans are influenced primarily by whether the mother is breast- or bottle-feeding her infant. The maternal milk supply must be well established prior to the initiation of most hormonal birth control methods. Low dose oral contraceptives would be the exception. Use of estrogen/progesterone based pills and progesterone only pills are commonly initiated from 4 to 6 weeks postpartum because the milk supply is well established by this time. Prior experiences with birth control methods have an impact on the method chosen as does the preferences of the client's partner; however, they are not the most influential factors. A history of blood clots or thrombophlebitis is the second most important factor as several methods will be eliminated because of their potential to place the client at risk for clotting disorders.

🔑 CN: Pharmacological and parenteral therapies; CL: Analysis

**3. 4.** The nurse determines that the client has understood the instructions when the client says that she will notify her physician if she notices discharge or bleeding because this may be symptomatic of underlying disease. Ideally, breast self-examination should be performed about 1 week after the onset of menses because hormonal influences on breast tissue are at a low ebb at this time. The client should perform breast self-examination on the same day each month only if she has stopped menstruating (as with menopause). The client's breasts should mirror each other. If one breast is significantly larger than the other, or if there is "pitting" of breast tissue, a tumor may be present.

🔑 CN: Reduction of risk potential;  
CL: Evaluate

**4. 3.** For a client with a menstrual cycle of 28 days, ovulation usually occurs on day 14, plus or minus 2 days, before the onset of the next menstrual cycle. Stated another way, the menstrual period begins about 2 weeks after ovulation has occurred. Ovulation does not usually occur during the menses component of the cycle when the uterine lining is being shed. In most women, the ovum survives for about 12 to 24 hours after ovulation, during which time conception is possible. The basal body temperature rises 0.5° to 1.0° F when ovulation occurs. Although some women experience some pelvic discomfort during ovulation (mittelschmerz), severe or unusual pain is rare. After ovulation, the cervical mucus is thin and copious.

🔑 CN: Health promotion and maintenance;  
CL: Create

**5. 1.** The nurse should instruct the client to take a mild analgesic, such as ibuprofen, if menstrual pain or "cramps" are present. The client should also eat foods rich in iron and should continue moderate exercise during menstruation, which increases abdominal tone. Avoiding cold foods will not decrease dysmenorrhea. Sexual intercourse is not prohibited during menstruation, but the male partner should wear a condom to prevent exposure to blood.


🔑 CN: Health promotion and maintenance;  
CL: Apply

**6. 1.** Under ideal conditions, sperm can reach the ovum in 15 to 30 minutes. This is an important point to make with adolescents who may be sexually active. Many people believe that the time interval is much longer and that they can wait until after intercourse to take steps to prevent conception. Without protection, pregnancy and sexually transmitted diseases can occur. When using the abstinence or calendar method, the couple should abstain from intercourse on the days of the menstrual cycle when the woman is most likely to conceive. Using a 28-day


cycle as an example, a couple should abstain from coitus 3 to 4 days before ovulation (days 10 through 14) and 3 to 4 days after ovulation (days 15 through 18). Sperm from a healthy male can remain viable for 24 to 72 hours in the female reproductive tract. If the female client ovulates after coitus, there is a possibility that fertilization can occur. Before fertilization, the ovum and sperm each contain 23 chromosomes. After fertilization, the conceptus contains 46 chromosomes unless there is a chromosomal abnormality.

 CN: Health promotion and maintenance;  
CL: Evaluate


**7. 3.** The symptothermal method is a natural method of fertility management that depends on knowing when ovulation has occurred. Because regular menstrual cycles can vary by 1 to 2 days in either direction, the symptothermal method requires daily basal body temperature assessments plus close monitoring of cervical mucus changes. The method relies on abstinence during the period of ovulation, which occurs approximately 14 days before the beginning of the next cycle. Abstinence from coitus for 5 days after menses is unnecessary because it is unlikely that ovulation will occur during this time period (days 1 through 10). Typically, the failure rate for this method is between 10% and 20%. Although a condom may increase the effectiveness of this method, most clients who choose natural methods are not interested in chemical or barrier types of family planning.

 CN: Health promotion and maintenance;  
CL: Create

**8. 2.** Before advising a client about oral contraceptives, the nurse needs to assess the client for signs and symptoms of hypertension. Clients who have hypertension, thrombophlebitis, obesity, or a family history of cerebral or cardiovascular accident are poor candidates for oral contraceptives. In addition, women who smoke, are older than 40 years of age, or have a history of pulmonary disease should be advised to use a different method. Iron-deficiency anemia, dysmenorrhea, and acne are not contraindications for the use of oral contraceptives. Iron-deficiency anemia is a common disorder in young women. Oral contraceptives decrease the amount of menstrual flow and thus decrease the amount of iron lost through menses, thereby providing a beneficial effect when used by clients with anemia. Low-dose oral contraceptives to prevent ovulation may be effective in decreasing the severity of dysmenorrhea (painful menstruation). Dysmenorrhea is thought to be caused by the release of prostaglandins in response to tissue destruction during the ischemic phase of the menstrual cycle. Use of oral contraceptives commonly improves facial acne.

 CN: Reduction of risk potential;  
CL: Analyze


**9. 4.** The nurse determines that the client needs further instruction when the client says that one of the adverse effects of oral contraceptive use is ovarian cancer. Some studies suggest that ovarian and endometrial cancer are reduced in women using oral contraceptives. Other adverse effects of oral contraceptives include weight gain, nausea, headache, breakthrough bleeding, and monilial infections. The most serious adverse effect is thrombophlebitis.

 CN: Pharmacological and parenteral therapies;  
CL: Evaluate

**10. 1.** The typical failure rate of a condom is approximately 12% to 14%. Adding a spermicide can decrease this potential failure rate because it offers additional protection against pregnancy. Natural skin condoms do not offer the same protection against sexually transmitted diseases caused by viruses as latex condoms do. Unlike latex condoms, natural skin (membrane) condoms do not prevent the passage of viruses. Most condom users report decreased penile gland sensitivity. However, some users do report an increased sensitivity or allergic reaction (such as a rash) to latex, necessitating the use of another method of family planning or a switch to a natural skin condom.


 CN: Health promotion and maintenance;  
CL: Apply

**11. 2.** The teaching plan should include a caution that a diaphragm should not be used if the client develops acute cervicitis, possibly aggravated by contact with the rubber of the diaphragm. Some studies have also associated diaphragm use with increased incidence of urinary tract infections. Douching after use of a diaphragm and intercourse is not recommended because pregnancy could occur. The diaphragm should be inspected and washed with mild soap and water after each use. A diaphragm should be left in place for at least 6 hours but no longer than 24 hours after intercourse. More spermicidal jelly or cream should be used if intercourse is repeated during this period.

 CN: Reduction of risk potential;  
CL: Create

**12. 4.** The client would need additional instructions when she says that she can still use the same diaphragm if she gains or loses 20 lb. Gaining or losing more than 15 lb can change the pelvic and vaginal contours to such a degree that the diaphragm will no longer protect the client against pregnancy. The diaphragm can be used for 2 to 3 years if it is cared for and well protected in its case. The client should be refitted for another diaphragm after pregnancy and delivery of a newborn because weight changes and physiologic changes of


pregnancy can alter the pelvic and vaginal contours, thus affecting the effectiveness of the diaphragm. The client should use a spermicidal jelly or cream before inserting the diaphragm.

 CN: Reduction of risk potential;  
CL: Evaluate

**13. 1,2,3,5,6.** The pregnancy requirement for folic acid is 600 micrograms/day. Major sources of folic acid include leafy green vegetables, strawberries and oranges, beans, particularly black and kidney beans, sunflower seeds, and lentils. Milk and fats contain no folic acid.

 CN: Health promotion and maintenance;  
CL: Apply

**14. 1.** Another method of contraception is needed until all sperm has been cleared from the body. The number of ejaculates for this to occur varies with the individual and laboratory analysis is required to determine when that has been accomplished. Vasectomy is considered a permanent sterilization procedure and requires microsurgery for anastomosis of the vas deferens to be completed. Studies have shown that there is no connection between cardiac disease in males and vasectomy. There is no need for follow-up once verification there is no sperm in the system.


 CN: Physiological adaptation; CL: Create

**15. 1.** Tubal ligation, a female sterilization procedure, involves ligation (tying off) or cauterization of the fallopian tubes through a small abdominal incision (laparotomy). Reversal of a tubal ligation is not easily done, and the pregnancy success rate after reversal is about 30%. After a tubal ligation, the client may engage in intercourse 2 to 3 days after the procedure. The ovaries are not generally removed during a tubal ligation. An oophorectomy involves removal of one or both ovaries.

 CN: Health promotion and maintenance;  
CL: Evaluate

**16. 2.** The basal body temperature method requires that the client take her temperature each morning before getting out of bed, preferably at the same time each day before eating or any other activity. Just before the day of ovulation, the temperature falls by 0.5° F. At the time of ovulation, the temperature rises 0.4° to 0.8° F because of increased progesterone secretion in response to the luteinizing hormone. The temperature remains higher for the rest of the menstrual cycle. The client should keep a diary of about 6 months of menstrual cycles to calculate “safe” days. There is no mucus for the first 3 or 4 days after menses, and then thick, sticky mucus begins to appear. As estrogen increases, the mucus changes to clear, slippery, and stretchy. This condition, termed spinnbarkeit, is present during

ovulation. After ovulation, the mucus decreases in amount and becomes thick and sticky again until menses. Because the ovum typically survives about 24 hours and sperm can survive up to 72 hours, couples must avoid coitus when the cervical mucus is copious and for about 3 to 4 days before and after ovulation to avoid a pregnancy.

 CN: Health promotion and maintenance;  
CL: Apply

**17. 4.** By the end of the first visit, the couple should be able to identify potential causes and treatment modalities for infertility. If their evaluation shows that a treatment or procedure may help them to conceive, the couple must then decide how to proceed, considering all of the various treatments before selecting one. Treatments can be difficult, painful, or risky. The first visit is not the appropriate time to decide on a treatment plan because the couple needs time to adjust to the diagnosis of infertility, a crisis for most couples. Although the couple may be in a hurry for definitive therapy, a thorough assessment of both partners is necessary before a treatment plan can be initiated. The success rate for achieving a pregnancy depends on both the cause and the effectiveness of the treatment, and in some cases it may be only as high as 30%. The couple may desire information about alternatives to treatment, but insufficient data are available to suggest that a specific treatment modality may not be successful. Suggesting that the couple consider adoption at this time may inappropriately imply that the couple has no other choice. If a specific therapy may result in a pregnancy, the couple should have time to consider their options. After a thorough evaluation, adoption may be considered by the couple as an alternative to the costly, time-consuming, and sometimes painful treatments for infertility.

 CN: Health promotion and maintenance;  
CL: Analyze

**18. 3.** The client’s understanding of the procedure is demonstrated by the statement describing IVF as a technique that involves bypassing the blocked or absent fallopian tubes. The physician removes the ova by laparoscope- or ultrasound-guided transvaginal retrieval and mixes them with prepared sperm from the woman’s partner or a donor. Two days later, up to four embryos are returned to the uterus to increase the likelihood of a successful pregnancy. Supplemental progesterone, not estrogen, is given to enhance the implantation process. Gamete intrafallopian transfer (GIFT) and tubal embryo transfer have a higher pregnancy rate than IVF. However, these procedures cannot be used for clients who have blocked or absent fallopian tubes because the fertilized ova are placed into the fallopian tubes, subsequently entering the uterus naturally for implantation. In IVF, fertilization of the ova by the

sperm occurs outside the client's body. In GIFT, both ova and sperm are implanted into the fallopian tubes and allowed to fertilize within the woman's body.

 CN: Reduction of risk potential;  
CL: Evaluate

**19. 4.** The client is verbalizing concerns about death during childbirth, thus providing the nurse with an opportunity to gather additional data. Asking the client about these concerns would be most helpful to determine the client's knowledge base and to provide the nurse with the opportunity to answer any questions and clarify any misconceptions. Although the maternal mortality rate is low in the United States, maternal deaths do occur, even with modern technology. Leading causes of maternal mortality in the United States include embolism, pregnancy-induced hypertension, hemorrhage, ectopic pregnancy, and infection. Telling the client not to concern herself about what has happened in the past is not useful. It only serves to discount the client's concerns and block further therapeutic communication. Also, postponing or ignoring the client's need for a discussion about complications of pregnancy may further increase the client's anxiety.

 CN: Health promotion and maintenance;  
CL: Apply

**20. 3.** As ovulation approaches, cervical mucus is abundant and clear, resembling raw egg white. Ovulation generally occurs 14 days (plus or minus 2 days) before the beginning of menses. During the luteal phase of the cycle, which occurs after ovulation, the cervical mucus is thick and sticky, making it difficult for sperm to pass. Changes in the cervical mucus are related to the influences of estrogen and progesterone. Cervical mucus is always present.

 CN: Health promotion and maintenance;  
CL: Create

**21. 1.** To ensure maximum effectiveness, the condom should always be placed over the erect penis before coitus. Some couples find condom use objectionable because foreplay may have to be interrupted to apply the condom. The penis, covered by the condom, should be withdrawn before the penis becomes flaccid. Otherwise sperm may escape from the condom, providing an opportunity for possible fertilization. Rather than having the condom pulled tightly over the penis before coitus, space should be left at the tip of the penis to allow the condom to hold the sperm. The client does not need a prescription for a condom with nonoxynol 9 because these are sold over the counter.

 CN: Reduction of risk potential;  
CL: Apply

**22. 3.** With medroxyprogesterone acetate, irregular menstrual cycles and amenorrhea are common adverse effects. Other adverse effects include weight gain, breakthrough bleeding, headaches, and depression. This method requires deep intramuscular injections every 3 months. The first injection should occur within 5 days after menses.

 CN: Reduction of risk potential;  
CL: Evaluate

**23. 4.** Severe cramping and pain may occur as the device is passed through the internal cervical os. The insertion of the device is generally done when the client is having her menses, because it is unlikely that she is pregnant at that time. Common adverse effects of IUDs are heavy menstrual bleeding and subsequent anemia, not amenorrhea. Uterine infection or ectopic pregnancy may occur. The IUD has an effectiveness rate of 98%. Therefore, additional protection is not necessary to prevent pregnancy. IUDs generally are less costly than other forms of contraception because they do not require additional expense. Only one insertion is necessary, in comparison to daily doses of oral contraceptives or the need for spermicides in conjunction with diaphragm use.

 CN: Reduction of risk potential;  
CL: Apply

**24. 1.** The American Cancer Society recommends an annual mammography screening examination for all women after the age of 40. Some high-risk women may begin annual screening at an earlier age. Some women have never had a mammogram because of fear or misconceptions. Mammography should be scheduled after the client's menses to reduce complaints of breast tenderness. Mammography screening is considered expensive, especially by low-income women. Although some discomfort is common because the breast is placed between two plates during the screening process, the procedure should not be considered extremely painful.

 CN: Health promotion and maintenance;  
CL: Evaluate

**25. 3.** Small-boned, fair-skinned women of northern European descent are at the greatest risk for osteoporosis, not African American women. One cup of yogurt or 1.5 oz of hard cheese is the equivalent of one glass of milk. Women who do not eat dairy products, such as women who are lactose intolerant, should consider using calcium supplements. Inadequate lifetime intake of calcium is a major risk factor for osteoporosis. Estrogen therapy, or some of the newer medications that are not estrogen based, can greatly reduce the incidence of osteoporosis.

 CN: Reduction of risk potential;  
CL: Evaluate

**26. 3.** Ceftriaxone sodium (Rocephin) may be used to treat *Neisseria gonorrhoeae* infections and is commonly combined with doxycycline hyclate (Vibramycin). Both the client and her partner should be treated if gonorrhea is present. Acyclovir (Zovirax) can be used to treat herpes genitalis; however, the drug does not cure the disease. *Chlamydia trachomatis* infections are usually treated with antibiotics such as doxycycline or azithromycin (Zithromax). Metronidazole (Flagyl) is used to treat trichomoniasis vaginalis, not condylomata acuminata (genital warts).

 CN: Pharmacological and parenteral therapies; CL: Create

**27. 1.** The client needs further instruction when he says that one cause of male infertility is decreased sperm count due to seminal fluid that has an alkaline pH. A slightly alkaline pH is necessary to protect the sperm from the acidic secretions of the vagina and is a normal finding. An alkaline pH is not associated with decreased sperm count. However, seminal fluid that is abnormal in amount, consistency, or chemical composition suggests obstruction, inflammation, or infection, which can decrease sperm production. The typical number of sperm produced during ejaculation is 400 million. Frequent exposure to heat sources, such as saunas and hot tubs, can decrease sperm production, as can abnormal hormonal stimulation. Immunologic factors produced by the man against his own sperm (autoantibodies) or by the woman can cause the sperm to clump or be unable to penetrate the ovum, thus contributing to infertility.

 CN: Health promotion and maintenance; CL: Evaluate

**28. 2.** A bicornate uterus has a “Y” shape and appears to be a double uterus but in fact has only one cervix. A septate uterus contains a septum that extends from the fundus to the cervix, thus dividing the uterus into two separate compartments. A double uterus has two uteri, each of which has a cervix. A uterus didelphys occurs when both uteri of a double uterus are fully formed.

 CN: Physiological adaptation; CL: Apply


### The Pregnant Client Receiving Prenatal Care

**29. 3.** At 16 weeks’ gestation, a primipara will not feel the baby moving. Quickening occurs between 18 and 20 weeks’ gestation for a primipara and between 16 and 18 weeks’ gestation for a multipara. Leaking fluid from the vagina should not occur until labor begins and may indicate a

rupture of the membranes. Bleeding and a fever are complications that warrant further evaluation and should be reported at any time during the pregnancy.

 CN: Health promotion and maintenance; CL: Evaluate

**30. 4.** Consuming most liquids between meals rather than at the same time as eating is an excellent strategy to deter nausea and vomiting in pregnancy but does not relieve heartburn. During the third trimester, progesterone causes relaxation of the sphincter and the pressure of the fetus against the stomach increases the potential of heartburn. Avoiding highly seasoned foods, remaining in an upright position after eating, and eating small, frequent meals are strategies to prevent heartburn.

 CN: Physiological adaptation; CL: Evaluate

**31. 2.** Iron deficiency anemia is caused by insufficient iron stores in the body, poor iron content in the diet of the pregnant woman, or both. Other thalassemias and sickle cell anemia, rather than iron deficiency anemia, can be associated with ethnicity but occur primarily in clients of African American or Mediterranean origin. Because red blood cells increase by about 50% during pregnancy, many clients will need to take supplemental iron to avoid iron deficiency anemia. A pregnant client is considered anemic when the hemoglobin is below 11 mg/dL. In most types of anemia, the heart must pump more often and harder to deliver oxygen to cells.

 CN: Reduction of risk potential; CL: Evaluate


**32. 4.** Many women in their first trimester feel ambivalent about being pregnant because of the significant life changes that occur for most women who have a child. Ambivalence can be expressed as a list of positive and negative consequences of having a child, consideration of financial and social implications, and possible career changes. During the second trimester, the infant becomes a separate individual to the mother. The mother will begin to enjoy the role of nurturer postpartum. During the third trimester, the mother begins to prepare for parenthood and all of the tasks that parenthood includes.

 CN: Health promotion and maintenance; CL: Apply


**33. 4.** Group B *Streptococcus* is a risk factor for all pregnant women and is not limited to those carrying twins. The multiple gestation client is at risk for preterm labor because uterine distention, a major factor initiating preterm labor, is more likely with a twin gestation. The normal uterus is only able to distend to a certain point and when that point is




reached, labor may be initiated. Twin-to-twin transfusion drains blood from one twin to the second and is a problem that may occur with multiple gestation. The donor twin may become growth restricted and can have oligohydramnios while the recipient twin may become polycythemic with polyhydramnios and develop heart failure. Anemia is a common problem with multiple gestation clients. The mother is commonly unable to consume enough protein, calcium, and iron to supply her needs and those of the fetuses. A maternal hemoglobin level below 11 g/dL is considered anemic.

 CN: Physiological adaptation;  
CL: Evaluate

**34. 2.** The plan of care should reflect that this woman is experiencing probable signs of pregnancy. She may be pregnant but the signs and symptoms may have another etiology. An enlarging abdomen and a positive pregnancy test may also be caused by tumors, hydatidiform mole, or other disease processes as well as pregnancy. Changes in the pigmentation of the face may also be caused by oral contraceptive use. Positive signs of pregnancy are considered diagnostic and include evident fetal heartbeat, fetal movement felt by a trained examiner, and visualization of the fetus with ultrasound confirmation. Presumptive signs are subjective and can have another etiology. These signs and symptoms include lack of menses, nausea, vomiting, fatigue, urinary frequency, and breast changes. The word “diagnostic” is not used to describe the condition of pregnancy.

 CN: Physiological adaptation;  
CL: Analyze

**35. 4.** Ex-Lax is considered too abrasive to use during pregnancy. In most instances, a Fleet enema will be given before Ex-Lax. Medications for constipation that are considered safe during pregnancy include compounds that produce bulk, such as Metamucil and Citrucel. Colace, Dulcolax, and Milk of Magnesia can also be used. Mineral oil prevents the absorption of vitamins and minerals within the GI tract. The strategies for heartburn are considered safe and Tylenol may be used as an over-the-counter analgesic.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**36. 1.** The radioimmunoassay pregnancy test, which uses an antiserum with specificity for the b-subunit of human chorionic gonadotrophin (hCG) in blood plasma, is highly accurate within 1 week after ovulation. The test is performed in a laboratory. Over-the-counter or home pregnancy tests are performed on urine and use the hemagglutination inhibition method. Radioimmunoassay tests usually use blood serum. A positive pregnancy test is

considered a probable sign of pregnancy. Certain conditions other than pregnancy, such as choriocarcinoma, can cause increased hCG levels.

 CN: Reduction of risk potential;  
CL: Apply

**37. 4.** The hormone analyzed in most pregnancy tests is hCG. In the pregnant woman, trace amounts of hCG appear in the serum as early as 24 to 48 hours after implantation owing to the trophoblast production of this hormone. Prolactin, follicle-stimulating hormone, and luteinizing hormone are not used to detect pregnancy. Prolactin is the hormone secreted by the pituitary gland to prepare the breasts for lactation. Follicle-stimulating hormone is involved in follicle maturation during the menstrual cycle. Luteinizing hormone is responsible for stimulating ovulation.

 CN: Reduction of risk potential;  
CL: Evaluate

**38. 4.** When using Nägele’s rule to determine the estimated date of delivery, the nurse would count back 3 calendar months from the first day of the last menstrual period and add 7 days. This means the client’s estimated date of delivery is February 17.

 CN: Health promotion and maintenance;  
CL: Apply

**39. 4.** The placenta does not produce testosterone. Human placental lactogen, hCG, estrogen, and progesterone are hormones produced by the placenta during pregnancy. The hormone hCG stimulates the synthesis of estrogen and progesterone early in the pregnancy until the placenta can assume this role. Estrogen results in uterine and breast enlargement. Progesterone aids in maintaining the endometrium, inhibiting uterine contractility, and developing the breasts for lactation. The placenta also produces some nutrients for the embryo and exchanges oxygen, nutrients, and waste products through the chorionic villi.

 CN: Health promotion and maintenance;  
CL: Evaluate


**40. 4,3,2,1.** While initially continuing to attempt to find the fetal heart beat, the nurse can ask the client if the baby has been moving. This will give a quick idea of status. The next step would be to obtain different equipment and attempt to find the fetal heart beat again. A simple statement of fact that the nurse cannot find the heartbeat and is taking steps to rule out equipment error is appropriate. Calling the health care provider would be the last step after it is determined that the baby does not have a heartbeat.

 CN: Reduction of risk potential;  
CL: Synthesize

**41. 1, 2.** Although ultrasounds are not considered part of routine care, the ultrasound is able to confirm the pregnancy, identify the major anatomic features of the fetus and possible abnormalities, and determine the gestational age by measuring crown-to-rump length of the embryo during the first trimester. At this time, the ultrasound cannot confirm the fetus is viable. The ultrasound will provide information about fetal position; however, this information would be more important later in the pregnancy, not during the first trimester. The ultrasound would provide no information about nutrient supply for the fetus.

 CN: Health promotion and maintenance;  
CL: Analyze


**42. 2.** This client is expressing a feeling of surprise about having a baby. Therefore, the nurse's best response would be to confirm the pregnancy, which is something that the client already suspects, and then ascertain how the client is feeling now that the suspicion is confirmed. Studies have shown that a common reaction to pregnancy is summarized as ambivalence or "someday, but not now." Such feelings are normal and are experienced by many women early in pregnancy. Offering a pamphlet on pregnancy does not respond to the client's feelings. Telling the client that she should be delighted ignores, rather than addresses, the client's feelings. Also, doing so imposes the nurse's opinion on the client. Ambivalence is a common reaction to pregnancy. Telling the client that she should be delighted may lead to feelings of guilt. Asking the client if she and her husband were trying to have a baby is a "yes-no" question and is not helpful. In addition, it ignores the client's underlying feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**43. 3.** Women normally experience ambivalence when pregnancy is confirmed, even if the pregnancy was planned. Although the client's culture may play a role in openly accepting the pregnancy, most new mothers who have been ambivalent initially accept the reality by the end of the first trimester. Ambivalence also may be expressed throughout the pregnancy; this is believed to be related to the amount of physical discomfort. The nurse should become concerned and perhaps contact a social worker if the client expresses ambivalence in the third trimester. The client's statement reflects ambivalence, not fear. There is no evidence to suggest or imply that the client is rejecting the fetus. The client's statement reflects ambivalence about the pregnancy, not her ability to care for the newborn.

 CN: Psychosocial adaptation;  
CL: Analyze

**44. 3.** Couvade syndrome refers to the situation in which the expectant father experiences some of the discomforts of pregnancy along with the pregnant woman as a means of identifying with the pregnancy. Ptyalism is the term for excessive salivation. Mittelschmerz is the lower abdominal discomfort felt by some women during ovulation. Pica refers to an oral craving for substances such as clay or starch that some pregnant clients experience.

 CN: Psychosocial adaptation;  
CL: Analyze

**45. 3.** Maternal alcohol use may result in fetal alcohol syndrome, marked by mild to moderate mental retardation, physical growth retardation, central nervous system disorders, and feeding difficulties. Because there is no definitive answer as to how much alcohol can be safely consumed by a pregnant woman, it is recommended that pregnant clients be taught to abstain from drinking alcohol during pregnancy. Smoking and other medications also may affect the fetus.


 CN: Reduction of risk potential;  
CL: Apply

**46. 4.** An increase in clear, highly acidic vaginal secretions is a normal finding during pregnancy that aids in controlling the growth of pathologic bacteria. Vaginal secretions increase because of the influence of estrogen secretion and increased vaginal and cervical vascularity. The highly acidic nature of the vaginal secretions is caused by the action of *Lactobacillus acidophilus*, which increases the lactic acid content of the secretions. The increased acidity helps to make the vagina resistant to bacterial growth. During pregnancy, estrogen secretion fosters a glycogen-rich environment. Unfortunately, this glycogen-rich, acidic environment fosters the development of yeast (*Candida albicans*) infections, manifested by itching, burning, and a cheese-like vaginal discharge. If the client had a sexually transmitted disease, most likely she would complain of additional symptoms, such as lesions in the genital area or changes in color, consistency, or odor of the vaginal secretions. An increase in vaginal secretions does not help prevent expulsion of the mucus plug. The mucus plug is held in place by the cervix until the cervix becomes ripe.


 CN: Health promotion and maintenance;  
CL: Analyze

**47. 2.** Measurement of the client's fundal height is a gross estimate of fetal gestational age. At 20 weeks' gestation, the fundal height should be at about the level of the client's umbilicus. The fundus typically is over the symphysis pubis at 12 weeks. A fundal height measurement between

these two areas would suggest a fetus with a gestational age between 12 and 20 weeks. The fundal height increases approximately 1 cm/week after 20 weeks' gestation. The fundus typically reaches the xiphoid process at approximately 36 weeks' gestation. A fundal height between the umbilicus and the xiphoid process would suggest a fetus with a gestational age between 20 and 36 weeks. The fundus then commonly returns to about 4 cm below the xiphoid owing to lightening at 40 weeks. Additionally, pressure on the diaphragm occurs late in pregnancy. Therefore, a fundal height measurement near the xiphoid process with diaphragmatic compression suggests a fetus near the gestational age of 36 weeks or older.

 CN: Health promotion and maintenance;  
CL: Apply

**48. 2.** The volume of fluid needed for amniocentesis is 15 mL and this is usually available at 15 weeks' gestation. Fetal development continues throughout the prenatal period. Cells necessary for testing for Hemophilia A are available during the entire pregnancy but are not accessible by amniocentesis until 12 weeks' gestation. Anomalies are not associated with amniocentesis testing.

 CN: Reduction of risk potential;  
CL: Apply

**49. 4.** The National Academy of Sciences Institute of Medicine recommends that women gain between 25 and 35 lb during pregnancy. These guidelines were developed to decrease the risk of intrauterine growth retardation. It is believed that the pattern of weight gain is as important as the total amount of weight gained. Underweight women and women carrying twins should have a greater weight gain. Typically, women should gain 3.5 lb during the first trimester and then 1 lb/week during the remainder of the pregnancy (24 weeks) for a total of about 27 to 28 lb. A weight gain of only 6.6 lb in the second and third trimesters is not considered normal because the client should be gaining about 1 lb/week, or 12 lb during the second and third trimesters. Gaining 12 lb during each trimester would total 36 lb, which is slightly more than the recommended weight gain. In addition, nausea and vomiting during the first trimester can contribute to a lack of appetite and smaller weight gain during this trimester.

 CN: Health promotion and maintenance;  
CL: Evaluate

**50. 1.** Green, leafy vegetables, such as asparagus, spinach, brussel sprouts, and broccoli, are rich sources of folic acid. The pregnant woman needs to eat foods high in folic acid to prevent folic acid deficits, which may result in neural tube defects in the newborn. A well-balanced diet must

include whole grains, dairy products, and fresh fruits; however, bananas are rich in potassium, seafood is rich in iodine, and yogurt is rich in calcium, not folic acid.

 CN: Reduction of risk potential;  
CL: Apply


**51. 3.** Egg yolks and squash and other yellow vegetables are rich sources of vitamin A. Pregnant women should avoid megadoses of vitamin A because fetal malformations may occur. Buttermilk and cheese are good sources of calcium. Strawberries, cantaloupe, citrus fruits (such as oranges), and tomatoes are good sources of vitamin C, not vitamin A.

 CN: Basic care and comfort; CL: Evaluate


**52. 1, 3, 4.** Dairy products, fresh fruit, vegetables, and foods high in protein (like cheese and peanut butter) are excellent choices. Fried foods, such as chicken nuggets and tater tots, and foods such as cheeseburgers and buttered popcorn are high in fat; carbonated drinks such as diet colas, and foods such as pickles and ketchup contain large amounts of sodium. These foods can lead to an increase in ankle edema and promote weight gain from empty calories.

 CN: Health promotion and maintenance;  
CL: Apply

**53. 1.** Milk contains a large amount of calcium but contains no iron. Coffee, tea, and caffeinated soft drinks inhibit the absorption of iron. The vitamin C found in orange juice enhances the absorption of iron. Cream of wheat (1 cup/10 mg iron) and molasses (1 tbsp/3.0 mg iron) are considered excellent sources of iron as they contain the indicated amounts of iron.

 CN: Physiological adaptation;  
CL: Evaluate

**54. 2.** Magnesium aids in the synthesis of protein, nucleic acids, proteins, and fats. It is important for cell growth and neuromuscular function. Magnesium also activates the enzymes for metabolism of protein and energy. Calcium prevents demineralization of the mother's bones. Vitamin B6 is important for amino acid metabolism. Folic acid assists in the development of neural pathways in the fetus.

 CN: Basic care and comfort; CL: Apply

**55. 1.** The diet for Vietnamese Americans typically consists of small portions of meat and ample amounts of rice. Fresh milk may not have been readily available in Vietnam, and many Asian clients are lactose intolerant. Therefore, the nurse would need to assess the client's diet for deficiencies of calcium and possibly iron. Traditionally,


Southeast Asian diets have an abundance of dark green leafy vegetables, such as mustard greens and bok choy, which contain adequate amounts of vitamin E and vitamin C. Seafood, which contains iodine, is usually adequate in the diets of Southeast Asian women.

 CN: Reduction of risk potential;  
CL: Analyze

**56. 3.** Chorionic villi sampling, which can be performed between 8 and 10 weeks' gestation, involves the insertion of a thin catheter into the vagina and uterus to obtain a sample of the chorionic cells. It is a useful diagnostic test to determine trisomy 13, translocations, fragile X syndrome, and trisomy 18. Fetoscopy is performed with a small fiberoptic fetoscope inserted through a small incision into the client's uterus to inspect the fetus for gross abnormalities. There are no food or fluid restrictions necessary before chorionic villi sampling. Ideally, the client should empty the bladder before this procedure. A full bladder would be needed if the client were scheduled to have an ultrasound examination.

 CN: Reduction of risk potential;  
CL: Evaluate

**57. 4.** Although most multiparous women experience quickening at about 17½ weeks' gestation, some women may perceive it between 14 and 20 weeks' gestation because they have been pregnant before and know what to expect. Detecting movement early does not suggest a twin pregnancy. If the multiparous client does not experience quickening by 20 weeks' gestation, further investigation is warranted, because the fetus may have died, the client has a hydatidiform mole, or the pregnancy dating is incorrect. There is no evidence that the client's expected date of delivery is erroneous.

 CN: Health promotion and maintenance;  
CL: Analyze

**58. 4.** AFP testing is usually performed between the 15th and 18th weeks of gestation. Abnormally high levels found in maternal serum may be indicative of neural tube defects such as anencephaly and spina bifida. Low levels may indicate trisomy 21 (Down syndrome). Culdocentesis is used to confirm a tubal pregnancy. Chorionic villus sampling is done as early as 10 weeks' gestation to detect anomalies. Ultrasound testing may be done in the first trimester to determine fetal viability and in the third trimester to determine pelvic adequacy and fetal or placental position.

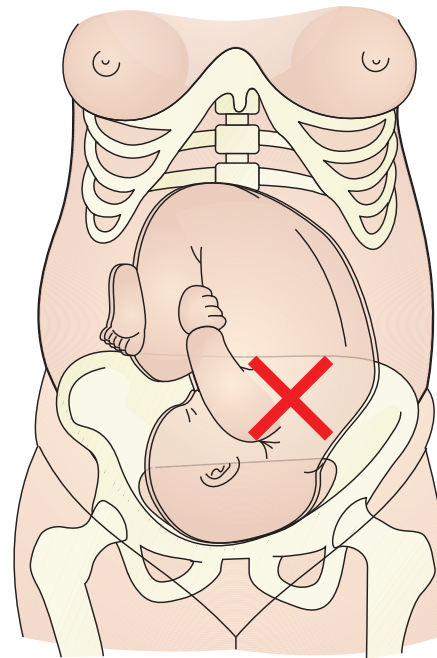
 CN: Reduction of risk potential;  
CL: Apply

**59. 2.** Leopold's maneuvers involve abdominal palpation. The client should empty her bladder before the nurse palpates the abdomen. Doing so increases the client's comfort and makes palpation more accurate. Although breathing deeply may help to relax the client, it has no effect on the accuracy of the results of Leopold's maneuvers. The client does not need to drink a full glass of water before the examination. The client should be lying in a supine position with the head slightly elevated for greater comfort and with the knees drawn up slightly.

 CN: Health promotion and maintenance;  
CL: Apply

**60.** Because the fetus is determined to be in an LOA, a vertex position, the convex portion of the fetus lying closest to the uterine wall would be located in the lower left quadrant of the abdomen. Placing the Doppler ultrasound over that area would produce the loudest fetal heart sounds.

 CN: Management of care; CL: Apply



**61. 1.** In left occipital transverse lie, the occiput faces the woman's left hip. In left occipital anterior lie, the occiput faces the left anterior segment of the woman's pelvis. In right occipital transverse lie, the occiput faces the woman's right hip. In right occipital anterior lie, the occiput faces the right anterior segment of the woman's pelvis.

 CN: Physiological adaptation; CL: Apply


**62. 1.** Discoloration on the face that commonly appears during pregnancy, called *chloasma* (mask of pregnancy), usually fades postpartum and is of no clinical significance. The client who is bothered by her appearance may be able to decrease its prominence with ordinary makeup. Chloasma is not a sign of skin melanoma. It is not caused by dilated capillaries. Rather, it results from increased secretion of melanocyte-stimulating hormones caused by estrogen and progesterone secretion. No treatment is necessary for this condition.

 CN: Health promotion and maintenance;  
CL: Apply

**63. 4.** Assessment of fundal height is a gross estimate of gestational age. By 20 weeks' gestation, the height of the fundus should be at the level of the umbilicus, after which it should increase 1 cm for each week of gestation until approximately 36 weeks' gestation. Fundal height that is significantly different from that implied by the estimated gestational age warrants further evaluation (e.g., ultrasound examination), because it possibly indicates multiple pregnancy or fetal growth retardation. Fundal height estimation will not determine uterine activity or a need for increased weight gain. Ultrasound examination, not fundal height estimation, will locate the placenta.

 CN: Health promotion and maintenance;  
CL: Apply

**64. 2.** One of the primary risks of amniocentesis is stimulation of the uterus and subsequent preterm labor. Other risks include hemorrhage from penetration of the placenta, infection of the amniotic fluid, and puncture of the fetus. There is little risk for rupture of the membranes, fetal limb malformations, or fetal organ malformations, if a practitioner skilled in using ultrasound performs the procedure. Fetal limb malformations have been associated with percutaneous umbilical blood sampling.

 CN: Reduction of risk potential;  
CL: Evaluate

**65. 3.** The client traveling by automobile should be advised to take intermittent breaks of 10 to 15 minutes, including walking, every 1 to 2 hours to stimulate the circulation, which becomes sluggish during long periods of sitting. Automobile travel is not contraindicated during pregnancy unless the client develops complications. There is no set maximum number of hours allowed. The pregnant client should always wear a seat belt when traveling by automobile. The client should be aware of the nearest health care facility in the city to which she is traveling.


 CN: Reduction of risk potential;  
CL: Apply

**66.** Seat belt safety is important for pregnant women because proper use reduces maternal mortality in car accidents. Both lap and shoulder belts are to be used. The lap portion of the belt is placed snugly but comfortably to fit under the abdominal bulge. Wearing the lap belt over the abdomen could increase the risk of uterine rupture and fetal complications due to belt tightening as the woman is propelled forward during an automobile accident. The shoulder belt is placed snugly across the shoulder, chest, and upper abdomen.


 CN: Safety and infection control;  
CL: Apply




**67. 3.** Leg cramps are thought to result from excessive amounts of phosphorus absorbed from milk products. Straightening the knee and flexing the toes toward the chin is an effective measure to relieve leg cramps. Also, decreasing milk intake and supplementing with calcium lactate may help to reduce the cramping. Keeping the legs warm and elevating them are good preventive measures. Changing positions frequently aids venous return but is not helpful in relieving leg cramps. Alternately flexing and extending the legs will not help to relieve the leg cramp. Lying prone in the bed is a difficult position for a client at 37 weeks' gestation to achieve and maintain because of the increase in abdominal size and therefore is not considered helpful.

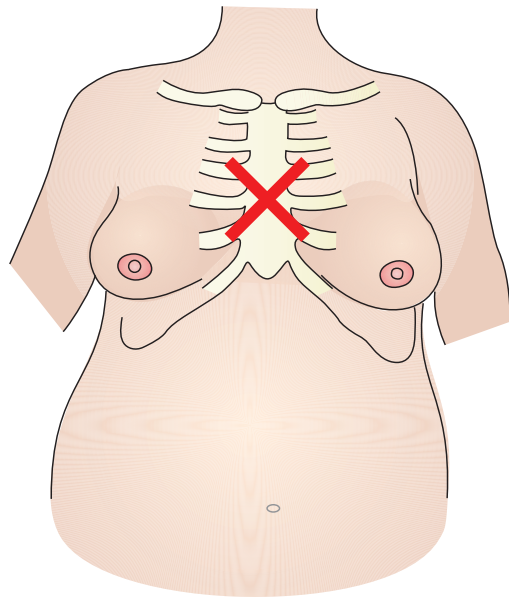
 CN: Basic care and comfort;  
CL: Synthesize

**68. 1.** Eating smaller and more frequent meals may help prevent heartburn because acid production is decreased and stomach displacement is reduced. Heartburn can occur at any time during pregnancy. Contributing factors include stress, tension, worry, fatigue, caffeine, and smoking. Certain spicy foods (e.g., tacos) may trigger heartburn in the pregnant client. The client should be advised to avoid sodium bicarbonate antacids (e.g., Alka-Seltzer), baking soda, Bicitra or sodium citrate, and fatty foods, which are high in sodium and can contribute to fluid retention. Increasing, not decreasing, fluid intake may help to relieve heartburn by diluting gastric juices. Caffeinated products such as coffee or tea can stimulate acid formation in the stomach, further contributing to heartburn.

 CN: Basic care and comfort;  
CL: Synthesize

**69.** The fist is placed against the middle of the woman's sternum, with backward thrusts until the foreign body is expelled. The pressure from the backward thrusts causes compression of the ribs, further adding to the chest and lung pressure, thereby forcing the foreign body to move upward.

 CN: Safety and infection control;  
CL: Apply



**70. 2.** In the first maneuver, which is done with the nurse facing the client's head, both hands are used to palpate and determine which fetal body part (e.g., the head or buttocks) is in the fundus. This first maneuver helps to determine the presenting part of the fetus. In the second maneuver, also done with the nurse facing the client's head, the palms of both hands are used to palpate the sides of the


uterus and determine the location of the fetal back and spine. In the third maneuver, one hand gently grasps the lower portion of the abdomen just above the symphysis pubis to determine whether the fetal head is at the pelvic inlet. The fourth maneuver, done with the nurse facing the client's feet, determines the degree of fetal descent and flexion into the pelvis.

 CN: Health promotion and maintenance;  
CL: Apply

**71. 4.** Increased AFP levels are associated with neural tube defects, such as spina bifida, anencephaly, and encephalocele. Ultrasonography is used to confirm a neural tube defect only when AFP levels are increased. Because AFP levels are usually highest at 15 to 18 weeks' gestation, this is the optimum time for testing. Performing the test after this time leads to inaccurate results. The client's blood, not urine, is used for the sample.

 CN: Reduction of risk potential;  
CL: Create

**72. 1.** Prenatal care is commonly the most critical factor influencing pregnancy outcome. This is especially true for adolescents, because the most significant medical complication in pregnant adolescents is pregnancy-induced hypertension. Continued prenatal care helps to allow for early detection and prompt intervention should the complication arise. Other risks for adolescents include low-birth-weight infant, preterm labor, iron-deficiency anemia, and cephalopelvic disproportion. Gestational diabetes can occur with any pregnancy regardless of the age of the mother. Generally, all first-time mothers need instruction related to discomforts. Adolescent mothers have better nutrition when they attend group classes and are subject to peer pressure. No evidence demonstrates that most adolescents lack support systems. Fathers may abandon mothers at any time during the pregnancy; other fathers, regardless of age, are supportive throughout the pregnancy.

 CN: Health promotion and maintenance;  
CL: Apply

**73. 3.** Colostrum is usually secreted by about the 16th week of gestation in preparation for breast-feeding. Growth of the milk ducts is greatest in the last trimester, not in the first 8 weeks of gestation. Enlargement of the breasts is usually caused by estrogen, not progesterone. Darkening of the areola can occur as early as the sixth week of gestation.

 CN: Health promotion and maintenance;  
CL: Create


**74. 2, 4, 6.** Understanding of breast-feeding education is demonstrated by statements involving knowledge of the several positions available for comfortable breast-feeding, oxytocin release from the pituitary leading to a let-down reflex and uterine contractions for involution, and feeding cues helpful in successful breast-feeding (because waiting until the infant is hungry and crying is stressful). Breast size does not ensure successful breast-feeding. Mastitis is an infectious process and is not influenced by latching on. Breast milk needs to be stored in the refrigerator or freezer to decrease the risk of bacterial growth.

 CN: Basic care and comfort; CL: Evaluate


**75. 2.** During pregnancy, the circulatory system undergoes tremendous changes. Cardiac output increases by 25% to 50%, and circulatory blood volume increases by about 30%. The client may experience transient hypotension and dizziness with sudden position changes. Early in pregnancy there is a slight increase in the temperature, and clients may attribute this to a sinus infection or a cold. The client may feel warm, but this sensation is transient. The level of circulating fibrinogen increases as much as 50% during pregnancy, probably because of increased estrogen. Any calf tenderness should be reported, because it may indicate a clot. Late in pregnancy, the posterior pituitary gland secretes oxytocin. The client may experience painful Braxton Hicks contractions or early labor symptoms.

 CN: Health promotion and maintenance;  
CL: Create


**76. 1.** The fetal biophysical profile includes fetal breathing movements, fetal body movements, tone, amniotic fluid volume, and fetal heart rate reactivity. A reactive nonstress test is a sign of fetal well-being and does not require further evaluation. A nonreactive nonstress test requires further evaluation. A contraction stress test or oxytocin challenge test should be performed only on women who are at risk for fetal distress during labor. The contraction stress test is rarely performed before 28 weeks' gestation because of the possibility of initiating labor. Percutaneous umbilical cord sampling requires the insertion of a needle through the abdomen to obtain a fetal blood sample.

 CN: Reduction of risk potential;  
CL: Apply

**77. 3.** The purpose of Kegel exercises is to strengthen the perineal muscles in preparation for the labor process. These movements strengthen the pubococcygeal muscle, which surrounds the urinary meatus and vagina. No evidence is available to support the idea that these exercises prevent vulvar edema, alleviate lower back discomfort, or strengthen the abdominal muscles.

 CN: Basic care and comfort; CL: Apply

**78. 4.** During the third trimester, it is not uncommon for clients to have dreams or fantasies about the baby. Sometimes the dreams are about infants who are malformed or, in this example, covered with hair. There is no evidence to suggest that the client is trying to cope with becoming a parent. Having dreams about the baby does not mean that labor will begin soon.

 CN: Psychosocial adaptation;  
CL: Synthesize

**79. 1.** Insomnia in the later part of pregnancy is not uncommon because the client has difficulty getting into a position of comfort. This is further compounded by frequent nocturia. The best suggestion would be to advise the client to practice relaxation techniques before bedtime. The client should avoid caffeine products such as chocolate and coffee before going to bed because caffeine is a stimulant. Alcohol consumption, regardless of the type or amount, should be avoided. Exercise is advised during the day, but it should be avoided before bedtime because exercise can stimulate the client and decrease the client's ability to fall asleep.

 CN: Basic care and comfort; CL: Apply

**80. 3.** The client needs further instruction when she says it is permissible to sit in a hot tub for 20 minutes to relax after working. Hot tubs and saunas should be avoided, particularly in the first trimester, because their use can lead to maternal hyperthermia, which is associated with fetal anomalies such as central nervous system defects. The client should use nonskid pads in the shower or bath to avoid slipping because the client's center of gravity has shifted and she may fall. The client should avoid using soap on the nipples to prevent removal of the natural protective oils. Douching is not recommended for pregnant women because it can destroy the normal flora and increase the client's risk of infection.

 CN: Health promotion and maintenance;  
CL: Evaluate

**81. 3.** The obstetric conjugate can be estimated by subtracting 1.5 to 2 cm from the diagonal conjugate, which can be measured during a pelvic examination. Transverse diameters of the pelvic inlet are not measured and the pubic arch has no relevance to the obstetrical conjugate.

 CN: Health promotion and maintenance;  
CL: Apply

## The Pregnant Client in Childbirth Preparation Classes

**82. 3, 4, 5, 6.** During the third trimester of pregnancy, the woman experiments with maternal and caregiver roles and may make plans for changes in employment, managing household tasks, and/or childcare. The woman is also concerned about safety and passage through labor and delivery. Other psychological tasks include preparation of the nursery, being tired of the pregnancy, and being introspective. A woman will begin to see herself as someone different from the fetus in the second trimester. Additionally, the mother may fantasize about the infant during the second trimester and be concerned about her changing body image. She may experience ambivalence about pregnancy in the first trimester.

 CN: Psychosocial adaptation; CL: Create

**83. 4.** Pregnancy creates changes in the mother and father. Being considerate, accepting changes, and being supportive of the current situation are considered acceptable responses by the father, rather than feeling irritation about these changes. Expressing concern with the financial changes pregnancy and an expanded family include is normal. The first trimester involves the client and family feeling ambivalent about pregnancy and moving toward acceptance of the changes associated with pregnancy. Maternal acceptance of the pregnancy and a subsequent change in her focus are normal occurrences.

 CN: Health promotion and maintenance; CL: Analyze

**84. 4.** Thyroid enlargement and increased basal body metabolism are common occurrences during pregnancy. Human placental lactogen enhances milk production. Estrogen is responsible for hyperpigmentation and vascular skin changes. Progesterone relaxes smooth muscle in the respiratory tract.

 CN: Health promotion and maintenance; CL: Create

**85. 1.** Although sex is not easily discerned at 9 to 12 weeks, external genitalia are developed at this period of fetal development. Myelination of the nerves begins at about 20 weeks' gestation. Brown fat stores develop at approximately 21 to 24 weeks. Air ducts and alveoli develop later in the gestational period, at approximately 25 to 28 weeks.

 CN: Health promotion and maintenance; CL: Apply

**86. 2.** Monozygotic twinning is independent of race, age, parity, or heredity. Monozygotic twins result from the fertilization of one ovum by two different sperm. Dizygotic twinning occurs with the fertilization of more than one ovum during conception. Dizygotic twins may be of the same sex or different sexes. Dizygotic twinning is correlated with increased parity, becoming pregnant within 1 month after stopping oral contraception, and infertility treatments. A primigravida client is less likely to conceive dizygotic twins.

 CN: Health promotion and maintenance; CL: Apply

**87.**

1. Engagement

3. Descent

2. Flexion

4. Internal rotation

Engagement refers to the fetus' entering the true pelvis and occurs before descent in primiparas and concurrently in multiparous women. If the head is the presenting part, the normal maneuvers during labor and delivery are (in order): descent, flexion, internal rotation, extension, external rotation, and expulsion. These maneuvers are called the *cardinal movements*. They occur as the fetal head passes through the maternal pelvis during the normal labor process.

 CN: Health promotion and maintenance; CL: Apply

**88. 1.** In a normal delivery and for the first 24 hours postpartum, a total blood loss not exceeding 500 mL is considered normal. Blood loss during delivery is almost always estimated because it provides a valuable indicator for possible hemorrhage. A blood loss of 1,000 mL is considered hemorrhage.

 CN: Health promotion and maintenance; CL: Apply

**89. 2.** Although the amniotic fluid promotes normal prenatal development by allowing symmetric development, it does not provide the fetus with nutrients. Rather, nutrients are provided by the placenta. The amniotic fluid does help dilate the cervix once labor begins by pressure and gravity forces. The amniotic fluid helps to protect the fetus from injury by cushioning against impact of the maternal abdomen and allows room and buoyancy for fetal movement. The amniotic fluid and sac keep the fetus at a stable temperature by maintaining a neutral thermal environment.


 CN: Health promotion and maintenance; CL: Evaluate




**90. 1.** Pelvic rocking helps to relieve backache during pregnancy and early labor by making the spine more flexible. Deep breathing exercises assist with relaxation and pain relief during labor. Tailor sitting and squatting help stretch the perineal muscles in preparation for labor.

 CN: Health promotion and maintenance;  
CL: Analyze

**91. 1, 2, 4.** Pain during the first stage of labor is primarily caused by hypoxia of the uterine and cervical muscle cells during contraction, stretching of the lower uterine segment, dilatation of the cervix and perineum, and pressure on adjacent structures. Ambulating will assist in increasing circulation of blood to the area and relaxing the muscles. Slow chest breathing is appropriate during the first stage of labor to promote increased oxygenation as well as relaxation. The woman or her coach can lightly massage the abdomen (effleurage) while using slow chest breathing. Chest breathing and massaging increase oxygenation and relaxation of uterine muscles. Pain medication is not used during the first stage of labor because most medications will slow labor; anesthesia may be considered during the second stage of labor. Sipping ice water, while helpful for maintaining hydration, will not be useful as a pain management strategy.

 CN: Health promotion and maintenance;  
CL: Synthesize

**92. 4.** With true labor, the contractions are felt first in the lower back and then the abdomen. They gradually increase in frequency and duration and do not disappear with ambulation, rest, or sleep. In true labor, the cervix dilates and effaces. Walking tends to increase true contractions. False labor contractions disappear with ambulation, rest, or sleep. False labor contractions commonly remain the same in duration and frequency. Clients who are experiencing false labor may have pain, even though the contractions are not very effective.

 CN: Health promotion and maintenance;  
CL: Apply

**93. 4.** Pelvic tilt exercises are useful to alleviate backache during pregnancy and labor but are not useful for the pain from contractions. Biofeedback (a conscious effort to control the response to pain), effleurage (light uterine massage), and guided imagery (focusing on a pleasant scene) are appropriate pain relief techniques to practice before labor begins. Various breathing exercises also can help to alleviate the discomfort from contraction pain.

 CN: Health promotion and maintenance;  
CL: Evaluate

**94. 2.** Increased vaginal discharge is normal during pregnancy, but yellow-gray frothy discharge with local itching is associated with infection (e.g., *Trichomonas vaginalis*). The client's symptoms must be further assessed by a health professional because the client needs treatment for this condition. *T. vaginalis* infection is commonly treated with metronidazole (Flagyl). However, this drug is not used in the first trimester. In the first trimester, the typical treatment is topical clotrimazole. Although a yeast infection is associated with vaginal itching, the vaginal discharge is cheese-like. Furthermore, because the client may have a serious vaginal infection, over-the-counter medications are not advised until the client has been evaluated. Douching is not recommended during pregnancy because it would predispose the client to an ascending infection. The client is not exhibiting signs and symptoms of preterm labor, such as contractions or leaking fluid. And although the client's complaints are suggestive of a *T. vaginalis* infection, which can lead to preterm labor and premature rupture of the membranes, further evaluation is needed to confirm the cause of the infection.

 CN: Health promotion and maintenance;  
CL: Synthesize

**95. 2.** During pregnancy, urinary tract infections are more common because of urinary stasis. Clients need instructions about increasing fluid volume intake. Plasma volume increases during pregnancy. The increase in plasma volume is more pronounced and occurs earlier than the increase in red blood cell mass, possibly resulting in physiologic anemia. Peripheral vascular resistance decreases during pregnancy, providing a relatively stable blood pressure. Hemoglobin levels decrease during pregnancy even though there is an increase in blood volume.


 CN: Health promotion and maintenance;  
CL: Apply

**96. 1.** The maternal mortality rate is defined as the number of maternal deaths related to childbearing divided by the number of live births. Maternal mortality in the United States has been increasing in part due to inadequate prenatal care and the increasing number of cesarean sections. Infant mortality rate is defined as the number of deaths of infants younger than 12 months of age per 1,000 live births. The perinatal mortality rate includes all stillborn infants with a gestational age of 28 weeks or more plus all neonatal deaths before 7 days of age per 1,000 of this population. The neonatal mortality rate is the number of deaths of infants younger than 28 days of age per 1,000 live births.

 CN: Health promotion and maintenance;  
CL: Analysis

## The Pregnant Client with Risk Factors

**97. 4.** For the Rh-negative client who may be pregnant with an Rh-positive fetus, an indirect Coombs test measures antibodies in the maternal blood. Titers should be performed monthly during the first and second trimesters and biweekly during the third trimester and the week before the due date.

 CN: Health promotion and maintenance; CL: Apply


**98. 2.** According to the New York Heart Association Cardiac Disease classification, this client would fit under Class II because she is symptomatic with increased activity (dyspnea with exertion). The New York Heart Association Cardiac Disease Classification identifies Class II clients as having cardiac disease and a slight limitation in physical activity. When physical activity occurs, the client may experience angina, difficulty breathing, palpitations, and fatigue. All of the client's other symptoms are within normal limits.

 CN: Management of care; CL: Analyze

**99. 1, 2, 5.** The test result indicates that the mother has an active hepatitis infection and is a carrier. Hepatitis B immune globulin at birth provides the infant with passive immunity against hepatitis B and serves as a prophylactic treatment. Additionally, the infant will be started on the vaccine series of three injections. The infant should not be screened or isolated because the infant is already hepatitis B positive. As with all clients, universal precautions should be used and are sufficient to prevent transmission of the virus. Women who are positive for hepatitis B surface antigen are able to breast-feed.

 CN: Management of care; CL: Create

**100. 4.** Asthma medications and bronchodilators should be continued during pregnancy as prescribed before the pregnancy began. The medications do not cause harm to the mother or fetus. Regular use of asthma medication will usually prevent asthma attacks. Prevention and limitation of an asthma attack is the goal of care for a client who is or is not pregnant and is the appropriate care strategy. During an asthma attack, oxygen needs continue as with any pregnant client but the airways are edematous, decreasing perfusion. Asthma exacerbations during pregnancy may occur as a result of infrequent use of medication rather than as a result of the pregnancy.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**101. 2.** The nurse seeing this client should refer her to a health care provider for further evaluation of the pain. This referral would allow a more definitive diagnosis and medical interventions that may include surgery. Referral would occur because of her high pain rating as well as the other symptoms, which suggest gallbladder disease. During pregnancy, the gallbladder is under the influence of progesterone, which is a smooth muscle relaxant. Because bile does not move through the system as quickly during pregnancy, bile stasis and gallstone formation can occur. Although education should be a continuous strategy, with pain at this level, a brief explanation is most appropriate. Major emphasis should be placed on determining the cause and treating the pain. It is not appropriate for the nurse to diagnose pain at this level as heartburn. Discussing nutritional strategies to prevent heartburn are appropriate during pregnancy, but not in this situation. Tylenol is an acceptable medication to take during pregnancy but should not be used on a regular basis as it can mask other problems.

 CN: Management of care; CL: Synthesize

**102. 3.** A fetus that has died and is retained in utero places the mother at risk for disseminated intravascular coagulation (DIC) because the clotting factors within the maternal system are consumed when the nonviable fetus is retained. The longer the fetus is retained in utero, the greater the risk of DIC. This client has no risk factors, history, or signs and symptoms that put her at risk for either abruptio placentae or placenta previa, such as sharp pain and “woody,” firm consistency of the abdomen (abruption) or painless bright red vaginal bleeding (previa). There is no evidence that she is threatening to abort as she has no complaints of cramping or vaginal bleeding.

 CN: Management of care; CL: Analyze


**103. 2.** Chorionic villus sampling (CVS) can be performed from approximately 8 to 12 weeks' gestation, while amniocentesis cannot be performed until between 11 weeks' gestation and the end of the pregnancy. Eleven weeks' gestation is the earliest possible time within the pregnancy to obtain a sufficient amount of amniotic fluid to sample. Because CVS take a piece of membrane surrounding the infant, this procedure can be completed earlier in the pregnancy. Amniocentesis and chorionic villus sampling identify the genetic makeup of the fetus in its entirety, rather than a portion of it. Laboratory analysis of chorionic villus sampling takes less time to complete. Both procedures place the fetus at risk and postprocedure teaching asks the client to report the same complicating events (bleeding, cramping, fever, and fluid leakage from the vagina).

 CN: Management of care; CL: Evaluate


**104. 4.** Additional teaching is needed when the parent says that adolescents are at greater risk for congenital anomalies. Although adolescents are at greater risk for denial of the pregnancy, lack of prenatal care, low-birth-weight infant, cephalopelvic disproportion, anemia, and nutritional deficits and have a higher maternal mortality rate, studies reveal that congenital anomalies are not more common in adolescent pregnancies.

 CN: Health promotion and maintenance; CL: Evaluate

**105. 4.** With a spontaneous abortion, many clients and their partners feel an acute sense of loss. Their grieving commonly includes feelings of guilt, which may be expressed as wondering whether the woman could have done something to prevent the loss. Anger, sadness, and disappointment are also common emotions after a pregnancy loss. Ambivalence, anxiety, and fear are not common emotions after a spontaneous abortion.

 CN: Psychosocial adaptation; CL: Analysis


**106. 1.** Hydroxyzine (Vistaril) has a tranquilizing effect and also decreases nausea and vomiting. It does not decrease fluid retention, reduce pain, decrease uterine cramping, or promote uterine contractility. One of the adverse effects of the medication is sleepiness. Ibuprofen may decrease pain from uterine cramping. Oxytocin may be used to increase uterine contractility.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**107. 3.** The death of a fetus at any time during pregnancy is a tragedy for most parents. After a spontaneous abortion, the client and family members can be expected to suffer from grief for several months or longer. When offering support, a simple statement such as “I’m truly sorry you lost your baby” is most appropriate. Therapeutic communication techniques help the client and family understand the meaning of the loss, move less stressfully through the grief process, and share feelings. Asking the client whether she is experiencing a great deal of uterine pain is inappropriate because this is a “yes-no” question and doesn’t allow the client to express her feelings. Saying that the embryo was defective is inappropriate because this may lead the client to think that she contributed to the fetus’s demise. This is not the appropriate time to discuss embryonic or fetal malformations. However, the nurse should explain to the client that this situation was not her fault. Telling the client that she should get pregnant again as soon as possible is not therapeutic and discounts the feelings of the expectant mother who had already begun to bond with the fetus.

 CN: Psychosocial adaptation; CL: Apply


**108. 4.** Rh sensitization can be prevented by Rho(D) immune globulin, which clears the maternal circulation of Rh-positive cells before sensitization can occur, thereby blocking maternal antibody production to Rh-positive cells. Administration of this drug will not prevent future Rh-positive fetuses, nor will it prevent future abortions. An antibody response will not occur to Rh-negative cells. Rh-negative mothers do not develop sensitivities if the fetus is also Rh negative.

 CN: Pharmacological and parenteral therapies; CL: Apply


**109. 2.** The client with leg varicosities should take frequent rest periods with the legs elevated above the hips to promote venous circulation. The client should avoid constrictive clothing, but support hose that reach above the varicosities may help alleviate the pain. Contracting and relaxing the feet and ankles twice daily is not helpful because it does not promote circulation. Taking a leave of absence from work may not be possible because of economic reasons. The client should try to rest with her legs elevated or walk around for a few minutes every 2 hours while on the job.

 CN: Reduction of risk potential; CL: Synthesis

**110. 1.** Cryotherapy, electrocautery, or laser therapy may be used to remove the genital warts. Podophyllin solution should not be used to decrease their size while the client is pregnant, because fetal malformations may result. A 25% trichloroacetic acid solution can decrease the size of the warts, but because this disease is caused by a virus, the disorder may recur. Condylomata acuminata has been associated with cervical cancer, and the client should have semiannual or annual Pap smears to detect cervical dysplasia.


 CN: Pharmacological and parenteral therapies; CL: Create

**111. 4.** The client is reporting symptoms typically associated with herpes genitalis. Some women have no symptoms of gonorrhea. Others may experience vaginal itching and a thick, purulent vaginal discharge. *C. trachomatis* infection in women is commonly asymptomatic, but symptoms may include a yellowish discharge and painful urination. The first symptom of syphilis is a painless chancre.

 CN: Physiological adaptation; CL: Apply

**112. 1.** The client may need surgery to remove a ruptured fallopian tube where the pregnancy has occurred, and the nurse is usually responsible for witnessing the signature on the informed consent. Typically, if bleeding is occurring, it is internal and there is only scant vaginal bleeding with no discoloration.

The nurse cannot determine whether the fallopian tube can be salvaged; this can be accomplished only during surgery. If the tube has ruptured, it must be removed. If the tube has not ruptured, a linear salpingostomy may be done to salvage the tube for future pregnancies. With an ectopic pregnancy, although the client is experiencing abdominal pain, she is not having uterine contractions.

 CN: Physiological adaptation;  
CL: Synthesize

**113. 1.** The optical density of the amniotic fluid is evaluated for bilirubin level with a spectrophotometer. The higher the optical density, the more bilirubin is present in the fluid, indicating that fetal red blood cells are being destroyed. From these findings, the severity of the disease can be estimated. Because light destroys bilirubin, specimens should be kept in a dark container until the analysis is complete. A clear, green, or amber container would allow light to enter, thus destroying bilirubin.


 CN: Reduction of risk potential;  
CL: Apply

### Managing Care Quality and Safety

**114. 2.** Late decelerations during an oxytocin challenge test indicate that the infant is not receiving enough oxygen during contractions and is exhibiting signs of utero-placental insufficiency. This client would need further medical intervention. Fetal movement 6 times in 2 hours is adequate in a healthy fetus and a biophysical profile of 9 indicates that the risk of fetal asphyxia is rare. A reactive non-stress test informs the health care provider that the fetus has 2 fetal heart rate accelerations of 15 beats per minute above baseline and lasting for 15 seconds within a 20-minute period, which is a reassuring result and an indication of fetal well-being.

 CN: Management of care; CL: Evaluate

**115. 1.** Folic acid supplementation is recommended to prevent neural tube defects and anemia in pregnancy. Deficiencies increase the risk of hemorrhage during delivery as well as infection. The recommended dose prior to pregnancy is 400 mcg/day; while breast-feeding and during pregnancy, the recommended dosage is 500 to 600 mcg/day. Blood glucose levels are not regulated by the intake of folic acid. Vitamin C potentiates the absorption of iron and is also associated with blood clotting or collagen formation.

 CN: Reduction of risk potential;  
CL: Apply

### 116.

**3.** A single mother at 4 months postpartum fearful of shaking her baby when he cries.

**4.** An antenatal client at 16 weeks' gestation who has occasional sharp pain on her left side radiating from her symphysis to her fundus.

**1.** A primigravid client at 10 weeks' gestation complaining of not feeling well with nausea and vomiting, urinary frequency, and fatigue.

**2.** A multiparous client at 32 weeks' gestation asking for assistance with finding a new physician.

The first client to be seen should be the postpartum mother who is fearful of shaking her infant. Postpartum depression is a disorder that may occur during the first year postpartum but peaks at 4 weeks postpartum, prior to menses, or upon weaning. As a single mother, this client may not have support, a large factor putting women at risk. Other factors accentuating risk include prior depressive or bipolar illness and self-dissatisfaction. Second, the nurse should see the 16-week antenatal client, who is likely experiencing round ligament syndrome. At this point in the pregnancy, the uterus is stretching into the abdomen causing this type of pain. The pain is on the wrong side to be attributed to appendicitis or gallbladder disease. Nursing interventions to ease the pain include a heating pad or bringing the legs toward the abdomen. The nurse should next see the primigravid client complaining of not feeling well because she is exhibiting signs and symptoms of discomfort experienced by most women in the first trimester. The multiparous client at 32 weeks' gestation is the lowest priority as she is physically well, while the other clients have physical and psychological problems. In most emergency department situations, she may not be seen by medical or nursing staff but would be given the names of health care providers in the reception area.

 CN: Management of care; CL: Synthesize

**117. 3.** The social worker is available to assist the client in finding services within the community to meet client needs. This individual is able to provide the names of pharmacies within the community that offer generic substitutes or others that utilize the client's insurance plan. The charge nurse of the unit would be able to refer the client to the social worker. The hospital finance office does not handle this type of situation and would refer the client back to the unit. The client's insurance company deals with payments for health care and would refer the client back to the local setting.

 CN: Management of care; CL: Apply

TEST  
2

## Complications of Pregnancy

- The Pregnant Client with Preeclampsia or Eclampsia
- The Pregnant Client with a Chronic Hypertensive Disorder
- The Pregnant Client with Third-Trimester Bleeding
- The Pregnant Client with Preterm Labor
- The Pregnant Client with Premature Rupture of the Membranes
- The Pregnant Client with Diabetes Mellitus
- The Pregnant Client with Heart Disease
- The Client with an Ectopic Pregnancy
- The Pregnant Client with Hyperemesis Gravidarum
- The Client with a Hydatidiform Mole
- The Pregnant Client with Miscellaneous Complications
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Pregnant Client with Preeclampsia or Eclampsia

**1.** A laboring client with preeclampsia is prescribed magnesium sulfate 2 g/hour I.V. piggyback. The pharmacy sends the I.V. to the unit labeled *magnesium sulfate 20 g/500 mL normal saline*. To deliver the correct dose, the nurse should set the pump to deliver how many milliliters per hour?

\_\_\_\_\_ mL.

**2.** A 32-year-old multigravida returns to the clinic for a routine prenatal visit at 36 weeks' gestation. She has had a prior pregnancy with pregnancy-induced hypertension. The assessments during this visit include BP 140/90, P 80, and + 2 edema of the ankles and feet. Based on the client's past history and current assessment, what further information should the nurse obtain to determine if this client is becoming preeclamptic?

- 1. Headaches.
- 2. Blood glucose level.
- 3. Proteinuria.
- 4. Edema in lower extremities.

**3.** The nurse is instructing a preeclamptic client about monitoring the movements of her fetus to determine fetal well-being. Which statement by the client indicates that she needs further instruction about when to call the health care provider concerning fetal movement?

- 1. "If the fetus is becoming less active than before."
- 2. "If it takes longer each day for the fetus to move 10 times."
- 3. "If the fetus stops moving for 12 hours."
- 4. "If the fetus moves more often than 3 times an hour."

**4.** A 29-year-old multigravida at 37 weeks' gestation is being treated for severe preeclampsia and has magnesium sulfate infusing at 3 g/hour. The nurse has determined the priority nursing diagnosis to be: risk for central nervous system injury related to hypertension, edema of cerebrum. To maintain safety for this client, the nurse should:

- 1. Maintain continuous fetal monitoring.
- 2. Encourage family members to remain at bedside.
- 3. Assess reflexes, clonus, visual disturbances, and headache.
- 4. Monitor maternal liver studies every 4 hours.

**5.** At 32 weeks' gestation, a 15-year-old primigravid client who is 5 feet, 2 inches tall has gained a total of 20 lb, with a 1-lb gain in the last 2 weeks. Urinalysis reveals negative glucose and a trace of protein. The nurse should advise the client that which of the following factors increases her risk for preeclampsia?

- 1. Total weight gain.
- 2. Short stature.
- 3. Adolescent age group.
- 4. Proteinuria.

**6.** A primigravid client's baseline blood pressure at her initial visit at 12 weeks' gestation was 110/70 mm Hg. During an assessment at 38 weeks' gestation, which of the following data would indicate mild preeclampsia?

- 1. Blood pressure of 160/110 mm Hg on two separate occasions.
- 2. Proteinuria, more than 5 g in 24 hours.
- 3. Serum creatinine concentration of 1.4 mL/dL.
- 4. Weight gain of 2 lb in the last week.

**7.** A 16-year-old client at 34 weeks' gestation, who is being monitored at home with home nursing visits, is diagnosed with mild preeclampsia and has gained 2 lb in the past week. Her current blood pressure is 144/92 mm Hg. Which assessment finding would require further action by the home health nurse?

- 1. Occasional headache.
- 2. Frequent voiding in large amounts.
- 3. 1 + pedal edema.
- 4. 3 + protein on urine dipstick.

**8.** When developing the teaching plan for a primigravid client at 30 weeks' gestation diagnosed with mild preeclampsia who is being treated at home, which of the following would the nurse identify as the **most** appropriate client-centered goal?

- 1. Return visit to the prenatal clinic in approximately 4 weeks.
- 2. Decreased edema after 1 week of a low-protein, low-fiber diet.
- 3. Bed rest on the left side during the day, with bathroom privileges.
- 4. Immediate reporting of adverse reactions to magnesium sulfate therapy.

**9.** After instructing a primigravid client at 38 weeks' gestation about how preeclampsia can affect the client and the growing fetus, the nurse realizes that the client needs additional instruction when she says that preeclampsia can lead to which of the following?

- 1. Hydrocephalic infant.
- 2. Abruptio placentae.
- 3. Intrauterine growth retardation.
- 4. Poor placental perfusion.

**10.** After instructing a multigravid client diagnosed with mild preeclampsia how to keep a record of fetal movement patterns at home, the nurse determines that the teaching has been effective when the client says that she will count the number of times the baby moves during which of the following time spans?

- 1. 30-minute period three times a day.
- 2. 45-minute period after lunch each day.
- 3. 1-hour period each day.
- 4. 12-hour period each week.

**11.** When teaching a multigravid client diagnosed with mild preeclampsia about nutritional needs, which of the following types of diet should the nurse discuss?

- 1. High-residue diet.
- 2. Low-sodium diet.
- 3. Regular diet.
- 4. High-protein diet.

**12.** A 17-year-old client at 33 weeks' gestation diagnosed with mild preeclampsia is prescribed bed rest at home. The nurse instructs the client to contact the health care provider immediately if she experiences which of the following?

- 1. Blurred vision.
- 2. Ankle edema.
- 3. Increased energy levels.
- 4. Mild backache.

**13.** One week after her prenatal visit, a primigravid client at 38 weeks' gestation diagnosed with mild pre-eclampsia calls the clinic nurse complaining of a continuous headache for the past 2 days accompanied by nausea. The client does not want to take aspirin. The nurse should tell the client:

- 1. "Take two acetaminophen tablets. They aren't as likely to upset your stomach."
- 2. "I think the doctor should see you today. Can you come to the clinic this morning?"
- 3. "You need to lie down and rest. Have you tried placing a cool compress over your head?"
- 4. "I'll ask the doctor to call in a prescription for aspirin with codeine. What's your pharmacy's number?"

**14.** When assessing a 16-year-old primigravid client at 37 weeks' gestation diagnosed with severe preeclampsia, which of the following indicates the client needs continued management for the preeclampsia?

- 1. Blood pressure of 138/94 mm Hg.
- 2. Severe blurring of vision.
- 3. Less than 2 g of protein in a 24-hour sample.
- 4. Weight gain of 0.5 lb in 1 week.

**15.** When preparing the room for admission of a multigravid client at 36 weeks' gestation diagnosed with severe preeclampsia, which of the following should the nurse obtain?

- 1. Oxytocin infusion solution.
- 2. Disposable tongue blades.
- 3. Portable ultrasound machine.
- 4. Padding for the side rails.

**16.** The physician orders intravenous magnesium sulfate for a primigravid client at 38 weeks' gestation diagnosed with severe preeclampsia. Which of the following medications should the nurse have readily available at the client's bedside?

- 1. Diazepam (Valium).
- 2. Hydralazine (Apresoline).
- 3. Calcium gluconate.
- 4. Phenytoin (Dilantin).

**17.** For the client who is receiving intravenous magnesium sulfate for severe preeclampsia, which of the following assessment findings would alert the nurse to suspect hypermagnesemia?

- 1. Decreased deep tendon reflexes.
- 2. Cool skin temperature.
- 3. Rapid pulse rate.
- 4. Tingling in the toes.

**18.** A 28-year-old multigravida at 37 weeks' gestation arrives at the emergency department with a blood pressure of 160/104 mm Hg and +3 reflexes without clonus. The client is diagnosed with severe preeclampsia. The nurse collaborates with the health care provider to develop a plan of care that care will **first** include:

- 1. Administration of glucocorticoids (Betamethasone).
- 2. Vaginal or cesarean delivery of the fetus.
- 3. Prevention of seizures with phenytoin (Dilantin).
- 4. Reduction of fluid retention with thiazides.

**19.** Which of the following would the nurse identify as the priority to achieve when developing the plan of care for a primigravid client at 38 weeks' gestation who is hospitalized with severe preeclampsia and receiving intravenous magnesium sulfate?

- 1. Decreased generalized edema within 8 hours.
- 2. Decreased urinary output during the first 24 hours.
- 3. Sedation and decreased reflex excitability within 48 hours.
- 4. Absence of any seizure activity during the first 48 hours.

**20.** The nurse is administering intravenous magnesium sulfate as ordered for a client at 34 weeks' gestation with severe preeclampsia. Which of the following are desired outcomes of this therapy? Select all that apply.

- 1. T 98, P 72, R 14.
- 2. Urinary output <30 mL/hr.
- 3. HR 120 BPM.
- 4. Fetal heart rate with late decelerations.
- 5. BP of <140/90.
- 6. DTR's 2+.
- 7. Magnesium level= 5.6 mg/dL.
- 8. Clonus = 2+.

**21.** Soon after admission of a primigravid client at 38 weeks' gestation with severe preeclampsia, the physician orders a continuous intravenous infusion of 5% dextrose in Ringer's solution and 4 g of magnesium sulfate. While the medication is being administered, which of the following assessment findings should the nurse report immediately?

- 1. Respiratory rate of 12 breaths/minute.
- 2. Patellar reflex of +2.
- 3. Blood pressure of 160/88 mm Hg.
- 4. Urinary output exceeding intake.

**22.** As the nurse enters the room of a newly admitted primigravid client diagnosed with severe preeclampsia, the client begins to experience a seizure. Which of the following should the nurse do **first**?

- 1. Insert an airway to improve oxygenation.
- 2. Note the time when the seizure begins and ends.
- 3. Call for immediate assistance.
- 4. Turn the client to her left side.

**23.** After administering hydralazine (Apresoline) 5 mg intravenously as ordered for a primigravid client with severe preeclampsia at 39 weeks' gestation, the nurse should assess the client for:

- 1. Tachycardia.
- 2. Bradypnea.
- 3. Polyuria.
- 4. Dysphagia.

**24.** A primigravid client with severe preeclampsia exhibits hyperactive, very brisk patellar reflexes with two beats of ankle clonus present. The nurse documents the patellar reflexes as which of the following?

- 1. 1+.
- 2. 2+.
- 3. 3+.
- 4. 4+.

**25.** A 16-year-old unmarried primigravid client at 37 weeks' gestation with severe preeclampsia is in early active labor. Her mother is at the bedside. The client's blood pressure is 164/110 mm Hg. Which of the following would alert the nurse that the client may be about to experience a seizure?

- 1. Decreased contraction intensity.
- 2. Decreased temperature.
- 3. Epigastric pain.
- 4. Hyporeflexia.

**26.** Fifteen minutes after a client experiences an eclamptic seizure, the nurse should assess the client for which of the following?

- 1. Polyuria.
- 2. Facial flushing.
- 3. Hypotension.
- 4. Uterine contractions.

**27.** A client at 36 weeks' gestation with eclampsia begins to exhibit signs of labor after an eclamptic seizure. The nurse should assess the client for:

- 1. Abruptio placentae.
- 2. Transverse lie.
- 3. Placenta accreta.
- 4. Uterine atony.

**28.** The nurse is reviewing the chart of a multigravid client at 39 weeks' gestation with suspected HELLP syndrome. The nurse should notify the health care provider about which of the following test results?

- 1. Platelets 200,000/mm<sup>3</sup>.
- 2. Lactate dehydrogenase (LDH) > 200 units/L.
- 3. Uric acid 3 mg/dL.
- 4. Aspartate aminotransferase (AST) 15 units/L.

### The Pregnant Client with a Chronic Hypertensive Disorder

**29.** An obese 36-year-old multigravid client at 12 weeks' gestation has a history of chronic hypertension. She was treated with methyldopa (Aldomet) before becoming pregnant. When counseling the client about diet during pregnancy, the nurse realizes that the client needs additional instruction when she states which of the following?

- 1. "I need to reduce my caloric intake to 1,200 calories a day."
- 2. "A regular diet is recommended during pregnancy."
- 3. "I should eat more frequent meals if I get heartburn."
- 4. "I need to consume more fluids and fiber each day."

**30.** After instructing a multigravid client at 10 weeks' gestation diagnosed with chronic hypertension about the need for frequent prenatal visits, the nurse determines that the instructions have been successful when the client states which of the following?

- 1. "I may develop hyperthyroidism because of my high blood pressure."
- 2. "I need close monitoring because I may have a small-for-gestational-age infant."
- 3. "It's possible that I will have excess amniotic fluid and may need a cesarean section."
- 4. "I may develop placenta accreta, so I need to keep my clinic appointments."

**31.** After reinforcing the danger signs to report with a gravida 2 client at 32 weeks' gestation with an elevated blood pressure, which client statements would demonstrate her understanding of when to call the physician's office? Select all that apply.

- 1. "If I get up in the morning and feel dizzy, even if the dizziness goes away."
- 2. "If I see any bleeding, even if I have no pain."
- 3. "If I have a pounding headache that doesn't go away."
- 4. "If I notice the veins in my legs getting bigger."
- 5. "If the leg cramps at night are waking me up."
- 6. "If the baby seems to be more active than usual."

### The Pregnant Client with Third-Trimester Bleeding

**32.** The nurse is caring for a 22-year-old G 2, P 2 client who has disseminated intravascular coagulation after delivering a dead fetus. Which findings are the **highest priority** to report to the health care provider?

- 1. Activated partial thromboplastin time (APTT) of 30 seconds.
- 2. Hemoglobin of 11.5 g/dL.
- 3. Urinary output of 25 mL in the past hour.
- 4. Platelets at 149,000/mm<sup>3</sup>.

**33.** A 24-year-old client, G 3, P 1, at 32 weeks' gestation, is admitted to the hospital because of vaginal bleeding. After reviewing the client's history, which of the following factors might lead the nurse to suspect abruptio placentae?

- 1. Several hypotensive episodes.
- 2. Previous low transverse cesarean delivery.
- 3. One induced abortion.
- 4. History of cocaine use.



**34.** When caring for a multigravid client admitted to the hospital with vaginal bleeding at 38 weeks' gestation, which of the following would the nurse anticipate administering intravenously if the client develops disseminated intravascular coagulation (DIC)?

- 1. Ringer's lactate solution.
- 2. Fresh frozen platelets.
- 3. 5% dextrose solution.
- 4. Warfarin sodium (Coumadin).

**35.** When assessing a 34-year-old multigravid client at 34 weeks' gestation experiencing moderate vaginal bleeding, which of the following would **most** likely alert the nurse that placenta previa is present?

- 1. Painless vaginal bleeding.
- 2. Uterine tetany.
- 3. Intermittent pain with spotting.
- 4. Dull lower back pain.

**36.** After giving instruction about the cause of the vaginal bleeding to a multigravid client at 36 weeks' gestation diagnosed with placenta previa, the nurse determines that the teaching has been effective when the client says that the bleeding results from which of the following?

- 1. Diminished clotting factors.
- 2. Exposure of maternal blood sinuses.
- 3. Increased platelet levels.
- 4. A large-for-gestational-age fetus.

**37.** The physician orders whole blood replacement for a multigravid client with abruptio placentae. Before administering the intravenous blood product, the nurse should **first**:

- 1. Validate client information and the blood product with another nurse.
- 2. Check the vital signs before transfusing over 5 to 6 hours.
- 3. Ask the client if she has ever had any allergies.
- 4. Administer 100 mL of 5% dextrose solution intravenously.

**38.** Following a cesarean delivery for abruptio placentae, a multigravid client tells the nurse, "I feel like such a failure. None of my other deliveries were like this." The nurse's response to the client is based on the understanding of which of the following?

- 1. The client will most likely have postpartum blues.
- 2. Maternal-infant bonding is likely to be difficult.
- 3. The client's feeling of grief is a normal reaction.
- 4. This type of delivery was necessary to save the client's life.

**39.** A client has received epidural anesthesia to control pain during a cesarean section. Place an X over the highest point on the body locating the level of anesthesia expected for a cesarean birth.



**40.** The nurse should do which of the following actions **first** when admitting a multigravid client at 36 weeks' gestation with a probable diagnosis of abruptio placentae?

- 1. Prepare the client for a vaginal examination.
- 2. Obtain a brief history from the client.
- 3. Insert a large-gauge intravenous catheter.
- 4. Prepare the client for an ultrasound scan.

### The Pregnant Client with Preterm Labor

**41.** The health care provider has determined that a preterm labor client at 34 weeks' gestation has no fetal fibronectin present. The nurse should assess the client for which of the following outcomes in the next week?

- 1. The client will develop preeclampsia.
- 2. The fetus will develop mature lungs.
- 3. The client will not likely develop preterm labor.
- 4. The fetus will not develop gestational diabetes.

**42.** A nurse is discussing preterm labor in a prenatal class. After class, a client and her partner ask the nurse to identify again the nursing strategies to prevent preterm labor. The clients need further instruction when they state which of the following?

- 1. "I need to stay hydrated all the time."
- 2. "I need to avoid any infections."
- 3. "I should include frequent rest breaks if we travel."
- 4. "Changing to filter cigarettes is helpful."

**43.** A multigravid client at 34 weeks' gestation is being treated with indomethacin (Indocin) to halt preterm labor. If the client delivers a preterm infant, the nurse should notify the nursery personnel about this therapy because of the possibility for which of the following?

- 1. Pulmonary hypertension.
- 2. Respiratory distress syndrome (RDS).
- 3. Hyperbilirubinemia.
- 4. Cardiomyopathy.

**44.** The nurse is preparing to administer terbutaline (Brethine) to a multigravid client in preterm labor. Before administering this drug intravenously, the nurse should determine the results of the following?

- 1. Hematocrit.
- 2. Weight gain.
- 3. Urinary output.
- 4. Heart rate.

**45.** In which of the following maternal locations would the nurse place the ultrasound transducer of the external electronic fetal heart rate monitor if a fetus at 34 weeks' gestation is in the left occipitoanterior (LOA) position?

- 1. Near the symphysis pubis.
- 2. Two inches above the umbilicus.
- 3. Below the umbilicus on the left side.
- 4. At the level of the umbilicus.

**46.** The physician orders betamethasone (Celestone) for a 34-year-old multigravid client at 32 weeks' gestation who is experiencing preterm labor. Previously, the client has experienced one infant death due to preterm birth at 28 weeks' gestation. The nurse explains that this drug is given for which of the following reasons?

- 1. To enhance fetal lung maturity.
- 2. To counter the effects of tocolytic therapy.
- 3. To treat chorioamnionitis.
- 4. To decrease neonatal production of surfactant.

**47.** A client at 28 weeks' gestation in premature labor was placed on ritodrine (Yutopar). To maintain the pregnancy, the physician orders the client to have 10 mg now, 10 mg in 2 hours, and then 20 mg every 4 hours while contractions persist, not to exceed the maximum daily oral dose of 120 mg. At what time will the client have reached the maximum dose if she begins taking the medication at 10:00 a.m. and follows the physician's order?

\_\_\_\_\_ a.m.

**48.** The nurse is caring for a multigravid client at 34 weeks' gestation diagnosed with preterm labor. The client has delivered two stillborn infants at 30 weeks' gestation. The client is scheduled for a sonogram before an amniocentesis. Which of the following would be a priority nursing diagnosis for the client?

- 1. *Acute pain* related to abnormal uterine contractions.
- 2. *Anxiety* related to diagnostic tests for fetal well-being.
- 3. *Ineffective coping* related to hospitalization.
- 4. *Deficient knowledge* related to consequences of preterm birth.

**49.** When preparing a multigravid client at 34 weeks' gestation experiencing preterm labor for the shake test performed on amniotic fluid, the nurse would instruct the client that this test is done to evaluate the maturity of which of the following fetal systems?

- 1. Urinary.
- 2. Gastrointestinal.
- 3. Cardiovascular.
- 4. Pulmonary.

### The Pregnant Client with Premature Rupture of the Membranes

**50.** The nurse is planning care for a multigravid client hospitalized at 36 weeks' gestation with confirmed rupture of membranes and no evidence of labor. Which of the following would the nurse expect the physician to order?

- 1. Frequent assessments of cervical dilation.
- 2. Intravenous oxytocin administration.
- 3. Vaginal culture for *Neisseria gonorrhoeae*.
- 4. Sonogram for amniotic fluid volume index.

**51.** A multigravid client at 34 weeks' gestation visits the hospital because she suspects that her water has broken. After testing the leaking fluid with nitrazine paper, the nurse confirms that the client's membranes have ruptured when the paper turns which of the following colors?

- 1. Yellow.
- 2. Green.
- 3. Blue.
- 4. Red.

**52.** A primigravid client at 30 weeks' gestation has been admitted to the hospital with premature rupture of the membranes without contractions. Her cervix is 2 cm dilated and 50% effaced. The nurse should next assess the client's:

- 1. Red blood cell count.
- 2. Degree of discomfort.
- 3. Urinary output.
- 4. Temperature.

**53.** A multigravid client at 34 weeks' gestation with premature rupture of the membranes tests positive for group B streptococcus. The client is having contractions every 4 to 6 minutes. Her vital signs are as follows: blood pressure, 120/80 mm Hg; temperature, 100° F (37.8° C); pulse, 100 bpm; respirations, 18 breaths/minute. Which of the following would the nurse expect the physician to order?

- 1. Intravenous penicillin.
- 2. Intravenous gentamicin sulfate (Garamycin).
- 3. Intramuscular betamethasone (Celestone).
- 4. Intramuscular cefaclor (Ceclor).

**54.** A primigravid client at 36 weeks' gestation with premature rupture of the membranes is to be discharged home on bed rest with follow-up by the home health nurse. After instruction about care while at home, which of the following client statements indicates effective teaching?

- 1. "It is permissible to douche if the fluid irritates my vaginal area."
- 2. "I can take either a tub bath or a shower when I feel like it."
- 3. "I should limit my fluid intake to less than 1 quart daily."
- 4. "I should contact the doctor if my temperature is 100.4° F or higher."

**55.** A primigravid client at 34 weeks' gestation is experiencing contractions every 3 to 4 minutes lasting for 35 seconds. Her cervix is 2 cm dilated and 50% effaced. While the nurse is assessing the client's vital signs, the client says, "I think my bag of water just broke." Which of the following would the nurse do **first**?

- 1. Check the status of the fetal heart rate.
- 2. Turn the client to her right side.
- 3. Test the leaking fluid with nitrazine paper.
- 4. Perform a sterile vaginal examination.

### The Pregnant Client with Diabetes Mellitus

**56.** A client with gestational diabetes who is entering her third trimester is learning how to monitor her fetus's movements. After teaching the client about the kick count, the nurse should provide further instruction if the client makes which of the following statements?

- 1. "The baby may be more active at different times of the day."
- 2. "How I feel my baby move is different than my friend."
- 3. "The baby should be moving less than 10 times in 3 hours."
- 4. "The baby may not move at times because it is asleep."

**57.** A 27-year-old primigravid client with insulin-dependent diabetes at 34 weeks' gestation undergoes a nonstress test, the results of which are documented as reactive. The nurse should tell the client that the test results indicate which of the following?

- 1. A contraction stress test is necessary.
- 2. The nonstress test should be repeated.
- 3. Chorionic villus sampling is necessary.
- 4. There is evidence of fetal well-being.

**58.** A primigravid client with insulin-dependent diabetes tells the nurse that the contraction stress test performed earlier in the day was suspicious. The nurse interprets this test result as indicating that the fetal heart rate pattern showed which of the following?

- 1. Frequent late decelerations.
- 2. Decreased fetal movement.
- 3. Inconsistent late decelerations.
- 4. Lack of fetal movement.

**59.** Which of the following statements about a fetal biophysical profile would be incorporated into the teaching plan for a primigravid client with insulin-dependent diabetes?

- 1. It determines fetal lung maturity.
- 2. It is noninvasive using real-time ultrasound.
- 3. It will correlate with the newborn's Apgar score.
- 4. It requires the client to have an empty bladder.

**60.** A 30-year-old multigravid client at 8 weeks' gestation has a history of insulin-dependent diabetes since age 20. When explaining about the importance of blood glucose control during pregnancy, the nurse should tell the client that which of the following will occur regarding the client's insulin needs during the first trimester?

- 1. They will increase.
- 2. They will decrease.
- 3. They will remain constant.
- 4. They will be unpredictable.

**61.** The nurse explains the complications of pregnancy that occur with diabetes to a primigravid client at 10 weeks' gestation who has a 5-year history of insulin-dependent diabetes. Which of the following, if stated by the client as a complication, indicates the need for additional teaching?

- 1. *Candida albicans* infection.
- 2. Twin-to-twin transfer.
- 3. Polyhydramnios.
- 4. Preeclampsia.

**62.** When developing a teaching plan for a primigravid client with insulin-dependent diabetes about monitoring blood glucose control and insulin dosages at home, which of the following would the nurse expect to include as a desired target range for blood glucose levels?

- 1. 40 to 60 mg/dL between 2:00 and 4:00 p.m.
- 2. 60 to 100 mg/dL before meals and bedtime snacks.
- 3. 110 to 140 mg/dL before meals and bedtime snacks.
- 4. 140 to 160 mg/dL 1 hour after meals.

**63.** When teaching a primigravid client with diabetes about common causes of hyperglycemia during pregnancy, which of the following would the nurse include?

- 1. Fetal macrosomia.
- 2. Obesity before conception.
- 3. Maternal infection.
- 4. Pregnancy-induced hypertension.

**64.** After teaching a diabetic primigravida about symptoms of hyperglycemia and hypoglycemia, the nurse determines that the client understands the instruction when she says that hyperglycemia may be manifested by which of the following?

- 1. Dehydration.
- 2. Pallor.
- 3. Sweating.
- 4. Nervousness.

**65.** At 38 weeks' gestation, a primigravid client with poorly controlled diabetes and severe preeclampsia is admitted for a cesarean delivery. The nurse explains to the client that delivery helps to prevent which of the following?

- 1. Neonatal hyperbilirubinemia.
- 2. Congenital anomalies.
- 3. Perinatal asphyxia.
- 4. Stillbirth.

**66.** A primigravid client with diabetes at 39 weeks' gestation is seen in the high-risk clinic. The physician estimates that the fetus weighs at least 4,500 g (10 lb). The client asks, "What causes the baby to be so large?" The nurse's response is based on the understanding that fetal macrosomia is usually related to which of the following?

- 1. Family history of large infants.
- 2. Fetal anomalies.
- 3. Maternal hyperglycemia.
- 4. Maternal hypertension.

**67.** With plans to breast-feed her neonate, a pregnant client with insulin-dependent diabetes asks the nurse about insulin needs during the postpartum period. Which of the following statements about postpartal insulin requirements for breast-feeding mothers should the nurse include in the explanation?

- 1. They fall significantly in the immediate postpartum period.
- 2. They remain the same as during the labor process.
- 3. They usually increase in the immediate postpartum period.
- 4. They need constant adjustment during the first 24 hours.

## The Pregnant Client with Heart Disease

**68.** After instruction of a primigravid client at 8 weeks' gestation diagnosed with class I heart disease about self-care during pregnancy, which of the following client statements would indicate the need for additional teaching?

- 1. "I should avoid being near people who have a cold."
- 2. "I may be given antibiotics during my pregnancy."
- 3. "I should reduce my intake of protein in my diet."
- 4. "I should limit my salt intake at meals."

**69.** While caring for a primigravid client with class II heart disease at 28 weeks' gestation, the nurse would instruct the client to contact her physician immediately if the client experiences which of the following?

- 1. Mild ankle edema.
- 2. Emotional stress on the job.
- 3. Weight gain of 1 lb in 1 week.
- 4. Increased dyspnea at rest.

**70.** When developing the collaborative plan of care with the health care provider for a multigravid client at 10 weeks' gestation with a history of cardiac disease who was being treated with digitalis therapy before this pregnancy, the nurse should instruct the client about which of the following regarding the client's drug therapy regimen?

- 1. Need for an increased dosage.
- 2. Continuation of the same dosage.
- 3. Switching to a different medication.
- 4. Addition of a diuretic to the regimen.

**71.** Which of the following anticoagulants would the nurse expect to administer when caring for a primigravid client at 12 weeks' gestation who has class II cardiac disease due to mitral valve stenosis?

- 1. Heparin.
- 2. Warfarin (Coumadin).
- 3. Enoxaparin (Lovenox).
- 4. Ardeparin (Normiflo).

**72.** A primigravid client with class II heart disease who is visiting the clinic at 8 weeks' gestation tells the nurse that she has been maintaining a low-sodium, 1,800-calorie diet. Which of the following instructions should the nurse give the client?

- 1. Avoid folic acid supplements to prevent megaloblastic anemia.
- 2. Severely restrict sodium intake throughout the pregnancy.
- 3. Take iron supplements with milk to enhance absorption.
- 4. Increase caloric intake to 2,200 calories daily to promote fetal growth.

### The Client with an Ectopic Pregnancy

**73.** On arrival at the emergency department, a client tells the nurse that she suspects that she may be pregnant but has been having a small amount of bleeding and has severe pain in the lower abdomen. The client's blood pressure is 70/50 mm Hg and her pulse rate is 120 bpm. The nurse notifies the physician immediately because of the possibility of:

- 1. Ectopic pregnancy.
- 2. Abruptio placentae.
- 3. Gestational trophoblastic disease.
- 4. Complete abortion.

**74.** The nurse is assessing a multigravida client at 12 weeks' gestation who has been admitted to the emergency department with sharp right-sided abdominal pain and vaginal spotting. Which of the following should the nurse obtain about the client's history? Select all that apply.

- 1. History of sexually transmitted infections.
- 2. Number of sexual partners.
- 3. Last menstrual period.
- 4. Cesarean section.
- 5. IUD use.
- 6. Contraceptive use.

**75.** Before surgery to remove an ectopic pregnancy and the fallopian tube, which of the following would alert the nurse to the possibility of tubal rupture?

- 1. Amount of vaginal bleeding and discharge.
- 2. Falling hematocrit and hemoglobin levels.
- 3. Slow, bounding pulse rate of 80 bpm.
- 4. Marked abdominal edema.

**76.** A multigravid client diagnosed with a probable ruptured ectopic pregnancy is scheduled for emergency surgery. In addition to monitoring the client's blood pressure before surgery, which of the following would the nurse assess?

- 1. Uterine cramping.
- 2. Abdominal distention.
- 3. Hemoglobin and hematocrit.
- 4. Pulse rate.

**77.** A 36-year-old multigravid client is admitted to the hospital with possible ruptured ectopic pregnancy. When obtaining the client's history, which of the following would be most important to identify as a predisposing factor?

- 1. Urinary tract infection.
- 2. Marijuana use during pregnancy.
- 3. Episodes of pelvic inflammatory disease.
- 4. Use of estrogen-progestin contraceptives.

**78.** After surgery to remove a ruptured fallopian tube, a multigravid client receives discharge instructions about potential complications to report to her physician. Which of the following, if stated by the client as a complication, indicates a need for additional teaching?

- 1. Pain.
- 2. Headache.
- 3. Fever.
- 4. Bleeding.

**79.** A multigravid client is admitted to the hospital with a diagnosis of ectopic pregnancy. The nurse anticipates that, because the client's fallopian tube has not yet ruptured, which of the following may be ordered?

- 1. Progestin contraceptives (Hylutin).
- 2. Medroxyprogesterone (Depo-Provera).
- 3. Methotrexate.
- 4. Dyphylline (Dilor).

### The Pregnant Client with Hyperemesis Gravidarum

**80.** After instruction of a primigravid client at 8 weeks' gestation about measures to overcome early morning nausea and vomiting, which of the following client statements indicates the need for additional teaching?

- 1. "I'll eat dry crackers or toast before arising in the morning."
- 2. "I'll drink adequate fluids separate from my meals or snacks."
- 3. "I'll eat two large meals daily with frequent protein snacks."
- 4. "I'll snack on a small amount of carbohydrates throughout the day."

**81.** A multigravid client thought to be at 14 weeks' gestation reports that she is experiencing such severe morning sickness that "she has not been able to keep anything down for a week." The nurse should assess for signs and symptoms of which of the following?

- 1. Hypercalcemia.
- 2. Hypobilirubinemia.
- 3. Hypokalemia.
- 4. Hyperglycemia.

**82.** A multigravid client is admitted at 16 weeks' gestation with a diagnosis of hyperemesis gravidarum. The nurse should explain to the client that hyperemesis gravidarum is thought to be related to high levels of which of the following hormones?

- 1. Progesterone.
- 2. Estrogen.
- 3. Somatotropin.
- 4. Aldosterone.

**83.** The physician orders 1000 mL of Ringers Lactate intravenously over an 8-hour period for a 29-year-old primigravid client at 16 weeks' gestation with hyperemesis. The drip factor is 12 gtts/mL. The nurse should administer the IV infusion at how many drops per minute?

\_\_\_\_\_ gtts/minute.

**84.** A primigravida admitted to the hospital with a diagnosis of hyperemesis gravidarum is placed on nothing-by-mouth (NPO) status and is receiving intravenous (IV) fluid replacement therapy. In planning this client's care, the nurse should collaborate with the health care provider (HCP) to carry out which of the following?

- 1. Withhold oral fluids indefinitely until acidosis is corrected.
- 2. Give oral fluids in small quantities whenever the client desires.
- 3. Per HCP orders, provide clear liquids by mouth after 24 hours if vomiting subsides.
- 4. Withhold oral fluids until total parenteral nutrition replaces lost electrolytes.

### The Client with a Hydatidiform Mole

**85.** A client at 15 weeks' gestation is admitted with dark brown vaginal bleeding and continuous nausea and vomiting. Her blood pressure is 142/98 and fundal height is 19 cm. The nurse should prepare to do which of the following?

- 1. Transfer the client to the antenatal unit.
- 2. Keep the client NPO for 24 hours.
- 3. Administer magnesium sulfate.
- 4. Obtain an ultrasound.

**86.** A 38-year-old client at about 14 weeks' gestation is admitted to the hospital with a diagnosis of complete hydatidiform mole. Soon after admission, the nurse would assess the client for signs and symptoms of which of the following?

- 1. Pregnancy-induced hypertension.
- 2. Gestational diabetes.
- 3. Hypothyroidism.
- 4. Polycythemia.

**87.** After a dilatation and curettage (D&C) to evacuate a molar pregnancy, assessing the client for signs and symptoms of which of the following would be most important?

- 1. Urinary tract infection.
- 2. Hemorrhage.
- 3. Abdominal distention.
- 4. Chorioamnionitis.

**88.** When preparing a multigravid client who has undergone evacuation of a hydatidiform mole for discharge, the nurse explains the need for follow-up care. The nurse determines that the client understands the instruction when she says that she is at risk for developing which of the following?

- 1. Ectopic pregnancy.
- 2. Choriocarcinoma.
- 3. Multifetal pregnancies.
- 4. Infertility.

**89.** After suction and evacuation of a complete hydatidiform mole, the 28-year-old multigravid client asks the nurse when she can become pregnant again. The nurse would advise the client not to become pregnant again for at least which of the following time spans?

- 1. 6 months.
- 2. 12 months.
- 3. 18 months.
- 4. 24 months.

### The Pregnant Client with Miscellaneous Complications

**90.** The nurse is working with four clients on the obstetrical unit. Which client will be the highest priority for a cesarean section?

- 1. Client at 40 weeks' gestation whose fetus weighs 8 lb by ultrasound estimate.
- 2. Client at 37 weeks' gestation with fetus in ROP position.
- 3. Client at 32 weeks' gestation with fetus in breech position.
- 4. Client at 38 weeks' gestation with active herpes lesions.

**91.** The nurse notices that a client who has just delivered her infant is short of breath, ashen in color, and begins to cough. She becomes limp on the delivery table. At last assessment ½ hour ago, her temperature was 98, pulse 78, respirations 16. Determine the nursing actions in the order they should occur.

1. Open airway using head tilt-chin lift.

2. Ask staff to activate emergency response system.

3. Establish unresponsiveness.

4. Give 2 breaths.

5. Check the pulse

**92.** A client in sickle cell crisis has been hospitalized during her pregnancy. After giving discharge instructions, the nurse determines the client needs further teaching when she states which of the following?

- 1. "I will need more frequent appointments during the remainder of the pregnancy."
- 2. "Signs of any type of infection must be reported immediately."
- 3. "At the earliest signs of a crisis, I need to seek treatment."
- 4. "I have this disease because I don't eat enough food with iron."

**93.** A laboring client at -2 station has a spontaneous rupture of the membranes and a cord immediately protrudes from the vagina. The nurse should **first**:

- 1. Place gentle pressure upward on the fetal head.
- 2. Place the cord back into the vagina to keep it moist.
- 3. Begin oxygen by face mask at 8 to 10 L/min.
- 4. Turn the client on her left side.

**94.** A client has just had a cesarean section for a prolapsed cord. In reviewing the client's history, which of the following factors places a client at risk for cord prolapse? Select all that apply.

- 1. -2 station.
- 2. Low birth weight infant.
- 3. Rupture of membranes.
- 4. Breech presentation.
- 5. Prior abortion.
- 6. Low lying placenta.

**95.** A woman who has delivered a healthy newborn is being discharged. As a part of the discharge teaching, the nurse should instruct the client to observe vaginal discharge for postpartum hemorrhage and notify the healthcare provider about?

- 1. Bleeding that becomes lighter each day
- 2. Clots the size of golf balls
- 3. Saturating a pad in an hour
- 4. Lochia that last longer than 1 week

**96.** A woman who is Rh-negative has delivered an Rh-positive infant. The nurse explains to the client that she will receive RhoGAM. The nurse determines that the client understands the purpose of RhoGAM when she states:

- 1. "RhoGAM will protect my next baby if it is Rh-negative."
- 2. "RhoGAM will prevent antibody formation in my blood."
- 3. "RhoGAM will be given to prevent German measles."
- 4. "RhoGAM will be used to prevent bleeding in my newborn."

**97.** A client at 4 weeks postpartum tells the nurse that she can't cope any longer and is overwhelmed by her newborn. The baby has old formula on her clothes and under her neck. The mother does not remember when she last bathed the baby and states she does not want to care for the infant. The nurse should encourage the client and her husband to call their health care provider because the mother should be evaluated further for?

- 1. Postpartum blues.
- 2. Postpartum depression.
- 3. Poor bonding.
- 4. Infant abuse.

**98.** The nurse and a nursing assistant are caring for clients in a birthing center. Which of the following tasks should the nurse delegate to the nursing assistant? Select all that apply.

- 1. Removing a Foley catheter from a preeclamptic client.
- 2. Assisting an active labor client with breathing and relaxation.
- 3. Ambulating a postcesarean client to the bathroom.
- 4. Calculating hourly I.V. totals for a preterm labor client.
- 5. Intake and output catheterization for culture and sensitivity.
- 6. Calling a report of normal findings to the health care provider.
- 7. Removing lunch trays and documenting lunch intake.

### Managing Care Quality and Safety

**99.** Several pregnant clients are waiting to be seen in the triage area of the obstetrical unit. Which client should the nurse see **first**?

- 1. A client at 13 weeks' gestation experiencing nausea and vomiting three times a day with +1 ketones in her urine.
- 2. A client at 37 weeks' gestation who is an insulin-dependent diabetic and experiencing 3 to 4 fetal movements per day.
- 3. A client at 32 weeks' gestation who has preeclampsia and +3 proteinuria who is returning for evaluation of epigastric pain.
- 4. A primigravida at 17 weeks' gestation complaining of not feeling fetal movement at this point in her pregnancy.

**100.** The nurse is planning care for a group of pregnant clients. Which of the following clients should be referred to a health care provider immediately?

- 1. A woman who is at 10 weeks' gestation, is having nausea and vomiting, and has +1 ketones in her urine.
- 2. A woman who is at 37 weeks' gestation and has insulin-dependent diabetes experiencing 2-3 hyperglycemic episodes weekly.
- 3. A woman at 32 weeks' gestation and is preeclamptic with +3 proteinuria.
- 4. A primigravida at 15 weeks' gestation who reports she is not feeling fetal movement.

**101.** A client with pregnancy-induced hypertension is to receive magnesium sulfate to run at 3 grams per hour with normal saline to maintain the total I.V. rate at 125 mL/hour. The nurse giving end of shift report stated the client's blood pressures have been elevated during the night. The oncoming nurse checked the client and found magnesium sulfate running at 2 grams per hour. Identify the nursing actions to be taken from first to last.

1. Notify the physician of the incident.

2. Assess the client's current status

3. Correct the I.V. rates to magnesium sulfate running at 3 grams/hour and normal saline to complete total rate at 125 mL/hour.

4. Initiate an incident report.

**102.** As the nurse enters the room of a newly admitted primigravid client diagnosed with severe preeclampsia, the client begins to experience a seizure. The nurse should do which in order of priority from first to last?

1. Call for immediate assistance.

2. Turn the client to her side.

3. Note the time when the seizure began.

4. Maintain airway.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Pregnant Client with Preeclampsia or Eclampsia


1. 50 mL

$$\frac{500 \text{ mL}}{20 \text{ g}} \times \frac{2 \text{ g}}{\text{hr}} = \frac{50}{1,000 \text{ g/mL}} \times \frac{20 \text{ g/hr}}{1} = \frac{50 \text{ mL}}{1 \text{ hr}}$$

🔑 CN: Pharmacological and parenteral therapies; CL: Apply




**2. 3.** The two major defining characteristics of preeclampsia are blood pressure elevation of 140/90 mm Hg or greater and proteinuria. Because the client's blood pressure meets the gestational hypertension criteria, the next nursing responsibility is to determine if she has protein in her urine. If she does not, then she may be having transient hypertension. The edema is within normal limits for someone at this gestational age, particularly because it is in the lower extremities. The preeclamptic client will have significant edema in the face and hands. Headaches are significant in pregnancy-induced hypertension but may have other etiologies. The client's blood glucose level has no bearing on a preeclampsia diagnosis.

 CN: Physiological adaptation;  
CL: Analysis

**3. 4.** The fetus is considered well if it moves more often than 3 times in 1 hour. Daily fetal movement counting is part of all high-risk assessments and is a noninvasive, inexpensive method of monitoring fetal well-being. The health care provider should be notified if there is a gradual slowing over time of fetal activity, if each day it takes longer for the fetus to move a minimum of 10 times, or if the fetus stops moving for 12 hours or longer.

 CN: Reduction of risk potential;  
CL: Evaluation


**4. 3.** The central nervous system (CNS) functioning and freedom from injury is a priority in maintaining well-being of the maternal-fetal unit. If the mother suffers CNS damage related to hypertension or stroke, oxygenation status is compromised and the well-being of both mother and infant are at risk. Continuous fetal monitoring is an assessment strategy for the infant only and would be of secondary importance to maternal CNS assessment because maternal oxygenation will dictate fetal oxygenation and well-being. In preeclampsia, frequent assessment of maternal reflexes, clonus, visual disturbances, and headache give clear evidence of the condition of the maternal CNS system. Monitoring the liver studies does give an indication of the status of the maternal system but the less invasive and highly correlated condition of the maternal CNS system in assessing reflexes, maternal headache, visual disturbances, and clonus is the highest priority. Psychosocial care is a priority and can be accomplished in ways other than having the family remain at the bedside.

 CN: Safety and infection control;  
CL: Synthesize

**5. 3.** Clients with increased risk for preeclampsia include primigravid clients younger than 20 years or older than 40 years, clients with five or more pregnancies, women of color, women with multifetal pregnancies, women with diabetes or heart disease, and women with hydramnios. A total weight gain of 20 lb at 32 weeks' gestation with a 1-lb weight gain in the last 2 weeks is within normal limits. Short stature is not associated with the development of preeclampsia. A trace amount of protein in the urine is common during pregnancy. However, protein amounts of 1+ or more may be a symptom of pregnancy-induced hypertension.

 CN: Reduction of risk potential;  
CL: Synthesize

**6. 4.** A weight gain of 2 lb (0.9 kg) in the last week during the third trimester and mild peripheral edema are associated with mild preeclampsia. With severe preeclampsia, peripheral edema is extensive. Blood pressure readings of 160 mm Hg systolic and 100 mm Hg diastolic on two separate occasions and oliguria (urine output less than 400 mL in 24 hours) are signs of severe preeclampsia. Proteinuria, 3+ to 4+ or more than 5 g in a 24-hour sample, also indicates severe preeclampsia. Normal serum creatinine levels range from 0.5 to 1.1 mL/dL. A serum creatinine concentration of 1.4 mL/dL is greatly elevated, indicating severe preeclampsia.


 CN: Physiological adaptation;  
CL: Analysis

**7. 4.** Protein on the urine dipstick with mild preeclampsia should not exceed 1 + and should be followed by a 24-hour urine collection. Occasional headache is normal but if these should increase in frequency and change in character, they would need to be further evaluated. Frequent voiding in large amounts is not related to preeclampsia. 1+ pedal edema is a frequent occurrence in a pregnant client, especially during the later part of pregnancy.


 CN: Reduction of risk potential;  
CL: Analyze

**8. 3.** The client with mild preeclampsia is commonly treated at home with activity restriction. Bed rest for most of the day with the client lying in the left lateral recumbent position is recommended. This position helps to decrease pressure on the vena cava, thus increasing venous return, circulatory volume, and renal and placental perfusion. A decrease in angiotensin II improves renal blood flow, lowers blood pressure, and increases diuresis. Typically, the client is monitored with home visits twice a week. The client usually returns to the clinic

every 2 weeks until 36 weeks' gestation. After that time, clinic visits occur at least every week or more often, if needed. The client's diet needs to be well balanced, with ample protein intake. Fiber intake may need to be increased to prevent complications from prolonged bed rest, such as constipation. If magnesium sulfate is necessary, as in severe preeclampsia, the drug is usually administered intravenously, and the client is carefully monitored in the hospital setting because of the possible risk of seizure activity.

 CN: Physiological adaptation;  
CL: Analysis

**9. 1.** Congenital anomalies such as hydrocephalus are not associated with preeclampsia. Conditions such as stillbirth, prematurity, abruptio placentae, intrauterine growth retardation, and poor placental perfusion are associated with preeclampsia. Abruptio placentae occurs because of severe vasoconstriction. Intrauterine growth retardation is possible owing to poor placental perfusion. Poor placental perfusion results from increased vasoconstriction.

 CN: Physiological adaptation;  
CL: Evaluate

**10. 3.** Numerous methods have been proposed to record the maternal perceptions of fetal movement or "kick counts." A commonly used method is the Cardiff count-to-10 method. The client begins counting fetal movements at a specified time (e.g., 8:00 a.m.) and notes the time when the 10th movement is felt. If the client does not feel at least 6 movements in a 1-hour period, she should notify the health care provider. The fetus typically moves an average of 1 to 2 times every 10 minutes or 10 to 12 times per hour. A 30- or 45-minute period is not enough time to evaluate fetal movement accurately. The client should monitor fetal movements more frequently than 1 time per week. One hour of monitoring each day is adequate.

 CN: Reduction of risk potential;  
CL: Evaluate

**11. 3.** For clients with mild preeclampsia, a regular diet with ample protein and calories is recommended. If the client experiences constipation, she should increase the fiber in her diet, such as by eating raw fruits and vegetables, and increase fluid intake. A high-residue diet is not a nutritional need in preeclampsia. Sodium and fluid intake should not be restricted or increased. A high-protein diet is unnecessary.

 CN: Basic care and comfort; CL: Apply

**12. 1.** Severe headache, visual disturbances such as blurred vision, and epigastric pain are associated with the development of severe preeclampsia and possibly eclampsia. These danger


signs and symptoms must be reported immediately. Severe headache and visual disturbances are related to severe vasoconstriction and a severe increase in blood pressure. Epigastric pain is related to hepatic dysfunction. Ankle edema is common during the third trimester. However, facial edema is associated with increased fluid retention and the progression from mild to severe preeclampsia. Increased energy levels are not associated with a progression of the client's preeclampsia or the development of complications. In fact, some women report an "energy spurt" before the onset of labor. Mild backache is a common discomfort of pregnancy, unrelated to a progression of the client's preeclampsia. It also may be associated with bed rest when the mattress is not firm. Some multiparous women have reported a mild backache as a sign of impending labor.

 CN: Reduction of risk potential;  
CL: Synthesize

**13. 2.** A client with preeclampsia complaining of a continuous headache for 2 days should be seen by a health care provider immediately. Continuous headache, drowsiness, and mental confusion indicate poor cerebral perfusion and are symptoms of severe preeclampsia. Immediate care is recommended because these symptoms may lead to eclampsia or seizures if left untreated. Advising the client to take two acetaminophen tablets would be inappropriate and may lead to further complications if the client is not evaluated and treated. Although the application of cool compresses may ease the pain temporarily, this would delay treatment. Aspirin with codeine may temporarily relieve the client's headache. However, this delays immediate treatment, which is crucial. Additionally, pregnant women are advised not to take aspirin at this time because it may cause clotting problems in the neonate. Codeine generally is not prescribed.

 CN: Reduction of risk potential;  
CL: Synthesize


**14. 2.** Signs of severe preeclampsia include blood pressure of 160/110 mm Hg or greater measured at two different times at least 6 hours apart, severe blurring of vision or seeing spots in front of the eyes, oliguria, proteinuria of 5 g or greater in a 24-hour specimen, a serum creatinine concentration of 1.2 mL/dL, and a urine specific gravity of 1.04 or greater. A blood pressure of 138/94 mm Hg would suggest mild preeclampsia, as would proteinuria of less than 2 g in a 24-hour urine specimen. A weight gain of 1 lb per week in the third trimester is normal. However, a weight gain of 2 lb or more suggests severe preeclampsia.

 CN: Physiological adaptation;  
CL: Synthesize


**15. 4.** The client with severe preeclampsia may develop eclampsia, which is characterized by seizures. The client needs a darkened, quiet room and side rails with thick padding. This helps decrease the potential for injury should a seizure occur. Airways, a suction machine, and oxygen also should be available. If the client is to undergo induction of labor, oxytocin infusion solution can be obtained at a later time. Tongue blades are not necessary. However, the emergency cart should be placed nearby in case the client experiences a seizure. The ultrasound machine may be used at a later point to provide information about the fetus. In many hospitals, the client with severe preeclampsia is admitted to the labor area, where she and the fetus can be closely monitored. The safety of the client and her fetus is the priority.

 CN: Physiological adaptation; CL: Apply

**16. 3.** The client receiving magnesium sulfate intravenously is at risk for possible toxicity. The antidote for magnesium sulfate toxicity is calcium gluconate, which should be readily available at the client's bedside. Diazepam (Valium), used to treat anxiety, usually is not given to pregnant women. Hydralazine (Apresoline) would be used to treat hypertension, and phenytoin (Dilantin) would be used to treat seizures.

 CN: Pharmacological and parenteral therapies; CL: Apply

**17. 1.** Typical signs of hypermagnesemia include decreased deep tendon reflexes, sweating or a flushing of the skin, oliguria, decreased respirations, and lethargy progressing to coma as the toxicity increases. The nurse should check the client's patellar, biceps, and radial reflexes regularly during magnesium sulfate therapy. Cool skin temperature may result from peripheral vasodilation, but the opposite—flushing and sweating—are usually seen. A rapid pulse rate commonly occurs in hypomagnesemia. Tingling in the toes may suggest hypocalcemia, not hypermagnesemia.

 CN: Physiological adaptation;  
CL: Analyze

**18. 2.** The only known cure for severe preeclampsia is delivery of the fetus. In severe cases, labor induction is initiated or a cesarean section is performed. Early diagnosis and careful management are used to control the disease. Medical treatment for severe preeclampsia includes bed rest in a quiet, darkened room, a regular diet, restoration of fluid and electrolyte balance, sedation and antihypertensive medications, usually magnesium sulfate. Glucocorticoids such as betamethasone are used to enhance fetal lung maturity and are administered at 35 weeks' gestation or less. Glucocorticoids would

not be indicated with this client who is 37 weeks' gestation. Phenytoin (Dilantin) may be used to control seizures in preeclampsia but is not a first line drug and does not reduce the blood pressure associated with preeclampsia. During pregnancy, the drug is usually not prescribed because of the risk for fetal malformations. Although reduction of fluid retention may make the client more comfortable, thiazide diuretics can result in serious sodium and potassium depletion, hemorrhagic pancreatitis, and neonatal thrombocytopenia.

 CN: Reduction of risk potential;  
CL: Create

**19. 4.** The highest priority for a client with severe preeclampsia is to prevent seizures, thereby minimizing the possibility of adverse effects on the mother and fetus, and then to deliver the infant safely. Efforts to decrease edema, reduce blood pressure, increase urine output, limit kidney damage, and maintain sedation are desirable but are not as important as preventing seizures. It would take several days or weeks for the edema to be decreased. Sedation and decreased reflex excitability can occur with the administration of intravenous magnesium sulfate, which peaks in 30 minutes, much sooner than 48 hours.


 CN: Physiological adaptation; CL: Create

**20. 1, 3, 5, 6, 7.** The use of magnesium sulfate as an anticonvulsant acts to depress the central nervous system by blocking peripheral neuromuscular transmissions and decreasing the amount of acetylcholine liberated. While being used, the temperature and pulse of the client should remain within normal limits. The respiratory rate needs to be greater than 12 respirations per minute (RPM). Rates at 12 RPM or lower are associated with respiratory depression and are seen with magnesium toxicity. Renal compromise is identified with a urinary output of <30 mL per hour. A fetal heart rate that is maintained within the 112–160 range is desired without later or variable decelerations. Deep tendon reflexes that are not diminished or exaggerated are a desired outcome. The therapeutic magnesium sulfate level of 5–8 mg/dL is to be maintained. Clonus and hyper-reflexivity are not desired outcomes.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**21. 1.** A respiratory rate of 12 breaths/minute suggests potential respiratory depression, an adverse effect of magnesium sulfate therapy. The medication must be stopped and the physician should be notified immediately. A patellar reflex of +2 is normal. Absence of a patellar reflex suggests magnesium toxicity. A blood pressure reading of 160/88 mm Hg

would be a common finding in a client with severe preeclampsia. Urinary output exceeding intake is not likely in a client receiving intravenous magnesium sulfate. Oliguria is more common.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**22. 3.** If a client begins to have a seizure, the first action by the nurse is to remain with the client and call for immediate assistance. The nurse needs to have some assistance in managing this client. After the seizure, the client needs intensive monitoring. An airway can be inserted, if appropriate, after the seizure ends. Noting the time the seizure begins and ends and turning the client to her left side should be done after assistance is obtained.

 CN: Reduction of risk potential; CL: Synthesize

**23. 1.** One of the most common adverse effects of the drug hydralazine (Apresoline) is tachycardia. Therefore, the nurse should assess the client's heart rate and pulse. Hydralazine acts to lower blood pressure by peripheral dilation without interfering with placental circulation. Bradypnea and polyuria are usually not associated with hydralazine use. Dysphagia is not a typical adverse effect of hydralazine.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**24. 4.** These findings would be documented as 4+. 1+ indicates a diminished response; 2+ indicates a normal response; 3+ indicates a response that is brisker than average but not abnormal. Mild clonus is said to be present when there are two movements.


 CN: Physiological adaptation; CL: Apply

**25. 3.** Epigastric pain or acute right upper quadrant pain is associated with the development of eclampsia and an impending seizure; this is thought to be related to liver ischemia. Decreased contraction intensity is unrelated to the severity of the preeclampsia. Typically, the client's temperature increases because of increased cerebral pressure. A decrease in temperature is unrelated to an impending seizure. Hyporeflexia is not associated with an impending seizure. Typically, the client would exhibit hyperreflexia.


 CN: Physiological adaptation; CL: Analyze

**26. 4.** After an eclamptic seizure, the client commonly falls into a deep sleep or coma. The nurse must continually monitor the client for signs of impending labor, because the client will not be able to verbalize that contractions are occurring. Oliguria is more common than polyuria after an eclamptic seizure. Facial flushing is not common unless it is

caused by a reaction to a medication. Typically, the client remains hypertensive unless medications such as magnesium sulfate are administered.

 CN: Physiological adaptation; CL: Analyze

**27. 1.** After an eclamptic seizure, the client is at risk for abruptio placentae due to severe vasoconstriction resulting in hemorrhage into the decidua basalis. Abruptio placentae is manifested by a board-like abdomen and nonreassuring fetal heart rate tracing. Transverse lie or shoulder presentation, placenta accreta, and uterine atony are not related to eclampsia. Causes of a transverse lie may include relaxation of the abdominal wall secondary to grand multiparity, preterm fetus, placenta previa, abnormal uterus, contracted pelvis, and excessive amniotic fluid. Placenta accreta, a rare phenomenon, refers to a condition in which the placenta abnormally adheres to the uterine lining. Uterine atony, or relaxed uterus, may occur after delivery, leading to postpartum hemorrhage.

 CN: Physiological adaptation; CL: Analyze

**28. 2.** The normal value of an LDH in a non-pregnant person is 45 to 90 units/L. LDH elevations indicate tissue destruction that can occur with HELLP syndrome. This platelet range is in the normal range of 150,000 to 400,000/mm<sup>3</sup> and remains unchanged during pregnancy. Uric acid in a non-pregnant woman is 2 to 6.6 mg/dL. AST normal range is 4 to 20 units/L, abnormal levels indicate liver damage.

 CN: Reduction of risk potential; CL: Synthesize

### The Pregnant Client with a Chronic Hypertensive Disorder

**29. 1.** Pregnancy is not the time for clients to begin a diet. Clients with chronic hypertension need to consume adequate calories to support fetal growth and development. They also need an adequate protein intake. Meat and beans are good sources of protein. Most pregnant women report that eating more frequent, smaller meals decreases heartburn resulting from the reflux of acidic secretions into the lower esophagus. Pregnant women need adequate hydration (fluids) and fiber to prevent constipation.

 CN: Basic care and comfort; CL: Evaluate

**30. 2.** Women with chronic hypertension during pregnancy are at risk for complications such as preeclampsia (about 25%), abruptio placentae, and intrauterine growth retardation, resulting in a small-for-gestational-age infant. There is no

association between chronic hypertension and hyperthyroidism. Pregnant women with chronic hypertension are not at an increased risk for hydramnios (polyhydramnios), an abnormally large amount of amniotic fluid. Clients with diabetes and multiple gestations are at risk for this condition. Placenta accreta, a rare placental abnormality, refers to a condition in which the placenta abnormally adheres to the uterine lining. It is not associated with chronic hypertension.

 CN: Reduction of risk potential;  
CL: Evaluate

**31. 2, 3, 6.** Vaginal bleeding with or without pain could signify placenta previa or abruptio placentae. Continuous or pounding headache could indicate an elevated blood pressure, and change in the strength or frequency of fetal movements could indicate that the fetus is in distress. Orthostatic hypotension can occur during pregnancy and can be alleviated by rising slowly. Leg veins may increase in size due to additional pressure from the increasing uterine size, while leg cramps may also occur and can commonly be decreased with calcium supplements.


 CN: Reduction of risk potential;  
CL: Evaluate

### The Pregnant Client with Third-Trimester Bleeding


**32. 3.** Urinary output of less than 30 mL/hour indicates renal compromise and would be the most important assessment finding to report to the health care provider. The APTT is within normal limits and the hemoglobin is lower than values for an adult female but within normal limits for a pregnant female. Although the platelet level is slightly low and may impact blood clotting, when compared to renal failure, it is less important.

 CN: Management of care; CL: Synthesize


**33. 4.** Although the exact cause of abruptio placentae is unknown, possible contributing factors include excessive intrauterine pressure caused by hydramnios or multiple pregnancy, cocaine use, cigarette smoking, alcohol ingestion, trauma, increased maternal age and parity, and amniotomy. A history of hypertension is associated with an increased risk of abruptio placentae. A previous low transverse cesarean section delivery and a history of one induced abortion are associated with increased risk of placenta previa, not abruptio placentae.

 CN: Physiological adaptation;  
CL: Analyze


**34. 2.** Treatment of DIC includes treating the causative factor, replacing maternal coagulation factors, and supporting physiologic functions. Intravenous infusions of whole blood, fresh-frozen plasma, or platelets are used to replace depleted maternal coagulation factors. Although Ringer's lactate solution and 5% dextrose solution may be used as intravenous fluid replacement, the client needs blood component therapy. Therefore, normal saline must be used. Intravenous heparin, not warfarin sodium (Coumadin) may be administered to halt the clotting cascade.

 CN: Physiological adaptation;  
CL: Analyze

**35. 1.** The most common assessment finding associated with placenta previa is painless vaginal bleeding. With placenta previa, the placenta is abnormally implanted, covering a portion or all of the cervical os. Uterine tetany, intermittent pain with spotting, and dull lower back pain are not associated with placenta previa. Uterine tetany is associated with oxytocin administration. Intermittent pain with spotting commonly is associated with a spontaneous abortion. Dull lower back pain is commonly associated with poor maternal posture or a urinary tract infection with renal involvement.


 CN: Physiological adaptation;  
CL: Analyze

**36. 2.** Bleeding precipitated by placenta previa results from exposure of the maternal sinuses when placental villi are torn from the uterine wall as the lower uterine segment contracts and dilates in the later weeks of pregnancy. The bleeding is not initiated because of diminished clotting factors. Diminished clotting factors are associated with DIC. Increased platelet levels would suggest an increased risk for clotting. A large-for-gestational-age fetus may be related to hereditary factors or diabetes.

 CN: Physiological adaptation;  
CL: Evaluate

**37. 1.** When administering blood replacement therapy, extreme caution is needed. Before administering any blood product, the nurse should validate the client information and the blood product with another nurse to prevent administration of the wrong blood transfusion. Although baseline vital signs are necessary, she should initiate the infusion of blood slowly for the first 10 to 15 minutes. Then, if there is no evidence of a reaction, she should adjust the rate of infusion to ensure that the blood product is infused over 2 to 4 hours. The nurse can ask the client if she has ever had a reaction to a blood product, but a general question about

allergies may not elicit the most complete response about any reactions to blood product administration. Blood transfusions are typically given with intravenous normal saline solution, not dextrose solutions.

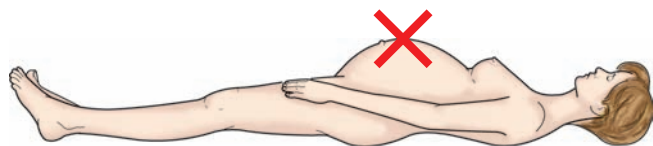
 CN: Pharmacological and parenteral therapies; CL: Apply

**38. 3.** Feelings of loss, grief, and guilt are normal after a cesarean section delivery, particularly if it was not planned. The nurse should support the client, listen with empathy, and allow the client time to grieve. The likelihood of the client experiencing postpartum blues is not known, and no evidence is presented. Although maternal-infant bonding may be delayed owing to neonatal complications or maternal pain and subsequent medications, it should not be difficult. Although the nurse is aware that that this type of delivery was necessary to save the client's life, using this as the basis for the response does not acknowledge the mother's feelings.

 CN: Psychosocial adaptation; CL: Apply

**39.** Epidural anesthesia for a cesarean birth must be at the level of T4 to T6, approximately the nipple line. The level of anesthesia achieved via epidural anesthesia for a vaginal birth is T10 (approximately the hips).

 CN: Pharmacological and parenteral therapies; CL: Apply




**40. 3.** Abruptio placentae is a medical emergency because the degree of hypovolemic shock may be out of proportion to visible blood loss. On admission, the nurse should plan to first insert a large-gauge intravenous catheter for fluid replacement and oxygen by mask to decrease fetal anoxia. Vaginal examination usually is not performed on pregnant clients who are experiencing third-trimester bleeding due to abruptio placentae because it can result in damage to the placenta and further fetal anoxia. The client's history can be obtained once the client has been admitted and the intravenous line has been started. The goal is to get the fetus delivered, usually by emergency cesarean delivery. The nurse should also plan to monitor the client's vital signs and the fetal heart rate. Ultrasound is of limited use in the diagnosis of abruptio placentae.

 CN: Reduction of risk potential; CL: Synthesize

## The Pregnant Client with Preterm Labor


**41. 3.** The absence of fetal fibronectin in a vaginal swab between 22 and 37 weeks' gestation indicates there is less than 1% risk of developing preterm labor in the next week. Fetal fibronectin is an extra cellular protein normal found in fetal membranes and deciduas and has no correlation with preeclampsia, fetal lung maturation, or gestational diabetes.

 CN: Reduction of risk potential; CL: Synthesize


**42. 4.** Smoking in any form is contraindicated in pregnancy, regardless of the type of filtering system used. Smoking is a major risk factor for preterm labor and decreased fetal weight. Dehydration is a risk factor for preterm labor as is prolonged standing and remaining in one position. Infection is thought to be a primary cause of preterm labor and the client would need to avoid contracting any type of infection. While taking trips, frequent emptying of the bladder prevents infection and ambulates the woman.

 CN: Management of care; CL: Evaluate

**43. 1.** Indomethacin (Indocin) has been successfully used to halt preterm labor. However, if the client should deliver a preterm infant, the nurse would notify the nursery personnel about the tocolytic therapy because this drug can lead to premature closure of the fetal ductus arteriosus, resulting in pulmonary hypertension. Prematurity is associated with RDS because of the immaturity of the fetal lungs. RDS is not a result of indomethacin. Hyperbilirubinemia is more common in preterm infants. Use of indomethacin to halt preterm labor is not associated with cardiomyopathy in the infant.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**44. 4.** Tachycardia is a common adverse effect of terbutaline therapy. If the client's heart rate is 130 bpm or faster, the nurse should contact the physician before administering the medication. After the drug has been administered, the client should also be carefully monitored for dyspnea or other symptoms of pulmonary edema. Other adverse effects include premature ventricular contractions, increased stroke volume, increased systolic pressure with decreased diastolic pressure, palpitations, tremors, nausea and vomiting, and shortness of breath. Other adverse effects include hyperglycemia, metabolic acidosis, hypokalemia, and anemia. Terbutaline has no known effects on the client's hemoglobin or hematocrit levels, or on weight. However, the drug can cause nausea. Terbutaline may result in perspiration, but there are no known effects on urinary output.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**45. 3.** As the uterus contracts, the abdominal wall rises and, when external monitoring is used, presses against the transducer. This movement is transmitted into an electrical current, which is then recorded. With the fetus in the LOA position, the cardiostimulator should be placed below the umbilicus on the side where the fetal back is located and uterine displacement during contractions is greatest. If the fetal back is near the symphysis pubis, the fetus is presenting as a transverse lie. If the fetus is in a breech position, the fetal back may be at or above the umbilicus.

 CN: Reduction of risk potential;  
CL: Apply

**46. 1.** Betamethasone therapy is indicated when the fetal lungs are immature. The fetus must be between 28 and 34 weeks' gestation and delivery must be delayed for 24 to 48 hours for the drug to achieve a therapeutic effect. Antibiotics would be used to treat chorioamnionitis. Betamethasone is not an antagonist for tocolytic therapy. It increases, not decreases, the production of neonatal surfactant.

 CN: Pharmacological and parenteral therapies; CL: Apply

**47. 8:00 a.m.** If 10 mg were administered at 10:00 a.m. and 12:00 p.m. and then 20 mg were administered at 4:00 p.m., 8:00 p.m., 10:00 p.m., 12:00 a.m., 4:00 a.m., and 8:00 a.m., the dose at 8:00 a.m. reached the maximum oral dose of 120 mg/day.

 CN: Pharmacological and parenteral therapies; CL: Apply

**48. 2.** For this client, who has experienced two stillbirths, the most appropriate diagnosis is *Anxiety* related to diagnostic tests for fetal well-being. With most antepartal diagnostic tests, pain is absent or minimal. Information to support the diagnoses of *Ineffective coping* or *Deficient knowledge* is lacking.

 CN: Reduction of risk potential;  
CL: Analyze

**49. 4.** The shake test helps determine the maturity of the fetal pulmonary system. The test is based on the fact that surfactant foams when mixed with ethanol. The more stable the foam, the more mature the fetal pulmonary system. Although the shake test is inexpensive and provides rapid results, problems have been noted with its reliability. Therefore, the lecithin-sphingomyelin ratio is usually determined in conjunction with the shake test.

 CN: Reduction of risk potential;  
CL: Apply

## The Pregnant Client with Premature Rupture of the Membranes

**50. 3.** Because an intrauterine infection may occur when membranes have ruptured, vaginal cultures for *N. gonorrhoeae*, group B streptococcus, and chlamydia are usually taken. Prophylactic antibiotics may be prescribed to reduce the risk of infection in the newborn. Frequent vaginal examinations should be avoided because they can further increase the client's risk for infection. Intravenous oxytocin to initiate labor may be used if an infection occurs. Bed rest can sometimes prolong the pregnancy and prevent a preterm birth. A sonogram may be used to validate rupture of the membranes with an amniotic fluid index. However, it is not needed if the physician has confirmed the rupture.

 CN: Reduction of risk potential;  
CL: Apply

**51. 3.** If the client's membranes have ruptured, the nitrazine paper will turn blue, an alkaline reaction. False positives may occur when the nitrazine paper is exposed to blood or semen. The definitive test for rupture of membranes is fern testing, where amniotic fluid is allowed to dry on a slide and then viewed under a microscope. Dried amniotic fluid will form a fern pattern. No other fluid forms this type of pattern.


 CN: Reduction of risk potential;  
CL: Analyze

**52. 4.** Premature rupture of the membranes is commonly associated with chorioamnionitis, or an infection. A priority assessment for the nurse to make is to document the client's temperature every 2 to 4 hours. Temperature elevation may indicate an infection. Lethargy and an elevated white blood cell count also indicate an infection. The red blood cell count would provide information related to anemia, not infection. The client is not in labor. Therefore, assessing the degree of discomfort is not a priority at this time. Urinary output is not a reliable indicator of an infection such as chorioamnionitis.

 CN: Reduction of risk potential;  
CL: Analyze

**53. 1.** Because group B streptococcus is a gram-positive bacteria, the physician probably will order intravenous penicillin to treat the mother's infection and prevent fetal infection. Gentamicin sulfate, which acts on gram-negative bacteria, would be inappropriate. Administering a corticosteroid, such as betamethasone, is inappropriate because the premature rupture of the membranes enhances fetal lung maturity. The lack of amniotic

fluid causes early maturation of lung tissue. Cefaclor, which is available only in the oral form, is used for upper and lower respiratory tract infections and urinary tract infections by gram-negative staphylococci.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**54. 4.** Because of the client's increased risk for infection, successful teaching is indicated when the client states that she will contact the doctor if her temperature is 100.4° F (38° C) or greater. The client should be instructed to monitor her temperature twice daily. The client should refrain from coitus, douching, and tub bathing, which can increase the potential for infection. Showering is permitted because water in the shower doesn't enter the vagina and increase the risk of infection. A fluid intake of at least 2 L daily is recommended to prevent potential urinary tract infection.


 CN: Reduction of risk potential; CL: Evaluate

**55. 1.** The priority is to determine whether a prolapsed cord has occurred as a result of the spontaneous rupture of membranes. The nurse's first action should be to check the status of the fetal heart rate. Complications of premature rupture of the membranes include a prolapsed cord or increased pressure on the fetal umbilical cord inhibiting fetal nutrient supply. Variable decelerations or fetal bradycardia may be seen on the external fetal monitor. The cord also may be visible. Turning the client to her right side is not necessary. If the cord does prolapse, the client should be placed in a knee-to-chest or Trendelenburg position. Checking the fluid with nitrazine paper and vaginal examination are appropriate once the status of the fetus has been evaluated.

 CN: Reduction of risk potential; CL: Synthesize

### The Pregnant Client with Diabetes Mellitus

**56. 3.** Feeling four kicks in 30 minutes or feeling 10 or more kicks in 3 hours are norms. Fetuses are more active at various times of the day particularly after a mother has eaten (when the blood glucose level is high) and in the evening. Each individual perceives their fetus to move differently. Fetuses do sleep several times per day for about 30 minutes each time.

 CN: Safety and infection control; CL: Evaluate


**57. 4.** The nonstress test is considered reactive when two or more fetal heart rate accelerations of at least 15 bpm occur (from a baseline fetal heart rate of 120 to 160 bpm), along with fetal movement, during a 10- to 20-minute period. A reactive nonstress test indicates fetal heart rate accelerations and well-being. There is no indication for further evaluation (such as a contraction stress test). However, contraction stress tests are commonly scheduled for pregnant clients with insulin-dependent diabetes in the latter part of pregnancy and are repeated periodically until delivery. Chorionic villus sampling is usually performed early in the pregnancy to detect fetal abnormalities.

 CN: Reduction of risk potential; CL: Synthesize

**58. 3.** A contraction stress test is used to evaluate fetal well-being during a simulated labor. A suspicious contraction stress test indicates inconsistent late deceleration patterns requiring further evaluation. A negative contraction stress test indicates no late decelerations and is the desired outcome. A positive contraction stress test indicates fetal compromise with frequent late decelerations. Fetal movements are one of the parameters of a biophysical profile and are detected with nonstress testing. Decreased or absent fetal movements may indicate central nervous system dysfunction or prematurity. Lack of fetal movement or decreased fetal movement is not associated with contraction stress testing.


 CN: Reduction of risk potential; CL: Analyze

**59. 2.** The fetal biophysical profile, a noninvasive test using real-time ultrasound, assesses five parameters: fetal heart rate reactivity, fetal breathing movements, gross fetal body movements, fetal tone, and amniotic fluid volume. Fetal heart rate reactivity is determined by a nonstress test; the other four parameters are determined by ultrasound scanning. The results are available as soon as the test is completed and interpreted. The lecithin-sphingomyelin ratio is used to determine fetal lung maturity. Although the fetal biophysical profile is useful in predicting which fetuses may be at greater risk for compromise, there is no correlation with the newborn's Apgar score. The biophysical score is sometimes referred to as the fetal Apgar score. A score of 8 to 10 indicates fetal well-being. Use of an ultrasound requires the mother to have a full bladder.

 CN: Pharmacological and parenteral therapies; CL: Apply




**60. 2.** During the first trimester, it is not unusual for insulin needs to decrease, commonly as a result of nausea and vomiting. Progressive insulin resistance is characteristic of pregnancy, particularly in the second half of pregnancy. It is not unusual for insulin needs to increase by as much as four times the nonpregnant dose after about the 24th week of gestation. This resistance is caused by the production of human placental lactogen, also called *human chorionic somatotropin*, by the placenta and by other hormones, such as estrogen and progesterone, which are insulin antagonists.

 CN: Pharmacological and parenteral therapies; CL: Apply

**61. 2.** Clients who are pregnant and have diabetes are not at greater risk for multifetal pregnancy and subsequent twin-to-twin transfer unless they have undergone fertility treatments. The pregnant diabetic client is at higher risk for complications such as infection, polyhydramnios, ketoacidosis, and preeclampsia, compared with the pregnant non-diabetic client.

 CN: Reduction of risk potential; CL: Evaluate

**62. 2.** The goal is to maintain blood plasma glucose levels at 60 to 100 mg/dL before meals and bedtime snacks. A range of 40 to 60 mg/dL indicates hypoglycemia. A range of 110 to 140 mg/dL suggests hyperglycemia. A range of 140 to 160 mg/dL 1 hour after meals suggests hyperglycemia. The target range 1 hour after meals is 100 to 120 mg/dL.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**63. 3.** Maternal infection is the most common cause of maternal hyperglycemia and can lead to ketoacidosis, coma, and death. The client should notify the physician immediately if she experiences symptoms of an infection. Fetal macrosomia, obesity before conception, and pregnancy-induced hypertension are not associated with maternal hyperglycemia during pregnancy.

 CN: Physiological adaptation; CL: Create


**64. 1.** Dehydration, polyuria, fatigue, flushed hot skin, dry mouth, and drowsiness are manifestations of hyperglycemia. Hyperglycemia is a medical emergency and requires immediate action to prevent maternal and fetal mortality. Pallor, sweating, and nervousness are early signs of hypoglycemia, not hyperglycemia.

 CN: Reduction of risk potential; CL: Evaluate


**65. 4.** Stillbirths caused by placental insufficiency occur with increased frequency in women with diabetes and severe preeclampsia. Clients with poorly controlled diabetes may experience unanticipated stillbirth as a result of premature aging of the placenta. Therefore, labor is commonly induced in these clients before term. If induction of labor fails, a cesarean delivery is necessary. Induction and cesarean delivery do not prevent neonatal hyperbilirubinemia, congenital anomalies, or perinatal asphyxia.

 CN: Reduction of risk potential; CL: Apply

**66. 3.** Maternal hyperglycemia and poor control of the mother's diabetes mellitus have been implicated in fetal macrosomia. When the mother is hyperglycemic, large amounts of amino acids, free fatty acids, and glucose are transferred to the fetus. Although maternal insulin does not cross the placenta, the fetal pancreas responds by hypertrophy of the islet cells of the pancreas. The islet cells produce large amounts of insulin, which acts as a growth hormone. A family history of large infants usually is not the reason for large-for-gestational-age fetuses in diabetic mothers. Maternal hypertension is associated with small-for-gestational-age fetuses because of vasoconstriction of the maternal and placental blood vessels.

 CN: Physiological adaptation; CL: Apply

**67. 1.** Insulin needs fall significantly for the first 24 hours postpartum because the client has usually been on nothing-by-mouth status for a period of time during labor and the labor process has used maternal glycogen stores. If the client breast-feeds, lower blood glucose levels decrease the insulin requirements. With insulin resistance gone, the client commonly needs little or no insulin during the immediate postpartum period. Although the need for insulin decreases during the intrapartum period, the insulin requirements fall further during the first 24 hours postpartum. After the first 24 hours postpartum, insulin requirements may fluctuate markedly, needing adjustment during the next few days as the mother's body returns to a nonpregnant state.

 CN: Pharmacological and parenteral therapies; CL: Create

## The Pregnant Client with Heart Disease

**68. 3.** The client needs a diet that is adequate in protein and calories to prevent anemia, which can place additional strain on the cardiac system, further compromising the client's cardiac status. The client should avoid contact with people who have infections because of the increased risk for developing endocarditis. The client may need antibiotics during the pregnancy to prevent endocarditis. Limiting sodium intake can help to prevent excessive expansion of blood volume and decrease cardiac workload.

 CN: Reduction of risk potential;  
CL: Evaluate


**69. 4.** Increased dyspnea at rest must be reported immediately because it may be indicative of increasing congestive heart failure. Mild ankle edema in the third trimester is a common finding. However, generalized or pitting edema, suggesting increasing congestive heart failure, must be reported immediately. Emotional stress on the job increases cardiac demand. However, it needs to be reported only if the client experiences symptoms, such as palpitations or irregular heart rate, indicating heart failure related to the increased stress. Weight gain of 1 lb per week is a normal finding during the third trimester.

 CN: Reduction of risk potential;  
CL: Apply

**70. 2.** Unless the client has cardiac decompensation during the pregnancy, she will most likely be able to continue taking the same dose of medication. The client may be prescribed prophylactic antibiotics, particularly if she has had rheumatic fever. The medication would be switched only if digitalis toxicity occurs. A diuretic is added only if congestive heart failure is not controlled by sodium and activity restrictions.

 CN: Management of care; CL: Apply

**71. 1.** Although there is no completely safe anticoagulant therapy during pregnancy, heparin is typically the drug of choice. Warfarin (Coumadin), a pregnancy category D drug, can cause fetal malformations. Enoxaparin (Lovenox) is not typically prescribed because it can result in thrombocytopenia. Ardeparin (Normiflo) also can cause fetal malformations.

 CN: Pharmacological and parenteral therapies; CL: Apply


**72. 4.** The client can continue a low-sodium diet but should increase the caloric intake to 2,200 calories daily to provide adequate nutrients to support fetal growth and development. Folic acid

supplements, a standard component of care, are used to prevent folic acid deficiency, which is associated with megaloblastic anemia during pregnancy. Severe restriction of sodium intake is not recommended because sodium is necessary to maintain fluid volume. Iron supplements should be taken with acidic foods and fluids (e.g., citrus juices) for maximum absorption. Milk decreases the absorption of iron.

 CN: Reduction of risk potential;  
CL: Apply

## The Client with an Ectopic Pregnancy

**73. 1.** The client's signs and symptoms indicate a probable ectopic pregnancy, which can be confirmed by ultrasound examination or by culdocentesis. The physician is notified immediately because hypovolemic shock may develop without external bleeding. Once the fallopian tube ruptures, blood will enter the pelvic cavity, resulting in shock. Abruptio placentae would be manifested by a board-like uterus in the third trimester. Gestational trophoblastic disease would be suspected if the client exhibited no fetal heart rate and symptoms of pregnancy-induced hypertension before 20 weeks' gestation. A client with a complete abortion would exhibit a normal pulse and blood pressure with scant vaginal bleeding.

 CN: Physiological adaptation;  
CL: Analyze

**74. 1, 2, 3, 5, 6.** The client may be experiencing an ectopic pregnancy. Contributing factors to an ectopic pregnancy include a prior history of sexually transmitted infection which can scar the fallopian tubes. Prior use of an IUD as contraception with multiple sex partners increases the risk of sexually transmitted infections. Knowledge of the client's last menstrual period and contraceptive use may support or rule out the possibility of an ectopic pregnancy. The client's history of cesarean sections would not contribute information valuable to the client's current situation or potential diagnosis of ectopic pregnancy.

 CN: Reduction of risk potential;  
CL: Analyze

**75. 2.** Falling hematocrit and hemoglobin levels indicate shock, which occurs if the tube ruptures. Other common symptoms of tubal rupture include severe knife-like lower quadrant abdominal pain and referred shoulder pain. The amount of vaginal bleeding that is evident is a poor estimate of actual blood loss. Slight vaginal bleeding, commonly described as *spotting*, is common. A rapid, thready


pulse, a symptom of shock, is more common with tubal rupture than a slow, bounding pulse. Abdominal edema is a late sign of a tubal rupture in ectopic pregnancy.

 CN: Reduction of risk potential;  
CL: Analyze

**76. 4.** Fallopian tube rupture is an emergency situation because of extensive bleeding into the peritoneal cavity. Shock soon develops if precautionary measures are not taken. The nurse readying a client for surgery should be especially careful to monitor blood pressure and pulse rate for signs of impending shock. The nurse should be prepared to administer fluids, blood, or plasma expanders as necessary through an intravenous line that should already be in place. Because the fertilized ovum has implanted outside the uterus, uterine cramping is unlikely. However, abdominal tenderness or knife-like pain may occur. Abdominal fullness may be present, but abdominal distention is rare unless peritonitis has developed. Although the hemoglobin and hematocrit may be checked routinely before surgery, the laboratory results may not truly reflect the presence or degree of acute hemorrhage.

 CN: Reduction of risk potential;  
CL: Analyze

**77. 3.** Anything that causes a narrowing or constriction in the fallopian tubes so that a fertilized ovum cannot be properly transported to the uterus for implantation predisposes an ectopic pregnancy. Pelvic inflammatory disease is the most common cause of constricted or narrow tubes. Developmental defects are other possible causes. Ectopic pregnancy is not related to urinary tract infections. Use of marijuana during pregnancy is not associated with ectopic pregnancy, but its use can result in cognitive reduction if the mother's use during pregnancy is extensive. Progestin-only contraceptives and intrauterine devices have been associated with ectopic pregnancy.


 CN: Physiological adaptation;  
CL: Analyze

**78. 2.** The client should not experience a headache or dizziness. Symptoms that the client should report include pain (caused by stretching of the tube), temperature elevation (suggesting infection), and bleeding (suggesting hemorrhage). The client should also be instructed that infertility may occur as a result of the removal of one fallopian tube.

 CN: Reduction of risk potential;  
CL: Evaluate

**79. 3.** Because the fallopian tube has not yet ruptured, methotrexate may be given, followed by leucovorin. This chemotherapeutic agent attacks the

fast-growing zygote and trophoblast cells. RU-486 is also effective. A hysterosalpingogram is usually performed after chemotherapy to determine whether the tube is still patent. Progestin-only contraceptives and medroxyprogesterone are ineffective in clearing the fallopian tube. Dyphylline is a bronchodilator and is not used.

 CN: Pharmacological and parenteral therapies; CL: Analyze

## The Pregnant Client with Hyperemesis Gravidarum

**80. 3.** The client needs further instructions when she says she should eat two meals a day with frequent protein snacks to decrease nausea and vomiting. The client should eat more frequent, smaller meals, with frequent carbohydrate snacks to decrease nausea and vomiting. Eating dry crackers or toast before arising, consuming fluids separately from meals, and avoiding greasy or spicy foods may also help to decrease nausea and vomiting.

 CN: Basic care and comfort; CL: Evaluate

**81. 3.** Gastrointestinal secretion losses from excessive vomiting, diarrhea, and excessive perspiration can result in hypokalemia, hyponatremia, decreased chloride levels, metabolic alkalosis, and eventual acidosis if precautionary measures are not taken. Ketones may be present in the urine. Dehydration can lead to poor maternal and fetal outcomes. Persistent vomiting can lead to hypocalcemia, not hypercalcemia. Hyperbilirubinemia, not hypobilirubinemia, is typical in clients with hyperemesis. Persistent vomiting may affect liver function and subsequently the excretion of bilirubin from the body. Hypoglycemia, not hyperglycemia, may occur as a result of decreased intake of food and fluids, decreased metabolism of nutrients, and excessive vomiting.

 CN: Reduction of risk potential;  
CL: Analyze

**82. 2.** Although the cause of hyperemesis is still unclear, it is thought to be related to high estrogen and human chorionic gonadotropin levels or to trophoblastic activity or gonadotrophin production. Hyperemesis is also associated with infectious conditions, such as hepatitis or encephalitis, intestinal obstruction, peptic ulcer, and hydatidiform mole. Progesterone is a relaxant used during pregnancy and would not stimulate vomiting. Somatotropin is a growth hormone used in children. Aldosterone is a male hormone.

 CN: Physiological adaptation; CL: Apply

**83. 25 gtts/minute**

$$\frac{\text{Gtts}}{\text{min}} = \frac{12 \text{ gtts}}{1 \text{ mL}} \times \frac{1000 \text{ mL}}{8 \text{ hr}} \times \frac{1 \text{ hr}}{60 \text{ min}} = 25 \text{ gtts/min}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**84. 3.** The client usually remains NPO for 24 hours after initiation of IV fluid replacement therapy. If the client is not vomiting after 24 hours, HCP orders generally allow for clients to be started on clear liquids. If the client tolerates liquids, then dry toast, crackers, or cereal may be given every 2 to 3 hours. The client should be given a choice of foods. The temperature of the foods and fluids should be appropriate (i.e., hot food served hot, cold foods served cold). Total parenteral nutrition is initiated only if other measures, such as IV fluid replacement and pharmacologic care, fail.

 CN: Physiological adaptation; CL: Create

### The Client with a Hydatidiform Mole

**85. 4.** The nurse should prepare the client for an ultrasound to determine the cause of the symptoms. Elevated blood pressure at this point in the pregnancy could indicate chronic hypertension as well as hydatidiform mole. The fundal height of 19 cm is higher than is typically found at 15 weeks' gestation and is indicative of a molar pregnancy (hydatidiform mole). The dark brown vaginal bleeding in isolation could indicate an abortion but when placed in context of the other symptoms is likely related to a hydatidiform mole. The continuous nausea and vomiting is abnormal at this point in the pregnancy and can be a result of the high levels of progesterone from a molar pregnancy. There is no fetus involved; the blood pressure elevation and the continuous nausea and vomiting will resolve with evacuation of the mole, negating the need for magnesium sulfate therapy and placing the client on NPO status.

 CN: Reduction of risk potential;  
CL: Synthesize

**86. 1.** Hydatidiform mole is suspected when the following are present: pregnancy-induced hypertension before the 24th week of gestation, brownish or prune-colored vaginal bleeding, anemia, absence of fetal heart tones, passage of hydropic vessels, uterine enlargement greater than expected for gestational age, and increased human chorionic gonadotrophin levels. Gestational diabetes is related to an increased risk of preeclampsia and urinary tract infections, but it is not associated with hydatidiform mole. Hyperthyroidism, not hypothyroidism, occurs

occasionally with hydatidiform mole. If it does occur, it can be a serious complication, possibly life-threatening to the mother and fetus from cardiac problems. Polycythemia is not associated with hydatidiform mole. Rather, anemia from blood loss is associated with molar pregnancies.

 CN: Reduction of risk potential;  
CL: Analyze

**87. 2.** After D&C to evacuate a molar pregnancy, the nurse should assess the client's vital signs and monitor for signs of hemorrhage, because the surgical procedure may have traumatized the uterine lining, leading to hemorrhage. Urinary tract infections, not common after evacuation of a molar pregnancy, are most commonly related to urinary catheterization. Typically, urinary catheters are not used during evacuation of a molar pregnancy. The client should not experience abdominal distention, because the contents of the uterus have been removed. Chorioamnionitis is an inflammation of the amniotic fluid membranes. With complete mole, no embryonic or fetal tissue or membranes are present.

 CN: Reduction of risk potential;  
CL: Analyze

**88. 2.** A client who has had a hydatidiform mole removed should have regular checkups to rule out the presence of choriocarcinoma, which may complicate the client's clinical picture. The client's human chorionic gonadotropin (hCG) levels are monitored for 1 year. During this time, she should be advised not to become pregnant because this would be reflected in rising hCG levels. Ectopic or multifetal pregnancy is not associated with hydatidiform mole. Women who have molar pregnancies have fertility rates similar to the general population.

 CN: Reduction of risk potential;  
CL: Synthesize

**89. 2.** A client who has experienced a molar pregnancy is at risk for development of choriocarcinoma and requires close monitoring of human chorionic gonadotropin (hCG) levels. Pregnancy would interfere with monitoring these levels. High hCG titers are common for up to 7 weeks after the evacuation of the mole, but then these levels gradually begin to decline. Clients should have a pelvic examination and a blood test for hCG titers every month for 6 months and then every 2 months for 1 year. Gradually declining hCG levels suggest no complications. Increasing levels are indicative of a malignancy and should be treated with methotrexate. If after 1 year the hCG levels are negative, the client is theoretically free of the risk of a malignancy developing and could plan another pregnancy.

 CN: Reduction of risk potential;  
CL: Apply

## The Pregnant Client with Miscellaneous Complications

**90. 4.** Herpes simplex virus can be transmitted to the infant during a vaginal delivery. The neonatal effects of herpes are severe enough that a cesarean birth is warranted if active lesions—primary or secondary—are present. A client with a primary infection during pregnancy sheds the virus for up to 3 months after the lesion has healed. The client carrying an infant weighing 8 lb will be given a trial of labor before a cesarean. The client with a fetus in the right occiput posterior position will have a slow labor with increased back pain but can deliver vaginally. The fetus in a breech position still has many weeks to change positions before being at term. At 7 months' gestation, the breech position is not a concern.

 CN: Physiological adaptation; CL: Evaluate

**91.**

3. Establish unresponsiveness.

2. Ask staff to activate emergency response system.

1. Open airway using head tilt-chin lift.

4. Give 2 breaths.

5. Check the pulse

The client's actions indicate distress and the nurse should initiate emergency procedures. The nurse should first establish unresponsiveness and then ask staff to activate the emergency response system. Next, the nurse should assure an open airway and then give 2 breaths. The nurse should then check the carotid pulse, and if necessary begin chest compressions.

 CN: management of care; CL: Synthesize

**92. 4.** Sickle cell disease is an autosomal recessive disorder requiring both parents to have a sickle cell trait to pass the disease to a child. Deoxygenated hemoglobin cells assume a sickle shape and obstruct tissues. Tissue obstruction causes hypoxia to the area (vasoocclusion) and results in pain, called *sickle cell crisis*. This type of anemia is an inherited disorder; it is not caused by lack of iron in the diet. Self-monitoring for any type of infections or sickle cell crisis and increased frequency of antenatal care visits are part of the teaching plan of care.

 CN: Physiological adaptation;  
CL: Evaluate

**93. 1.** The nurse should place a hand on the fetal head and provide gentle upward pressure to relieve the compression on the cord. Doing so allows oxygen to continue flowing to the fetus. The cord should never be placed back into the vagina because doing so may further compress it. Administering oxygen is an appropriate measure but will not serve a useful purpose until the pressure is relieved on the cord, enabling perfusion to the infant. Turning the client to her left side facilitates better perfusion to the mother but, until the compression on the cord is relieved, the increased oxygen will not serve its purpose. Placing the client in a Trendelenburg or knee-chest position would be position changes to increase perfusion to the infant by relieving cord compression.

 CN: management of care; CL: Synthesize


**94. 1, 2, 3, 4.** Having the fetus at a negative station places the client at risk for a cord prolapse. With a negative station, there is room between the fetal head and the maternal pelvis for the cord to slip through. A small infant is more mobile within the uterus and the cord can rest between the fetus and the inside of the uterus or below the fetal head. With a large infant, the head is usually in a vertex presentation and occludes the lower portion of the uterus, preventing the cord from slipping by. When membranes rupture, the cord can be swept through with the amniotic fluid. In a breech presentation, the fetal head is in the fundus and smaller portions of the fetus settle into the lower portion of the uterus, allowing the cord to lie beside the fetus. Prior abortion and a low lying placenta have no correlation to cord prolapse.

 CN: Physiological adaptation;  
CL: Analyze

**95. 3.** A postpartum client who saturates a pad in an hour or less at any time in the postpartum period is considered to be hemorrhaging. As the normal postpartum client heals, bleeding changes from red to pink to off-white. It also decreases in amount each day. Passing blood clots the size of a fist or larger is a reportable problem. Lochia varies in how long it lasts and is considered normal up to 6 weeks postpartum.

 CN: Health promotion and maintenance;  
CL: Create

**96. 2.** RhoGAM is given to new mothers who are Rh-negative and not previously sensitized and who have delivered an Rh-positive infant. RhoGAM must be given within 72 hours of the delivery of the infant because antibody formation begins at that time. The vaccine is used only when the mother delivered an Rh-positive infant—not an Rh-negative infant. RhoGAM does not prevent German measles and is not given to a newborn.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**97. 2.** The client is experiencing and verbalizing signs of postpartum depression, which usually appears at about 4 weeks postpartum but can occur at any time within the first year after birth. It is more severe and lasts longer than postpartum blues, also called “baby blues.” Baby blues are the mildest form of depression and are seen in the later part of the first week after birth. Symptoms usually disappear shortly. Depression may last several years and is disabling to the woman. Poor bonding may be seen at any time but commonly becomes evident as the mother begins interacting with the infant shortly after birth. Infant abuse may take the form of neglect or injuries to the infant. A depressed mother is at risk for injuring or abusing her infant.

 CN: Reduction of risk potential; CL: Synthesize

**98. 2, 3, 7.** The nursing assistant could assist the client with breathing and relaxation, and ambulate the postcesarean client to the bathroom. Removing lunch trays and adding the intake to the input and output sheet is a nursing assistant responsibility. Removing a Foley catheter would also involve assessment of bladder status and totaling the intake and output and would be a nursing responsibility. Calculating the hourly I.V. totals for a preterm labor client would involve assessments that require nursing expertise. In-and-out catheterization, a sterile procedure, and calling reports to health care providers, which requires gathering and analysis of data, are responsibilities of the nurse.

 CN: Management of care; CL: Evaluate

### Managing Care Quality and Safety

**99. 3.** A preeclamptic client with +3 proteinuria and epigastric pain is at risk for seizing, which would jeopardize the mother and the fetus. Thus, this client would be the highest priority. The client at 13 weeks’ gestation with nausea and vomiting is a concern because the presence of ketones indicates that her body does not have glucose to break down. However, this situation is a lower priority than the preeclamptic client or the insulin-dependent diabetic. The insulin-dependent diabetic is a high priority; however, fetal movement indicates that the fetus is alive but may be ill. As few as four fetal movements in 12 hours can be considered normal. (The client may need additional testing to further evaluate fetal well-being.) The primigravida who is at 17 weeks’ gestation is too early in her pregnancy to experience fetal movement and would be the last person to be seen.

 CN: Management of care; CL: Evaluate

**100. 3.** The nurse should refer the client who is preeclamptic client with 3+ proteinuria to a health care provider. The 3+ urine is significant, indicating there is much protein circulating. The woman who is 37 weeks’ gestation with insulin-dependent diabetes who has experienced hypoglycemic episodes in the past week can be managed with food and glucose tablets until the client can obtain an appointment with the care provider. The client at 10 weeks’ gestation with nausea and vomiting and + 1 ketones should also be seen by a health care provider, but at this point this client is uncomfortable but her life is not in danger. The 15-week primigravid client will not be feeling her baby move this soon in the pregnancy and this would not be considered a problem that requires immediate referral to a health care provider.

 CN: Management of care; CL: Evaluate

**101.**

3. Correct the I.V. rates to magnesium sulfate running at 3 grams/hour and normal saline to complete total rate at 125 mL/hour.

2. Assess the client’s current status

1. Notify the physician of the incident.

4. Initiate an incident report.

The nurse should first change the I.V. magnesium sulfate and normal saline infusion rates, and then assess the current status of the client. The nurse should then notify the physician to explain the error and, report the action taken. A medication error has occurred and the nurse will need to initiate an incident report.

 CN: Management of care; CL: Synthesize

**102.**

1. Call for immediate assistance.

3. Maintain airway.

2. Turn the client to her side.

4. Note the length of time of seizure.

If a client begins to have a seizure, the first action by the nurse is to remain with the client and call for immediate assistance. Next, the nurse should turn the client to her side and then maintain the airway by keeping the neck hyperextended. Noting the length of the seizure and the limb involvement are observations that are ongoing.

 CN: Management of care; CL: Synthesize

**TEST**  
**3**

## The Birth Experience

- The Primigravid Client in Labor
- The Multigravid Client in Labor
- The Labor Experience
- The Intrapartal Client with Risk Factors
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Primigravid Client in Labor

**1.** The nurse is managing care of a primigrada at full term who is in active labor. What should be included in developing the plan of care for this client?

- 1. Oxygen saturation monitoring every half hour.
- 2. Supine positioning on back, if it is comfortable.
- 3. Anesthesia/pain level assessment every 30 minutes.
- 4. Vaginal bleeding, ROM assessment every shift.

**2.** The physician orders intermittent fetal heart rate monitoring for a 20-year-old obese primigravid client at 40 weeks' gestation who is admitted to the birthing center in the first stage of labor. The nurse should monitor the client's fetal heart rate pattern at which of the following intervals?

- 1. Every 15 minutes during the latent phase.
- 2. Every 30 minutes during the active phase.
- 3. Every 60 minutes during the initial phase.
- 4. Every 2 hours during the transition phase.

**3.** Assessment reveals that the fetus of a multigravid client is at + 1 station and 8 cm dilated. Based on these data, the nurse should first:

- 1. Ask anesthesia to increase epidural rate.
- 2. Assist the client to push if she feels the need to do so.
- 3. Encourage the client to breathe through the urge to push.
- 4. Support family members in providing comfort measures.

**4.** Assessment of a primigravid client in active labor who has had no analgesia or anesthesia reveals complete cervical effacement, dilation of 8 cm, and the fetus at 0 station. The nurse should expect the client to exhibit which of the following behaviors during this phase of labor?

- 1. Excitement.
- 2. Loss of control.
- 3. Numbness of the legs.
- 4. Feelings of relief.

**5.** The nurse is explaining to a primigravida in labor that her baby is in a breech presentation, with the baby's presenting part in a left, sacrum, posterior (LSP) position. Which illustration should the nurse use to help the client understand how her baby is positioned?

1.



2.



3.



4.



**6.** While caring for a moderately obese primigravid client in active labor at term, the nurse should monitor the client for signs of which of the following?

- 1. Hypotonic reflexes.
- 2. Increased uterine resting tone.
- 3. Soft tissue dystocia.
- 4. Increased fear and anxiety.

**7.** The nurse is caring for a primigravid client in active labor at 42 weeks' gestation. The client has had no analgesia or anesthesia and has been pushing for 2 hours. The nurse can be **most** helpful to this client by:

- 1. Changing her pushing position every 15 minutes.
- 2. Notifying the health care provider of her current status.
- 3. Continuing with current pushing technique.
- 4. Assessing the client's current pain and fetal status.

**8.** The physician has ordered prostaglandin gel to be administered vaginally to a newly admitted primigravid client. Which of the following indicate that the client has had a therapeutic response to the medication?

- 1. Resting period of 2 minutes between contractions.
- 2. Normal patellar and elbow reflexes for the past 2 hours.
- 3. Softening of the cervix and beginning effacement.
- 4. Leaking of clear amniotic fluid in small amounts.

**9.** A primigravid client is admitted as an outpatient for an external cephalic version. The nurse should assess the client for which of the following contraindications for the procedure?

- 1. Multiple gestation.
- 2. Breech presentation.
- 3. Maternal Rh-negative blood type.
- 4. History of gestational diabetes.

**10.** A primigravida is admitted to the labor area with ruptured membranes and contractions occurring every 2 to 3 minutes, lasting 45 seconds. After 3 hours of labor, the client's contractions are now every 7 to 10 minutes, lasting 30 seconds. The nurse administers oxytocin (Pitocin) as ordered. The expected outcome of this drug is:

- 1. The cervix will begin to dilate 2 centimeters per hour.
- 2. Contractions will occur every 2 to 3 minutes, lasting 40 to 60 seconds, moderate intensity, resting tone between contractions.
- 3. The cervix will change from firm to soft, efface to 40% to 50%, and move from a posterior to anterior position.
- 4. Contractions will be every 2 minutes, lasting 60 to 90 seconds, with intrauterine pressure of 70 mm Hg.

**11.** A primigravid client in the second stage of labor feels the urge to push. The client has had no analgesia or anesthesia. Anatomically, which of the following would be the best position for the client to assume?

- 1. Dorsal recumbent.
- 2. Lithotomy.
- 3. Hands and knees.
- 4. Squatting.

**12.** A 21-year-old primigravid client at 40 weeks' gestation is admitted to the hospital in active labor. The client's cervix is 8 cm and completely effaced at 0 station. During the transition phase of labor, which of the following is a priority nursing diagnosis?

- 1. *Impaired urinary elimination* related to nothing-by-mouth status.
- 2. *Risk for injury* related to hyperventilation and dizziness.
- 3. *Ineffective coping* related to lack of confidence.
- 4. *Pain* related to increasing frequency and intensity of uterine contractions.

**13.** A 24-year-old primigravid client who delivers a viable term neonate is ordered to receive oxytocin intravenously after delivery of the placenta. Which of the following signs would indicate to the nurse that the placenta is about to be delivered?

- 1. The cord lengthens outside the vagina.
- 2. There is decreased vaginal bleeding.
- 3. The uterus cannot be palpated.
- 4. Uterus changes to discoid shape.

**14.** A primiparous client, who has just delivered a healthy term neonate after 12 hours of labor, holds and looks at her neonate and begins to cry. The nurse interprets this behavior as a sign of which of the following?

- 1. Disappointment in the baby's gender.
- 2. Grief over the ending of the pregnancy.
- 3. A normal response to the birth.
- 4. Indication of postpartum "blues."

**15.** The cervix of a 15-year-old primigravid client admitted to the labor area is 2 cm dilated and 50% effaced. Her membranes are intact, and contractions are occurring every 5 to 6 minutes. Which of the following should the nurse recommend at this time?

- 1. Resting in the right lateral recumbent position.
- 2. Lying in the left lateral recumbent position.
- 3. Walking around in the hallway.
- 4. Sitting in a comfortable chair for a period of time.



**16.** Which of the following would the nurse include in the teaching plan for a 16-year-old primigravid client in early labor concerning active relaxation techniques to help her cope with pain?

- 1. Relaxing uninvolved body muscles during uterine contractions.
- 2. Practicing being in a deep, meditative, sleep-like state.
- 3. Focusing on an object in the room during the contractions.
- 4. Breathing rapidly and deeply between contractions.

**17.** The nurse is performing effleurage for a primigravid client in early labor. The nurse should do which of the following?

- 1. Deep kneading of superficial muscles.
- 2. Secure grasping of muscular tissues.
- 3. Light stroking of the skin surface.
- 4. Prolonged pressure on specific sites.

**18.** A 24-year-old primigravid client in active labor requests use of the jet hydrotherapy tub to aid in pain relief. The nurse bases the response on the understanding that this therapy is commonly contraindicated for clients with which of the following?

- 1. Ruptured membranes.
- 2. Multifetal gestation.
- 3. Diabetes mellitus.
- 4. Hypotonic labor patterns.

**19.** A primigravid client admitted to the labor area in early labor tells the nurse that her brother was born with cystic fibrosis and she wonders if her baby will also have the disease. The nurse can tell the client that cystic fibrosis is:

- 1. X-linked recessive and the disease will only occur if the baby is a boy.
- 2. X-linked dominant and there is no likelihood of the baby having cystic fibrosis.
- 3. Autosomal recessive and that unless the baby's father has the gene, the baby will not have the disease.
- 4. Autosomal dominant and there is a 50 per cent chance of the baby having the disease.

**20.** The physician orders an amniocentesis for a primigravid client at 35 weeks' gestation in early labor to determine fetal lung maturity. Which of the following is an indicator of fetal lung maturity?

- 1. Amount of bilirubin present.
- 2. Presence of red blood cells.
- 3. Barr body determination.
- 4. Lecithin-sphingomyelin (L/S ratio).

**21.** Assessment of a 15-year-old primigravid client at term in active labor reveals cervical dilation at 7 cm with complete effacement. The nurse should assess the client for which of the following **first**?

- 1. Uterine inversion.
- 2. Cephalopelvic disproportion (CPD).
- 3. Rapid third stage of labor.
- 4. Decreased ability to push.

**22.** A 19-year-old primigravid client at 38 weeks' gestation is admitted to the hospital in active labor that began 8 hours ago. When the client's cervix is 7 cm dilated and the presenting part is at +1 station, the client tells the nurse, "I need to push!" Which of the following would the nurse do next?

- 1. Use the McDonald procedure to widen the pelvic opening.
- 2. Increase the rate of oxygen and intravenous fluids.
- 3. Instruct the client to use a pant-blow pattern of breathing.
- 4. Tell the client to push only when absolutely necessary.

**23.** Which of the following would be the priority when caring for a primigravid client whose cervix is dilated at 8 cm when the fetus is at 1+ station and the client has had no analgesia or anesthesia?

- 1. Giving frequent sips of water.
- 2. Applying extra blankets for warmth.
- 3. Providing frequent perineal cleansing.
- 4. Offering encouragement and support.

**24.** To determine whether a primigravid client in labor with a fetus in the left occipitoanterior (LOA) position is completely dilated, the nurse performs a vaginal examination. During the examination the nurse should palpate which of the following cranial sutures?

- 1. Sagittal.
- 2. Lambdoidal.
- 3. Coronal.
- 4. Frontal.

**25.** After a lengthy labor process, a primigravid client delivers a healthy newborn boy with a moderate amount of skull molding. Which of the following would the nurse include when explaining to the parents about this condition?

- 1. It is typically seen with breech deliveries.
- 2. It usually lasts a day or two before resolving.
- 3. It is unusual when the brow is the presenting part.
- 4. Surgical intervention may be necessary to alleviate pressure.

**26.** A primiparous client has just delivered her baby. The physician has informed the labor nurse that he believes the uterus has inverted. Which of the following would help to confirm this diagnosis? Select all that apply.

- 1. Hypotension.
- 2. Gush of blood from the vagina.
- 3. Intense, severe, tearing type of abdominal pain.
- 4. Uterus is hard and in a constant state of contraction.
- 5. Inability to palpate the uterus.
- 6. Diaphoresis.

**27.** After delivery of a viable neonate, a 20-year-old primiparous client comments to her mother and the nurse about the baby. Which of the following comments would the nurse interpret as a possible sign of potential maternal-infant bonding problems?

- 1. "He's got my funny-looking ears!"
- 2. "I think my mother should give him the first feeding."
- 3. "He's a lot bigger than I expected him to be."
- 4. "I want to buy him a blue outfit to wear when we get home."

**28.** Assessment of a 23-year-old primigravid client at term who is admitted to the birthing unit in active labor reveals that her cervix is 4 cm dilated and 100% effaced. Contractions are occurring every 4 minutes. The nurse is developing a care plan with the client to relieve pain based on the gate-control theory of pain. The nurse should explain which of the following to the client?

- 1. Input from the large sensory fibers opens the gate.
- 2. Labor pain is a matter of individual perception.
- 3. Slow abdominal breathing can open the gate.
- 4. The gating mechanism is in the spinal cord.

**29.** The nurse explains to a newly admitted primigravid client in active labor that, according to the gate-control theory of pain, a closed gate means that the client should experience which of the following?

- 1. No pain.
- 2. Sharp pain.
- 3. Light pain.
- 4. Moderate pain.

**30.** The cervix of a primigravid client in active labor who received epidural anesthesia 4 hours ago is now completely dilated, and the client is ready to begin pushing. Before the client begins to push, the nurse should assess:

- 1. Fetal heart rate variability.
- 2. Cervical dilation again.
- 3. Status of membranes.
- 4. Bladder status.

**31.** For the past 8 hours, a 20-year-old primigravid client in active labor with intact membranes has been experiencing regular contractions. The fetal heart rate is 136 bpm with good variability. After determining that the client is still in the latent phase of labor, the nurse should observe the client for:

- 1. Exhaustion.
- 2. Chills and fever.
- 3. Fluid overload.
- 4. Meconium-stained fluid.

**32.** A primigravid client whose cervix is 7 cm dilated with the fetus at 0 station and in a left occipitoposterior (LOP) position requests pain relief for severe back pain. The nurse should:

- 1. Provide firm pressure to the client's sacral area.
- 2. Prepare the client for a cesarean delivery.
- 3. Prepare the client for a precipitate delivery.
- 4. Maintain the client in a left side-lying position.

**33.** A primigravid client in active labor has had no anesthesia. The client's cervix is 7 cm dilated, and she is starting to feel considerable discomfort during contractions. The nurse should instruct the client to change from slow chest breathing to which of the following?

- 1. Rapid, shallow chest breathing.
- 2. Deep chest breathing.
- 3. Rapid pant-blow breathing.
- 4. Slow abdominal breathing.

**34.** A 16-year-old primigravid client, with a history of attending one prenatal visit, is admitted to the hospital in active labor at 37 weeks' gestation. Her cervix is 7 cm dilated with the presenting part at 0 station. She enters the labor unit appearing anxious and hyperventilating. Because of the hyperventilation, the nurse should assess the client for:

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

**35.** The physician orders scalp stimulation of the fetal head for a primigravid client in active labor. When explaining to the client about this procedure, which of the following would the nurse include as the purpose?

- 1. Assessment of the fetal hematocrit level.
- 2. Increase in the strength of the contractions.
- 3. Increase in the fetal heart rate and variability.
- 4. Assessment of fetal position.

**36.** The nurse is caring for a primigravid client in active labor who has had two fetal blood samplings to check for fetal hypoxia. The nurse determines that the fetus is showing signs of acidosis when the scalp blood pH is below which of the following?

- 1. 7.5.
- 2. 7.4.
- 3. 7.3.
- 4. 7.2.

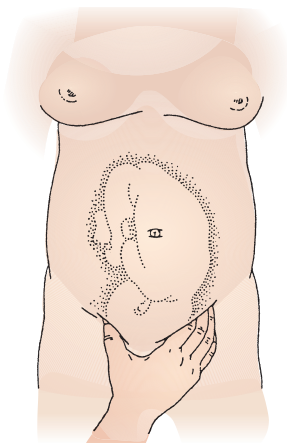
**37.** Assessment of a primigravid client reveals cervical dilation at 8 cm and complete effacement. The client complains of severe back pain during this phase of labor. The nurse explains that the client's severe back pain is most likely caused by the fetal occiput being in a position that is identified as which of the following?

- 1. Breech.
- 2. Transverse.
- 3. Posterior.
- 4. Anterior.

**38.** The nurse assesses a primiparous client in labor for 20 hours. The nurse identifies late decelerations on the monitor and initiates standard procedures for the labor client with this wave pattern. Which interventions should the nurse perform? Select all that apply.

- 1. Administering oxygen via mask to the client.
- 2. Questioning the client about the effectiveness of pain relief.
- 3. Placing the client on her side.
- 4. Readjusting the monitor to a more comfortable position.
- 5. Applying an internal fetal monitor to help identify the cause of the decelerations.

**39.** When performing Leopold's maneuvers on a primigravid client, the nurse is palpating the uterus as shown below. Which of the following maneuvers is the nurse performing?



- 1. First maneuver.
- 2. Second maneuver.
- 3. Third maneuver.
- 4. Fourth maneuver.

**40.** Before placing the fetal monitoring device on a primigravid client's fundus, the nurse performs Leopold's maneuvers. When performing the third maneuver, the nurse explains that this maneuver is done for which of the following reasons?

- 1. To determine whether the fetal presenting part is engaged.
- 2. To locate the fetal cephalic prominence.
- 3. To distinguish between a breech and a cephalic presentation.
- 4. To locate the position of the fetal arms and legs.

**41.** A primigravid client in active labor with a fetus in LOP position complains of severe back pressure. Which of the following would be the priority nursing diagnosis for this client?

- 1. *Anxiety* related to fear of maternal-fetal outcomes.
- 2. *Ineffective coping* related to lack of experience in labor.
- 3. *Urinary retention* related to prolonged labor process.
- 4. *Pain* related to occipitoposterior position and prolonged fetal descent.

**42.** One-half hour after vaginal delivery of a term neonate, the nurse palpates the fundus of a primigravid client, noting several large clots and a small trickle of bright red vaginal bleeding. The client's blood pressure is 136/92 mm Hg. Which of the following would the nurse do **first**?

- 1. Continue to monitor the client's fundus every 15 minutes.
- 2. Ask the physician for an order for methylergonovine (Methergine).
- 3. Immediately notify the physician of the client's symptoms.
- 4. Change the client's perineal pads every 15 minutes.

## The Multigravid Client in Labor

**43.** A multigravida in active labor is 7 cm dilated. The fetal heart rate baseline is 130 bpm with moderate variability. The client begins to have variable decelerations to 100 to 110 bpm. What should the nurse do next?

- 1. Perform a vaginal examination.
- 2. Notify the physician of the decelerations.
- 3. Reposition the client and continue to evaluate the tracing.
- 4. Administer oxygen via mask at 2 L/minute.

**44.** A nurse is preparing a change-of-shift report and has been caring for a multigravid client with a normally progressing labor. Which of the following information should be part of this report? Select all that apply.

- 1. Interpretation of the fetal monitor strip.
- 2. Analgesia or anesthesia being used.
- 3. Anticipated method of birth control.
- 4. Amount of vaginal bleeding or discharge.
- 5. Support persons with the client.
- 6. Prior delivery history.

**45.** A multigravid client is admitted at 4-cm dilation and requesting pain medication. The nurse gives the client Nubain 15 mg and Phenergan 25 mg slow I.V. push. Within 5 minutes, the client tells the nurse she feels like she needs to have a bowel movement. The nurse should **first**:

- 1. Have naloxone hydrochloride (Narcan) available in the delivery room.
- 2. Complete a vaginal examination to determine dilation, effacement, and station.
- 3. Prepare for delivery.
- 4. Document the client's relief due to pain medication.

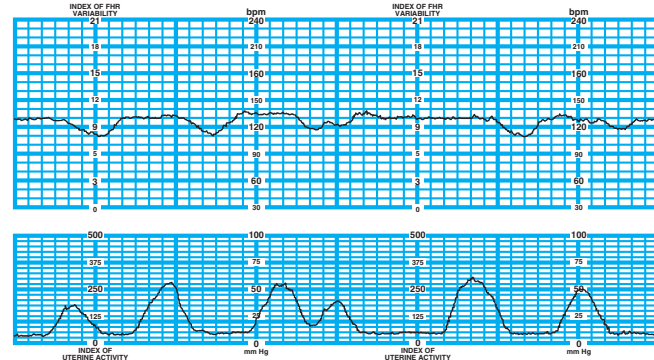
**46.** A multigravid laboring client has an extensive documented history of drug addiction. Her last reported usage was 5 hours ago. She is 2 cm dilated with contractions every 3 minutes of moderate intensity. The physician orders nalbuphine (Nubain) 15 mg slow I.V. push for pain relief followed by an epidural when the client is 4 cm dilated. Within 10 minutes of receiving the nalbuphine, the client states she thinks she is going to have her baby now. Of the following drugs available at the time of the delivery, which should the nurse avoid using with this client in this situation?

- 1. 1% lidocaine (Xylocaine).
- 2. Naloxone hydrochloride (Narcan).
- 3. Local anesthetic.
- 4. Pudendal block.

**47.** A 31-year-old multigravid client at 39 weeks' gestation admitted to the hospital in active labor is receiving intravenous lactated Ringer's solution and a continuous epidural anesthetic. During the first hour after administration of the anesthetic, the nurse should monitor the client for:

- 1. Hypotension.
- 2. Diaphoresis.
- 3. Headache.
- 4. Tremors.

**48.** A 30-year-old G 3, P 2 is being monitored internally. She is being induced with I.V. oxytocin (Pitocin) because she is overdue. The nurse notes the pattern below. The client is wedged to her side while lying in bed and is approximately 6 cm dilated and 100% effaced. The nurse should **first**:



- 1. Continue to observe the fetal monitor.
- 2. Anticipate rupture of the membranes.
- 3. Prepare for fetal oximetry.
- 4. Discontinue the Pitocin infusion.

**49.** The nurse, while shopping in a local department store, hears a multiparous woman say loudly, "I think the baby's coming." After asking someone to call 911, the nurse assists the client to deliver a term neonate. While waiting for the ambulance, the nurse suggests that the mother initiate breast-feeding, primarily for which of the following reasons?

- 1. To begin the parental-infant bonding process.
- 2. To prevent neonatal hypothermia.
- 3. To provide glucose to the neonate.
- 4. To contract the mother's uterus.

**50.** Approximately 15 minutes after delivery of a viable term neonate, a multiparous client complains of a chill. Which of the following should the nurse do next?

- 1. Assess the client's pulse rate.
- 2. Decrease the rate of intravenous fluids.
- 3. Provide the client with a warm blanket.
- 4. Assess the amount of blood loss.

**51.** The physician plans to perform an amniotomy on a multiparous client admitted to the labor area at 41 weeks' gestation for labor induction. After the amniotomy, the nurse should **first**:

- 1. Monitor the client's contraction pattern.
- 2. Assess the fetal heart rate (FHR) for 1 full minute.
- 3. Assess the client's temperature and pulse.
- 4. Document the color of the amniotic fluid.

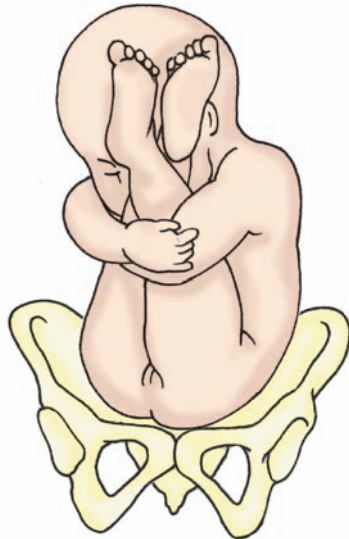
**52.** Which of the following nursing diagnoses is the priority after delivery for a multiparous client who received an epidural anesthetic?

- 1. *Pain* related to episiotomy and exhaustive pushing efforts.
- 2. *Anxiety* related to inability to move legs and toes.
- 3. *Risk for injury* related to epidural anesthesia.
- 4. *Excess fluid volume* overload related to labor process and intravenous fluids.

**53.** Which of the following would the nurse expect as a common finding for a multiparous client delivering a viable neonate at 41 weeks' gestation with the aid of a vacuum extractor?

- 1. Caput succedaneum.
- 2. Cephalohematoma.
- 3. Maternal lacerations.
- 4. Neonatal intracranial hemorrhage.

**54.** The nurse is assessing fetal presentation in a multiparous client. The illustration below indicates which of the following types of presentation?



- 1. Frank breech.
- 2. Complete breech.
- 3. Footling breech.
- 4. Vertex.

**55.** Two hours ago, a multigravid client was admitted in active labor with her cervix dilated at 5 cm and completely effaced and the fetus at 0 station. Currently, the client is experiencing nausea and vomiting, a slight chill with perspiration beads on her lip, and extreme irritability. The nurse should **first**:

- 1. Warm the temperature of the room by a few degrees.
- 2. Increase the rate of intravenous fluid administration.
- 3. Obtain an order for an intramuscular antiemetic medication.
- 4. Assess the client's cervical dilation and station.

**56.** When assessing the frequency of contractions of a multiparous client in active labor admitted to the birthing area, the nurse should assess the interval between which of the following?

- 1. Acme of one contraction to the beginning of the next contraction.
- 2. Beginning of one contraction to the end of the next contraction.
- 3. End of one contraction to the end of the next contraction.
- 4. Beginning of one contraction to the beginning of the next contraction.

**57.** While a client is being admitted to the birthing unit she states, "My water broke last night, but my labor started two hours ago." Which of the following is a concern? Select all that apply.

- 1. Maternal vital signs: T. 99.5, HR 80, R 24, BP 130/80 mm Hg.
- 2. Blood and mucus on perineal pad.
- 3. Baseline fetal heart rate of 140 with a range between 110 and 160 with contractions.
- 4. Peripad stained with green fluid.
- 5. The client states, "This baby wants out—he keeps kicking me."

**58.** While the nurse is caring for a multiparous client in active labor at 36 weeks' gestation, the client tells the nurse, "I think my water just broke." Which of the following should the nurse do **first**?

- 1. Turn the client to the right side.
- 2. Assess the color, amount, and odor of the fluid.
- 3. Assess the fetal heart rate pattern.
- 4. Check the client's cervical dilation.

**59.** The nurse has obtained a urine specimen from a G 6, P 5 client admitted to the labor unit. The woman asks to go to the bathroom and reports that she feels she has to move her bowels. Which actions would be appropriate? Select all that apply.

- 1. Assisting her to the bathroom.
- 2. Applying an external fetal monitor to obtain fetal heart rate.
- 3. Assessing her stage of labor.
- 4. Asking if she had back labor pains like this with any of her other deliveries.
- 5. Allowing her support person to take her to the bathroom to maintain privacy.
- 6. Checking the degree of fetal descent.

**60.** A multigravid client admitted to the labor area is scheduled for a cesarean delivery under spinal anesthesia. After instructions by the anesthesiologist, the nurse determines that the client has understood the instructions when she says which of the following?

- 1. "The medication will be administered while I am in a side-lying position."
- 2. "The anesthetic may cause a severe headache which is treatable."
- 3. "My blood pressure may increase if I lie down too soon after the injection."
- 4. "I can expect immediate anesthesia that can be reversed very easily."

**61.** When developing the plan of care for a multiparous client in active labor who receives an epidural anesthetic, which of the following would the nurse anticipate that the physician will order if the client develops moderate hypotension?

- 1. Ephedrine sulfate.
- 2. Epinephrine (Adrenalin Chloride).
- 3. Methylergonovine (Methergine).
- 4. Atropine sulfate.

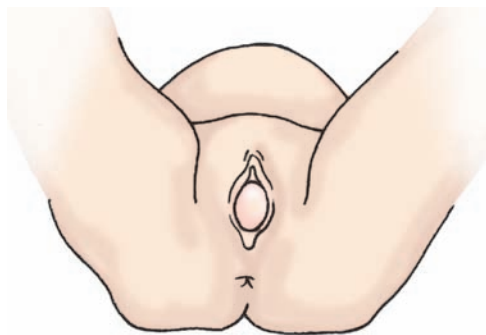
**62.** The physician determines that the fetus of a multiparous client in active labor is in distress, necessitating a cesarean delivery with general anesthesia. Before the cesarean delivery, the anesthesiologist orders cimetidine (Tagamet) 300 mg PO. After administering the drug, the nurse should assess the client for reduction in which of the following?

- 1. Incidence of bronchospasm.
- 2. Oral and respiratory secretions.
- 3. Acid level of the stomach contents.
- 4. Incidence of postoperative gastric ulcer.

**63.** The nurse prepares a client for lumbar epidural anesthesia. Before anesthesia administration, the nurse instructs the client to assume which of the following positions?

- 1. Lithotomy.
- 2. Side-lying.
- 3. Knee-to-chest.
- 4. Prone.

**64.** The nurse is assessing the perineal changes of a multigravid client in the second stage of labor. The illustration below represents which of the following perineal changes?



- 1. Anterior-posterior slit.
- 2. Oval opening.
- 3. Circular shape.
- 4. Crowning.

**65.** After suctioning to clear the airway of a term neonate who appears in good condition after spontaneous vaginal delivery, which of the following would the nurse do next?

- 1. Place the infant in a radiant warmer.
- 2. Instill erythromycin in the eyes.
- 3. Obtain the neonate's weight.
- 4. Put identification bracelets on each wrist.

## The Labor Experience

**66.** A client is admitted at 30 weeks' gestation with contractions every 3 minutes. Her cervix is 1 to 2 cm dilated and 75% effaced. Following a 4-g bolus dose, I.V. magnesium sulfate is infusing at 2 g/hour. How will the nurse know the medication is having the intended effect?

- 1. Contractions will increase in frequency, leading to delivery.
- 2. The client will maintain a respiratory rate greater than 12 breaths per minute.
- 3. Contractions will decrease in frequency, intensity, and duration.
- 4. The client will maintain blood pressure readings of 120/80 mm Hg.

**67.** A client at 33 weeks' gestation is admitted in preterm labor. She is given betamethasone (Celestone) 12 mg I.M. q 24 hours  $\times$  2. What is the expected outcome of this drug therapy?

- 1. The contractions will end within 24 hours.
- 2. The client will deliver a neonate without respiratory distress.
- 3. The client will deliver a full-term neonate.
- 4. The neonate will be delivered with mature lungs.

**68.** A full-term client is admitted for an induction of labor. The health care provider has assigned a Bishop score of 10. Which drug would the nurse anticipate administering to this client?

- 1. Oxytocin (Pitocin) 10 units in 500 mL D<sub>5</sub>W.
- 2. Prostaglandin gel (Prepidil) 0.5 mg.
- 3. Misoprostol (Cytotec) 50 mcg P.O.
- 4. Dinoprostone (Cervidil) 10 mg.

**69.** A full-term client is admitted for induction of labor. When admitted, her cervix is 25/0. The initial goal is cervical ripening prior to labor induction. Which drug will prepare her cervix for induction?

- 1. Nalbuphine (Nubain).
- 2. Oxytocin (Pitocin).
- 3. Dinoprostone (Cervidil).
- 4. Betamethasone (Celestone).

**70.** The nurse is explaining the medication options available for pain relief during labor. The nurse realizes the client needs further teaching when the client states which of the following?

- 1. "Nubain (nalbuphine) and Phenergan (promethazine) will give relief from pain and nausea during early labor."
- 2. "I can have an epidural as soon as I start contracting."
- 3. "If I have a cesarean, I can have an epidural."
- 4. "If I have an emergency cesarean, I may be put to sleep for the delivery."

**71.** The health care provider has performed an amniotomy on a laboring client. Which of the following details must be included in the documentation of this procedure? Select all that apply.

- 1. Time of rupture.
- 2. Color and clarity of fluid.
- 3. Fetal heart rate (FHR) and pattern before and after the procedure.
- 4. Size of amnio-hook used during the procedure.
- 5. Odor and amount of fluid.

**72.** Following an epidural and placement of internal monitors, a client's labor is augmented. Contractions are lasting greater than 90 seconds and occurring every 1½ minutes. The uterine resting tone is greater than 20 mm mercury with a nonreassuring fetal heart rate and pattern. Which of the following actions should the nurse take **first**?

- 1. Notify the health care provider.
- 2. Turn off the oxytocin (Pitocin) infusion.
- 3. Turn the client to her left side.
- 4. Increase the maintenance I.V. fluids.

**73.** A client is induced with oxytocin (Pitocin). The fetal heart rate is showing accelerations lasting 15 seconds and exceeding the baseline with fetal movement. What action associated with this finding should the nurse take?

- 1. Turn the client to her left side.
- 2. Administer oxygen via facemask at 10 to 12 L/minute.
- 3. Notify the health care provider of the situation.
- 4. Document fetal well-being.

**74.** As a nurse begins her shift on the obstetrical unit, there are several new admissions. The client with which of the following conditions would be a candidate for induction?

- 1. Pregnancy-induced hypertension (PIH).
- 2. Active herpes.
- 3. Face presentation.
- 4. Fetus with late decelerations.

**75.** A nurse and an LPN are working in the labor and delivery unit. Of the following assessments and interventions that must be done immediately, which should the nurse assign to the LPN?

- 1. Complete an initial assessment on a client.
- 2. Increase the oxytocin (Pitocin) rate on a laboring client.
- 3. Perform a straight catheterization for protein analysis.
- 4. Assess a laboring client for a change in labor pattern.

**76.** A nurse and a nursing assistant are caring for clients in a labor and delivery unit. Which task should the registered nurse assign to the nursing assistant?

- 1. Perform a fundal check on a 2-day postpartum client.
- 2. Remove a fetal monitor and assist a client to the bathroom.
- 3. Give ibuprofen 800 mg by mouth to a newly delivered client.
- 4. Teach a new mother how to bottle-feed her infant.

**77.** A laboring client smiles pleasantly at the nurse when asked simple questions. The client speaks no English and the interpreter is busy with an emergency situation. At her last vaginal examination, the client was 5 cm dilated, 100% effaced, and at 0 station. While working with this client, which of the following responses indicates that the client may be approaching delivery?

- 1. The fetal monitor strip shows late decelerations.
- 2. The client begins to speak to her family in her native language.
- 3. The fetal monitor strip shows early decelerations.
- 4. The client's facial expressions become animated.

### The Intrapartal Client with Risk Factors

**78.** A client is admitted with a suspected abruption placentae. The nurse should assess the client for which of the following signs and symptoms? Select all that apply.

- 1. Bleeding that is concealed or apparent.
- 2. Abdominal rigidity.
- 3. Painful abdomen.
- 4. Painless bleeding.
- 5. Large placenta.
- 6. Bleeding that stops spontaneously.

**79.** A multigravid client is in active labor with twins at 38 weeks' gestation. The nurse should monitor the client closely for symptoms of which of the following?

- 1. Pregnancy-induced hypertension.
- 2. Urinary tract infection.
- 3. Chorioamnionitis.
- 4. Precipitous delivery.

**80.** A 39-year-old multigravid client at 39 weeks' gestation admitted to the hospital in active labor has been diagnosed with class II heart disease. To ensure cardiac emptying and adequate oxygenation during labor, the nurse plans to encourage the client to do which of the following?

- 1. Breathe slowly after each contraction.
- 2. Avoid the use of analgesics for the labor pain.
- 3. Remain in a side-lying position with the head elevated.
- 4. Request local anesthesia for vaginal delivery.

**81.** When developing the plan of care for a multigravid client with class III heart disease, which of the following areas should the nurse expect to assess frequently?

- 1. Dehydration.
- 2. Nausea and vomiting.
- 3. Iron-deficiency anemia.
- 4. Tachycardia.

**82.** A multigravid client in active labor has been diagnosed with class II heart disease and has had a prosthetic valve replacement. When developing the plan of care for this client, the nurse should anticipate that the physician most likely will order which of the following medications?

- 1. Anticoagulants.
- 2. Antibiotics.
- 3. Diuretics.
- 4. Folic acid supplements.

**83.** A primigravid client at 39 weeks' gestation is admitted to the hospital for induction of labor. The physician has ordered prostaglandin E<sub>2</sub> gel (Dinoprostone) for the client. Before administering prostaglandin E<sub>2</sub> gel to the client, which of the following should the nurse do **first**?

- 1. Assess the frequency of uterine contractions.
- 2. Place the client in a side-lying position.
- 3. Determine whether the membranes have ruptured.
- 4. Prepare the client for an amniotomy.

**84.** A multigravid client at 39 weeks' gestation diagnosed with insulin-dependent diabetes is admitted for induction of labor with oxytocin (Pitocin). Which of the following should the nurse include in the teaching plan as a possible disadvantage of this procedure?

- 1. Urinary frequency.
- 2. Maternal hypoglycemia.
- 3. Preterm birth.
- 4. Neonatal jaundice.

**85.** Which of the following nursing diagnoses would be the priority for a multigravid diabetic client at 38 weeks' gestation who is scheduled for labor induction with oxytocin (Pitocin)?

- 1. *Risk for deficient fluid volume* related to oxytocin infusion.
- 2. *Pain* related to prolonged labor and uterine ischemia.
- 3. *Fear* related to possible need for cesarean delivery.
- 4. *Risk for injury, maternal or fetal*, related to potential uterine hyperstimulation.

**86.** A multigravid client is receiving oxytocin (Pitocin) augmentation. When the client's cervix is dilated to 6 cm, her membranes rupture spontaneously with meconium-stained amniotic fluid. Which of the following actions should the nurse do **first**?

- 1. Increase the rate of the oxytocin infusion.
- 2. Turn the client to a knee-to-chest position.
- 3. Assess cervical dilation and effacement.
- 4. Monitor the fetal heart rate continuously.

**87.** A multigravid client in active labor at 39 weeks' gestation has a history of smoking one to two packs of cigarettes daily. For which of the following should the nurse be alert when assessing the client's neonate?

- 1. Hyperirritability.
- 2. Hyperbilirubinemia.
- 3. Low birth weight.
- 4. Hypocalcemia.

**88.** A primigravid client who has had a prolonged labor but now is completely dilated has received epidural anesthesia. Which of the following should the nurse include in the teaching plan about pushing?

- 1. The client needs to push for at least 1 to 3 minutes.
- 2. Pushing is most effective when the client holds her breath.
- 3. The client should be urged to push with an open glottis.
- 4. Pushing is limited to times when she feels the urge.

**89.** The physician determines that outlet forceps are needed to assist in the delivery of a primigravid client in active labor with a large-for-gestational-size fetus. The nurse reinforces the physician's explanation for using forceps based on the understanding about which of the following concerning the location of the fetal skull?

- 1. It is engaged past the inlet.
- 2. It is at +1 station.
- 3. It is visible at the perineal floor.
- 4. It has reached the level of the ischial spines.



**90.** The physician orders an amnioinfusion for a primigravid client at term who is diagnosed with oligohydramnios. Which of the following should the nurse include in the client's teaching plan about the purpose of this procedure?

- 1. To decrease the frequency and severity of variable decelerations.
- 2. To minimize the possibility of fetal metabolic alkalosis.
- 3. To increase the fetal heart rate accelerations during a contraction.
- 4. To raise the amniotic fluid index to more than 15 cm.

**91.** The nurse is admitting a primigravid client at 37 weeks' gestation who has been diagnosed with pregnancy-induced hypertension to the labor and delivery area. Which of the following client care rooms is **most** appropriate for this client?

- 1. A brightly lit private room at the end of the hall from the nurses' station.
- 2. A semiprivate room midway down the hall from the nurses' station.
- 3. A private room with many windows that is near the operating room.
- 4. A darkened private room as close to the nurses' station as possible.

**92.** A multigravid client is admitted to the labor area from the emergency room. At the time of admission, the fetal head is crowning, and the client yells, "The baby's coming!" To help the client remain calm and cooperative during the imminent delivery, which of the following responses by the nurse is most appropriate?

- 1. "You're right, the baby is coming, so just relax."
- 2. "Please don't push because you'll tear your cervix."
- 3. "Your doctor will be here as soon as possible."
- 4. "I'll explain what's happening to guide you as we go along."

**93.** The nurse is caring for a multigravid client who speaks little English. As the nurse enters the client's room, the nurse observes the client squatting on the bed and the fetal head crowning. After calling for assistance and helping the client lie down, which of the following actions should the nurse do next?

- 1. Tell the client to push between contractions.
- 2. Provide gentle support to the fetal head.
- 3. Apply gentle upward traction on the neonate's anterior shoulder.
- 4. Massage the perineum to stretch the perineal tissues.

**94.** During the first hour after a precipitous delivery, the nurse should monitor a multiparous client for signs and symptoms of which of the following?

- 1. Postpartum "blues."
- 2. Uterine atony.
- 3. Intrauterine infection.
- 4. Urinary tract infection.

**95.** A multigravid client in labor at 38 weeks' gestation has been diagnosed with Rh sensitization and probable fetal hydrops and anemia. When the nurse observes the fetal heart rate pattern on the monitor, which of the following patterns is most likely?

- 1. Early deceleration pattern.
- 2. Sinusoidal pattern.
- 3. Variable deceleration pattern.
- 4. Late deceleration pattern.

**96.** The physician orders oxytocin to be added to the intravenous fluids of a 30-year-old multigravid client at 37 weeks' gestation with twins after vaginal delivery. The nurse should administer the oxytocin after delivery of which of the following?

- 1. First placenta.
- 2. First twin.
- 3. Second placenta.
- 4. Second twin.

**97.** The nurse in the labor and delivery area receives a telephone call from the emergency room announcing that a multigravid client in active labor is being transferred to the labor area. The client has had no prenatal care. When the client arrives by stretcher, she says, "I think the baby's coming ... Help!" The fetal skull is crowning. The nurse should obtain which of the following information **first**?

- 1. Estimated date of delivery.
- 2. Amniotic fluid status.
- 3. Gravida and parity.
- 4. Prenatal history.

**98.** A multiparous client delivers dizygotic twins at 37 weeks' gestation. The twin neonates require additional hospitalization after the client is discharged. In planning the family's care, an appropriate goal for the nurse to formulate is that, while the twins are hospitalized, the parents will do which of the following?

- 1. Discuss how they will cope with twin infants at home.
- 2. Participate in care of the twins as much as possible.
- 3. Take turns providing 24-hour observation of the twins.
- 4. Identify complications that may occur as the twins develop.

**99.** A primigravid client at 41 weeks' gestation is admitted to the hospital's labor and delivery unit in active labor. After 25 hours of labor with membranes ruptured for 24 hours, the client delivers a healthy neonate vaginally with a midline episiotomy. Which of the following nursing diagnoses should the nurse identify as the priority for the client?

- 1. *Activity intolerance* related to difficult labor process.
- 2. *Sleep deprivation* related to prolonged labor.
- 3. *Situational low self-esteem* related to lengthy labor process.
- 4. *Risk for infection* related to birth trauma and prolonged ruptured membranes.

**100.** The nurse is caring for a primiparous client and her neonate immediately after delivery. The neonate was born at 41 weeks' gestation and weighs 4,082 g (9 lb). Assessing for signs and symptoms of which of the following conditions should be a priority in this neonate?

- 1. Anemia.
- 2. Hypoglycemia.
- 3. Delayed meconium.
- 4. Elevated bilirubin.

**101.** A multigravid client in active labor at term is diagnosed with polyhydramnios. The physician has instructed the client about possible neonatal complications related to the polyhydramnios. The nurse determines that the client has understood the instructions when the client states that polyhydramnios is associated with which of the following in the fetus or neonate?

- 1. Renal dysfunction.
- 2. Intrauterine growth retardation.
- 3. Pulmonary hypoplasia.
- 4. Gastrointestinal disorders.

**102.** A primigravid client at 39 weeks' gestation is admitted to the hospital in active labor. On admission, the client's cervix is 6 cm dilated. After 2 hours of active labor, the client's cervix is still dilated at 6 cm with 100% effacement at 21 station. Contractions are 3 to 5 minutes apart, lasting 45 seconds, and of moderate intensity. The nurse determines that the client is most likely experiencing which of the following?

- 1. Cephalopelvic disproportion.
- 2. Prolonged latent phase.
- 3. Prolonged transitional phase.
- 4. Hypotonic contraction pattern.

**103.** The physician who elects to perform a cesarean delivery on a primigravid client for fetal distress has informed the client of possible risks during the procedure. When the nurse asks the client to sign the consent form, the client's husband says, "I'll sign it for her. She's too upset by what is happening to make this decision." The nurse should:

- 1. Ask the client if this is acceptable to her.
- 2. Have the client and her husband both sign the consent form.
- 3. Ask the client to sign the consent form.
- 4. Ask the doctor to witness the consent form.

**104.** A multigravid client at term is admitted to the hospital for a trial labor and possible vaginal birth. She has a history of previous cesarean delivery because of fetal distress. When the client is 4 cm dilated, she receives nalbuphine (Nubain) intravenously. While monitoring the fetal heart rate, the nurse observes minimal variability and a rate of 120 bpm. The nurse should explain to the client that the decreased variability is most likely caused by which of the following?

- 1. Maternal fatigue.
- 2. Fetal malposition.
- 3. Small-for-gestational-age fetus.
- 4. Effects of analgesic medication.

**105.** The nurse is caring for a primipara in active labor when the fetus develops severe bradycardia with late decelerations, and an emergency cesarean delivery is performed with the client under general anesthesia. After the delivery, the client tells the nurse, "I feel terrible. This is exactly what I didn't want to happen!" Which of the following is a priority nursing diagnosis for this client?

- 1. *Interrupted family processes* related to cesarean delivery.
- 2. *Anxiety* related to incisional scar and neonatal outcome.
- 3. *Pain* related to surgical incision and uterine cramping.
- 4. *Situational low self-esteem* related to inability to deliver vaginally.

**106.** During a scheduled cesarean delivery of a primigravid client with a fetus at 39 weeks' gestation in a breech presentation, a neonatologist is present in the operating room. The nurse explains to the client that the neonatologist is present because neonates born by cesarean delivery tend to have an increased incidence of which of the following?

- 1. Congenital anomalies.
- 2. Pulmonary hypertension.
- 3. Meconium aspiration syndrome.
- 4. Respiratory distress syndrome.

**107.** A 28-year-old multigravid client at 28 weeks' gestation diagnosed with acute pyelonephritis is receiving intravenous fluids and antibiotics. After teaching the client about the rationale for the aggressive therapy, the nurse determines that the client needs further instruction when she says that acute pyelonephritis can lead to which of the following?

- 1. Preterm labor.
- 2. Maternal sepsis.
- 3. Intrauterine growth retardation.
- 4. Congenital fetal anomalies.

**108.** A primigravid client at 38 weeks' gestation is admitted to the labor suite in active labor. The client's physical assessment reveals a chlamydial infection. The nurse explains that if the infection is left untreated, the neonate may develop which of the following?

- 1. Conjunctivitis.
- 2. Heart disease.
- 3. Harlequin sign.
- 4. Brain damage.

**109.** A 34-year-old primigravid client at 39 weeks' gestation admitted to the hospital in active labor has type B Rh-negative blood. The nurse should instruct the client that if the neonate is Rh positive, the client will receive an Rh immune globulin (RHIG) injection for which of the following reasons?

- 1. To prevent Rh-positive sensitization with the next pregnancy.
- 2. To provide active antibody protection for this pregnancy.
- 3. To decrease the amount of Rh-negative sensitization for the next pregnancy.
- 4. To destroy fetal Rh-positive cells during the next pregnancy.

**110.** A 16-year-old primigravid client admitted at 38 weeks' gestation with severe pregnancy-induced hypertension is given intravenous magnesium sulfate and lactated Ringer's solution. The nurse should obtain which of the following information?

- 1. Urinary output every 8 hours.
- 2. Deep tendon reflexes every 4 hours.
- 3. Respiratory rate every hour.
- 4. Blood pressure every 6 hours.

**111.** The labor and delivery room nurse has received a telephone call from the emergency room indicating that a multigravid client in early labor and diagnosed with probable placenta previa will be arriving soon. In preparation for the client's arrival, the nurse anticipates that the physician will order which of the following?

- 1. Whole blood replacement.
- 2. Continuous blood pressure monitoring.
- 3. Internal fetal heart rate monitoring.
- 4. An immediate cesarean delivery.

**112.** During admission, a multigravida in early active labor acts somewhat euphoric and tells the nurse that she smoked some crack cocaine before coming to the hospital. In addition to fetal heart rate assessment, the nurse should monitor the client for symptoms of which of the following?

- 1. Placenta previa.
- 2. Ruptured uterus.
- 3. Maternal hypotension.
- 4. Abruptio placentae.

**113.** A primigravid client in early labor tells the nurse that she was exposed to rubella at about 14 weeks' gestation. After delivery, the nurse should assess the neonate for which of the following?

- 1. Hydrocephaly.
- 2. Cardiac disorders.
- 3. Renal disorders.
- 4. Bulging fontanel.

**114.** A primigravid client in early labor with abruptio placentae develops disseminated intravascular coagulation (DIC). Which of the following should the nurse expect the physician to order?

- 1. Magnesium sulfate.
- 2. Warfarin sodium (Coumadin).
- 3. Fresh-frozen platelets.
- 4. Meperidine hydrochloride (Demerol).

**115.** A multigravid client diagnosed with chronic hypertension is now in preterm labor at 34 weeks' gestation. The physician has ordered magnesium sulfate at 3 g/hour. Which assessment finding indicates that the intended therapeutic effect has occurred?

- 1. Decrease in fetal heart rate accelerations.
- 2. Decrease in the frequency and number of contractions.
- 3. Decrease in maternal blood pressure rate.
- 4. Decrease in maternal respiratory rate.

**116.** A primigravid client who was successfully treated for preterm labor at 30 weeks' gestation had a history of mild hyperthyroidism before becoming pregnant. The nurse should instruct the client to do which of the following?

- 1. Continue taking low-dose oral propylthiouracil (PTU) as ordered.
- 2. Discontinue taking the methimazole (Tapazole) until after delivery.
- 3. Consider breast-feeding the neonate after the delivery.
- 4. Contact the physician if bradycardia occurs.

**117.** A primigravid client at 37 weeks' gestation has been hospitalized for several days with severe pregnancy-induced hypertension. While caring for the client, the nurse observes that the client is beginning to have a seizure. Which of the following actions should the nurse do **first**?

- 1. Pad the side rails of the client's bed.
- 2. Turn the client to the right side.
- 3. Insert a padded tongue blade into the client's mouth.
- 4. Call for immediate assistance in the client's room.

**118.** While assessing a primigravid client admitted at 36 weeks' gestation, the nurse observes multiple bruises on the client's face, neck, and abdomen. When asked about the bruises, the client admits that her boyfriend beats her now and then and says, "I want to leave him because I'm afraid he will hurt the baby." Which of the following actions is the nurse's **most** appropriate response?

- 1. Tell the client to leave the boyfriend immediately.
- 2. Ask the client when she last felt the baby move.
- 3. Refer the client to a social worker for possible options.
- 4. Report the incident to the unit nursing supervisor.

**119.** A multigravid client in active labor at term suddenly sits up and says, "I can't breathe! My chest hurts really bad!" The client's skin begins to turn a dusky gray color. After calling for assistance, which of the following should the nurse do next?

- 1. Administer oxygen by face mask.
- 2. Begin cardiopulmonary resuscitation.
- 3. Administer intravenous oxytocin.
- 4. Obtain an order for intravenous fibrinogen.

### Managing Care Quality and Safety

**120.** The nurse is working on a busy labor and delivery unit with other nurses and a licensed practical nurse. Which of the following labor clients would the nurse assign to the licensed practical nurse?

- 1. A G 4, P 3 client with a history of gestational diabetes.
- 2. A G 3, P 1, Ab 1 client at 35 weeks' gestation.
- 3. A G 1, P 0 client with leaking green amniotic fluid.
- 4. A G 2, P 1 client with a history of hyperemesis gravidarum.

**121.** A newly delivered client is asking to go to the bathroom 45 minutes after delivery. She had an epidural for labor & delivery, has an IV infusing, and every 15 minutes assessments are in progress. To provide the safest care for this client the nurse should:

- 1. Ask her to remain in bed until the 15-minute assessments are complete.
- 2. Assess client's ability to stand and bear weight before going to the bathroom.
- 3. Encourage the client to sit at the side of the bed before ambulating to the bathroom.
- 4. Ask the client to ambulate the first time with a staff member at her side.

**122.** The charge nurse is preparing for the day shift on the Labor and Delivery unit. Which of the following would be included in the responsibilities for this position? Select all that apply.

- 1. Review the current status of each labor client with the primary nurse.
- 2. Admit the new labor client sent from the triage area.
- 3. Complete the work of the nurse who had to leave 30 minutes early.
- 4. Follow up with the primary nurse after a delivery.
- 5. Complete report of unit with the oncoming charge nurse.

**123.** The labor and delivery nurse is assigned to triage for the day. There are four clients already in rooms and the following reports have been received about each of these clients. To provide the safest care and best manage time, the nurse should plan to see which client first?

- 1. A primipara in active labor at 5 cm asking to be admitted and wanting an epidural.
- 2. A primipara who is 100% effaced, 8 cm dilated, + 2 station complaining of nausea.
- 3. A client with no prenatal care, occasional contractions, BP 148/90, c/o and swollen feet.
- 4. A client who is at 42 weeks' gestation with bloody show, no contractions, ROM 1 hour ago leaking green fluid.

**124.** The triage nurse is giving a telephone report to the receiving nurse in the labor and delivery unit. The client is a G4 P3 who is 8 cm dilated and is being transferred to the labor and delivery unit. How should the labor and delivery nurse manage the next ten minutes with the client? Select all that apply.

- 1. Place client on the fetal and contraction monitor.
- 2. Call other staff to set up the delivery table.
- 3. Assess comfort needs of client.
- 4. Determine support systems for client.
- 5. Prepare to give an early report to the nurse arriving on the next shift.

**125.** A client has experienced a post partum hemorrhage. The physician verbally ordered 0.2 mg Methergine IM stat at the time of the hemorrhage and this was given by the nurse. The physician put an order into the electronic medical record for 0.2 mg Methergine by mouth stat. When seeing the order, how should the nurse administering the Methergine respond?

- 1. Ask the charge nurse to have a discussion with the physician about the order.
- 2. Initiate an incident report.
- 3. Call the physician; discuss the order, and request revision if heard correctly.
- 4. Wait until the physician returns to the unit and discuss the situation in person.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Primigravid Client in Labor

**1. 3.** The nurse should monitor anesthesia/pain levels every 30 minutes during active labor to ascertain that this client is comfortable during the labor process and particularly during active labor when pain often accelerates for the client. When in active labor, oxygen saturation is not monitored unless there is a specific need, such as heart disease. The client should not be on her back but wedged to the right or left side to take the pressure off the vena cava. When lying on the back, the fetus compresses the major blood vessels. Vaginal bleeding in active labor should be monitored every 30 minutes to 1 hour.

🔑 CN: Reduction of risk potential;  
CL: Create

**2. 2.** Labor is categorized into three phases: latent, active, and transition. During the active stage of labor, intermittent fetal monitoring is performed every 30 minutes to detect changes in fetal heart rate such as bradycardia, tachycardia, or decelerations. If complications develop, more frequent or continuous electronic fetal monitoring may be needed. During the latent phase, intermittent monitoring is usually performed every 2 hours because contractions during this time are usually less frequent. During the transition

phase, intermittent monitoring is performed every 5 to 15 minutes because the client is getting closer to delivery of the baby. There is no initial phase of labor.

🔑 CN: Reduction of risk potential;  
CL: Analyze

**3. 3.** The urge to push is often present when the fetus reaches + stations. This client does not have a cervix that is completely dilated and pushing in this situation may tear the cervix. Encouraging the client to breathe through the urge to push is the most appropriate strategy and allows the cervix to dilate before pushing. Increasing the level of the epidural is inappropriate as nursing would like to have the client be able to push when she is fully dilated. This may occur quickly with a multigravid client. Comfort measures are important for the client at this time, but are not the highest priority for the nurse.

🔑 CN: Management of care; CL: Synthesize

**4. 2.** Assessment findings indicate that the client is in the transition phase of labor. During this phase, it is not unusual for clients to exhibit a loss of control or irritability. Leg tremors, nausea, vomiting, and an urge to bear down also are common. Excitement is associated with the latent phase of labor. Numbness of the legs may occur when epidural anesthesia has been given; however, it is rare when no anesthesia is given. Feelings of relief generally occur during the second stage, when the client begins bearing-down efforts.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**5. 1.** This figure shows the client's baby in a breech presentation with the baby facing the pelvis on the left, the sacrum as the presenting part, and the presenting part (sacrum) is posterior in the pelvis. Figure 2 shows a vertex presentation with the baby in a left, occiput, anterior position (LOA). Figure 3 shows a vertex presentation, left, occiput, posterior (LOP). Figure 4 shows a face position with the baby in a left, mentum, transverse position (LMT).


🔑 CN: Physiological adaptation;  
CL: Synthesize




**6. 3.** The obese pregnant client is more susceptible to soft tissue dystocia, which can impede the progress of labor. Symptoms of soft tissue dystocia would include an arrest of labor, prolonged labor, or an arrest of descent of the fetus. Hypotonic reflexes are associated with magnesium sulfate therapy, and increased uterine resting tone is associated with hypertonic labor patterns in early labor, not with obesity and pregnancy. Increased fear and anxiety are also not associated with obesity. However, they may be associated with a primigravid client who does not know what to expect during labor.

 CN: Reduction of risk potential;  
CL: Analyze

**7. 2.** The normal length of time for pushing is 2 hours. Anything over that time becomes an abnormal situation and the health care provider needs to be notified. Changing the client's position is an appropriate nursing action within the 2-hour time period based on client need and fetal descent. Continuing current pushing supports techniques that have not been successful in delivering this client within the 2-hour time frame. Assessing client pain and fetal status are standards of care for laboring clients, but will not expedite the delivery of a client who has been pushing this long.


 CN: Safety and infection control;  
CL: Synthesize

**8. 3.** Prostaglandin gel may be used for cervical ripening before the induction of labor with oxytocin. It is usually administered by catheter or suppository, or by vaginal insertion. Two to three doses are usually needed to begin the softening process. Common adverse effects include nausea, vomiting, fever, and diarrhea. Continuous fetal heart rate monitoring and close monitoring of maternal vital signs are necessary to detect subtle changes or adverse effects. Prostaglandin gel usually does not initiate contractions; therefore, the rest period between contractions will be greater than 2 minutes. There is no need to assess reflexes based on prostaglandin use. Leaking of amniotic fluid is not caused by the use of this gel.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**9. 1.** External cephalic version is the turning of the fetus from a breech position to the vertex position to prevent the need for a cesarean delivery. Gentle pressure is used to rotate the fetus in a forward direction to a cephalic lie. Contraindications to the procedure include multiple gestation because of the potential for fetal injury or uterine injury, severe oligohydramnios (decreased amniotic fluid), contraindications to a vaginal birth (e.g., cephalopelvic disproportion), and unexplained third trimester bleeding. If the mother has Rh-negative blood type, the procedure can be performed and

Rh immunoglobulin should be administered in case minimal bleeding occurs. A history of gestational diabetes is not a contraindication unless the fetus is large for gestational age and the client has cephalopelvic disproportion.

 CN: Reduction of risk potential;  
CL: Analyze

**10. 2.** The goal of oxytocin (Pitocin) administration in labor augmentation is to establish an adequate contraction pattern to enhance the forces of labor. The expected outcome is a pattern of contractions occurring every 2 to 3 minutes, lasting 40 to 60 seconds, of moderate intensity with a palpable resting tone between contractions. Other contraction patterns will cause the cervix to dilate too quickly or too slowly. Cervical changes in softening, effacement, and moving to an anterior position are associated with use of cervical ripening agents, such as prostaglandin gel. Cervical dilation of 2 centimeters per hour is too rapid for the induction/augmentation process.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**11. 4.** Anatomically, the best position for the client to assume is the squatting position because this enhances pelvic diameters and allows gravity to assist in the expulsion stage of labor. This position also provides for natural pressure anesthesia as the fetal presenting part presses on the stretched perineum. If the client is extremely fatigued from a lengthy labor process, she may prefer the dorsal recumbent position. However, this position is not considered the best position anatomically. The lithotomy position may be ineffective and uncomfortable for a client who is ready to push. The hands and knees position may help to alleviate some back pain. However, this position can cause discomfort to the arms and wrists and is tiring over a long period of time.

 CN: Health promotion and maintenance;  
CL: Apply

**12. 4.** During transition, contractions are increasing in frequency, duration, and intensity. The most appropriate nursing diagnosis is *Pain* related to strength and duration of the contractions. Insufficient information is provided in the scenario to support the other listed nursing diagnoses. *Impaired urinary elimination* would be appropriate if the client had a full bladder and was unable to void. *Risk for injury* might apply if the client were completely out of control or thrashing around in the bed. *Ineffective coping* might apply if the client said, "I can't do this" or something similar.

 CN: Health promotion and maintenance;  
CL: Analyze

**13. 1.** The most reliable sign that the placenta has detached from the uterine wall is lengthening of the cord outside the vagina. Other signs include a sudden gush of (rather than a decrease in) vaginal blood. Usually, when placenta detachment occurs, the uterus becomes more firm and changes in shape from discoid to globular. This process takes about 5 minutes. If the placenta does not separate, manual removal may be necessary to prevent postpartum hemorrhage.

 CN: Health promotion and maintenance;  
CL: Analyze

**14. 3.** Childbirth is a very emotional experience. An expression of happiness with tears is a normal reaction. Cultural factors, exhaustion, and anxieties over the new role can all affect maternal responses, so the nurse must be sensitive to the client's emotional expressions. There is no evidence to suggest that the mother is disappointed in the baby's gender, grieving over the end of the pregnancy, or a candidate for postpartum "blues." However, approximately 80% of postpartum clients experience transient postpartum blues several days after delivery.

 CN: Health promotion and maintenance;  
CL: Analyze

**15. 3.** Most authorities suggest that a woman in an early stage of labor should be allowed to walk if she wishes as long as no complications are present. Birthing centers and single-room maternity units allow women considerable latitude without much supervision at this stage of labor. Gravity and walking can assist the process of labor in some clients. If the client becomes tired, she can rest in bed in the left lateral recumbent position or sit in a comfortable chair. Resting in the left lateral recumbent position improves circulation to the fetus.

 CN: Health promotion and maintenance;  
CL: Synthesize

**16. 1.** Childbirth educators use various techniques and methods to prepare parents for labor and delivery. Active relaxation involves relaxing uninvolved muscle groups while contracting a specific group and using chest breathing techniques to lift the diaphragm off the contracting uterus. A deep, meditative, sleep-like state is a form of passive relaxation. Focusing on an object in the room is part of Lamaze technique for distraction. Breathing rapidly and deeply can lead to hyperventilation and is not recommended.

 CN: Health promotion and maintenance;  
CL: Synthesize

**17. 3.** Light stroking of the skin, or *effleurage*, is commonly used with the Lamaze method of childbirth preparation. Light abdominal massage with just enough pressure to avoid tickling is thought to


displace the pain sensation during a contraction. Deep kneading and secure grasping are typically associated with relaxation massages to relieve stress. Prolonged pressure on specific sites is associated with acupressure.

 CN: Health promotion and maintenance;  
CL: Apply


**18. 1.** Some physicians do not allow clients with ruptured membranes to use a hot tub or jet hydrotherapy tub during labor for fear of infections. The temperature of the water should be between 98° and 100° F (36.7° to 37.8° C) to prevent hyperthermia. Jet hydrotherapy is not contraindicated for clients with multifetal gestation, diabetes mellitus, or hypotonic labor patterns.

 CN: Reduction of risk potential;  
CL: Synthesize

**19. 3.** Cystic fibrosis and other inborn errors of metabolism are inherited as autosomal recessive traits. Such diseases do not occur unless there are two genes for the disease present. If one of the parents does not have the gene, the child will not have the disease. X-linked recessive genes can result in hemophilia A or color blindness. X-linked recessive genes are present only on the X chromosome and are typically manifested in the male child. X-linked dominant genes, which are located on and transmitted only by the female sex chromosome, can result in hypophosphatemia, an inborn error of metabolism marked by abnormally low serum alkaline phosphatase activity and excretion of phosphoethanolamine in the urine. This disorder is manifested as rickets in infants and children. Autosomal dominant gene disorders can result in muscular dystrophy, Marfan's syndrome, and osteogenesis imperfecta (brittle bone disease). Typically, a dominant gene for the disease trait is present along with a corresponding healthy recessive gene.

 CN: Health promotion and maintenance;  
CL: Apply

**20. 4.** To determine fetal lung maturity, the sample of amniotic fluid will be tested for the L/S ratio. When fetal lungs are mature, the ratio should be 2:1. Bilirubin indicates hemolysis and, if present in the fluid, suggests Rh disease. Red blood cells should not appear in the amniotic fluid because their presence suggests fetal bleeding. Barr body determination is a chromosome analysis of the sex chromosomes that is sometimes used when a child is born with ambiguous genitalia.

 CN: Health promotion and maintenance;  
CL: Analyze

**21. 2.** Adolescent pregnancy carries an increased risk of pregnancy-induced hypertension, iron-deficiency anemia, and CPD. CPD is a concern because maturation of the skeletal bones (including the

pelvis) is commonly not complete in adolescents. Adolescent labor does not differ from labor in the older woman if no CPD is present. A prolonged first stage of labor and poor fetal descent may indicate that CPD exists. Uterine inversion, a rapid third stage of labor, or decreased ability to push may occur regardless of the client's age.

 CN: Reduction of risk potential;  
CL: Analyze

**22. 3.** Pushing during the first stage of labor, when the urge is felt but the cervix is not completely dilated, may produce cervical swelling, making labor more difficult. The client should be encouraged to use a pant-blow (or blow-blow) pattern of breathing to help overcome the urge to push. The McDonald procedure is used for cervical cerclage for an incompetent cervix and is inappropriate here. Increasing the rate of oxygen and intravenous fluids will not alleviate the pressure that the client is feeling. The client should not push even if she feels the urge to do so because this may result in cervical edema at 7 cm dilation.

 CN: Health promotion and maintenance;  
CL: Synthesize

**23. 4.** The client is in the transition phase of the first stage of labor. During this phase, the client needs encouragement and support because this is a difficult and painful time, when contractions are especially strong. Usually, the client finds it difficult to maintain self control. Everything else seems secondary to her as she progresses into the second stage of labor and delivery. Although ice chips may be given, typically the client does not desire sips of water. Labor is hard work. Generally, the client is perspiring and does not desire additional warmth. Frequent perineal cleansing is not necessary unless there is excessive amniotic fluid leaking.

 CN: Health promotion and maintenance;  
CL: Synthesize

**24. 1.** The sagittal suture is the most readily felt during a vaginal examination. When the fetus is in the LOA position, the occiput faces the mother's left. The lambdoid suture is on the side of the skull. The coronal suture is a horizontal suture across the front portion of the fetal skull that forms the anterior fontanel. It may be felt with a brow presentation. The frontal suture may be felt with a brow or face presentation.

 CN: Health promotion and maintenance;  
CL: Apply

**25. 2.** Molding occurs with vaginal deliveries and is commonly seen in newborns. This is especially true with primigravid clients experiencing a lengthy labor process. Parents need to be reassured that it is not permanent and that it typically lasts

a day or two before resolving. Molding rarely is present if the fetus is in a breech or brow presentation. Surgical intervention is not necessary.

 CN: Health promotion and maintenance;  
CL: Create

**26. 1, 2, 5, 6.** Uterine inversion is indicated by a sudden gush of blood from the vagina leading to decreased blood pressure, and an inability to palpate the uterus since it may be in or protruding from the vagina and any signs of blood loss such as diaphoresis, paleness, or dizziness could be observed at this time. Intense pain and a hard contracting uterus are not associated with uterine inversion.

 CN: Reduction of risk potential;  
CL: Analyze

**27. 2.** Avoidance, hostility, or low-key (passive) behavior toward the baby may be a cue to potential bonding problems. The nurse should encourage the client to give the baby the first feeding to begin the bonding process. Expressions of disappointment with the baby's gender may also signal problems with maternal-infant bonding. Comparing the baby's features to her own indicates identification of the neonate as belonging to her, suggesting bonding with neonate. Comparing the actual neonate with the "fantasized neonate" is a normal maternal reaction. Wanting to buy a blue outfit indicates an interest in and connection with the neonate and is a sign of bonding.

 CN: Reduction of risk potential;  
CL: Analyze

**28. 4.** According to the gate-control theory of pain perception, when the endings of small peripheral nerve fibers detect a stimulus, they transmit it to cells in the dorsal horn of the spinal cord. These impulses pass through a network of cells in the spinal cord called the substantia gelatinosa, and a synapse occurs that returns the transmission to the peripheral site through a motor nerve. The impulse is then transmitted through the spinal cord to the brain, where the impulse is perceived as pain. Gate-control mechanisms in the spinal cord are capable of halting these impulses (closing the gate), so that pain is not perceived. Input from the large sensory fibers closes the gate. Telling the client that labor pain is a matter of individual perception is not helpful and does not explain the gate-control theory. Deep chest breathing or other breathing techniques can help to keep the "gate" closed, not open.

 CN: Health promotion and maintenance;  
CL: Apply

**29. 1.** According to the gate-control theory of pain, a closed gate means that the client should feel no pain. The gate-control theory of pain refers to the gate-control mechanisms in the substantia gelatinosa




that are capable of halting an impulse at the level of the spinal cord so the impulse is never perceived at the brain level as pain (i.e., a process similar to keeping a gate closed).

 CN: Health promotion and maintenance;  
CL: Evaluate

**30. 4.** The bladder status should be monitored throughout the labor process, but especially before the client begins pushing. A full bladder can impede the progress of labor and slow fetal descent. Because she has had an epidural anesthetic, it is most likely that the client is receiving intravenous fluids, contributing to a full bladder. The client also does not feel the urge to void because of the anesthetic. Although it is important to monitor membrane status and fetal heart rate variability throughout labor, this does not affect the client's ability to push. There is no need to recheck cervical dilation because increasing the frequency of examinations can increase the client's risk for infection.

 CN: Reduction of risk potential;  
CL: Analyze

**31. 1.** The normal length of the latent stage of labor in a primigravid client is 6 hours. If the client is having prolonged labor, the nurse should monitor the client for signs of exhaustion as well as dehydration. Hypotonic contractions, which are painful but ineffective, may be occurring. Oxytocin augmentation may be necessary. Chills and fever are manifestations of an infection and are not associated with a prolonged latent phase of labor. Fluid overload can occur from rapid infusion of intravenous fluids administered if the client is experiencing hemorrhage or shock. It is not associated with prolonged latent phase. The client's membranes are intact, so it would be difficult to assess meconium staining of the fluid. Meconium-stained fluid is associated with fetal distress, and this fetus appears to be in a healthy state, as evidenced by a fetal heart rate within normal range and good variability.


 CN: Reduction of risk potential;  
CL: Analyze

**32. 1.** The client who has back pain during labor experiences marked discomfort because the fetus is in an LOP position. This pain is much greater than when the fetus is in the anterior position because the fetal head impinges on the sacrum in the course of rotating to the anterior position. Application of firm pressure to the sacral area can help alleviate the pain. Complaints of severe back pain during labor do not typically require a cesarean delivery. The physician may elect to do an episiotomy, but it is not necessarily required. It is unlikely that a primigravid client with a fetus in an LOP position will have a precipitous delivery; rather, labor is usually more prolonged. A hands-and-knees position or a


right side-lying position may help to rotate the fetal head and thus alleviate some of the back pain.

 CN: Health promotion and maintenance;  
CL: Synthesize


**33. 1.** The psychoprophylaxis method of childbirth suggests using slow chest breathing until it becomes ineffective during labor contractions, then switching to shallow chest breathing (mostly at the sternum) during the peak of a contraction. The rate is 50 to 70 breaths per minute. Deep chest breathing is appropriate for the early phase of labor, in which the client exhibits less frequent contractions. When transition nears, a rapid pant-blow pattern of breathing is used. Slow abdominal breathing is very difficult for clients in labor.

 CN: Health promotion and maintenance;  
CL: Apply


**34. 3.** The carbon dioxide insufficiency that occurs during hyperventilation will lead to respiratory alkalosis. Symptoms include confusion, unconsciousness, elevated plasma pH (greater than 7.45), and elevated urine pH (above 7). The nurse should try to calm the client and, if the hyperventilation persists, should ask the client to breathe into a paper bag. Metabolic alkalosis is associated with vomiting when a large amount of hydrochloric acid is lost. Metabolic acidosis is associated with loss of sodium ions through diarrhea. Respiratory acidosis is associated with shallow breathing and an inability to expire completely.

 CN: Reduction of risk potential;  
CL: Analyze

**35. 3.** Fetal scalp stimulation is commonly ordered when there is decreased fetal heart rate variability. Pressure is applied with the fingers to the fetal scalp through the dilated cervix. This should cause a tactile response in the fetus and increase the fetal heart rate and variability. However, if the fetus is in distress and becoming acidotic, fetal heart rate acceleration will not occur. The fetal hematocrit level can be measured by fetal blood sampling. Scalp stimulation does not increase the strength of the contractions. However, it can increase fetal heart rate and variability. Fetal position is assessed by identifying skull landmarks (sutures) during a vaginal examination.

 CN: Reduction of risk potential;  
CL: Apply

**36. 4.** If the fetus is hypoxic, the pH will fall below 7.2 and be indicative of fetal distress. This finding typically requires immediate vaginal or cesarean delivery. A scalp pH reading of 7.21 to 7.25 should be repeated again in 30 minutes for assessment of hypoxia and acidosis.

 CN: Physiological adaptation;  
CL: Analyze

**37. 3.** When a client complains of severe back pain during labor, the fetus is most likely in an occipitoposterior position. This means that the fetal head presses against the client's sacrum, causing marked discomfort during contractions. These sensations may be so intense that the client requests medication for relief of the back pain rather than the contractions. Breech presentation and transverse lie are usually known prior to 8-cm dilation and a cesarean section is performed. Fetal occiput anterior position does not increase the pain felt during labor.

 CN: Health promotion and maintenance;  
CL: Apply


**38. 1, 3, 5.** Decelerations alert the nurse that the fetus is experiencing decreased blood flow from the placenta. Administering oxygen will increase tissue perfusion. Placing the mother on her side will increase placental perfusion and decrease cord compression. Using an internal fetal monitor would help in identifying the possible underlying cause of the decelerations, such as metabolic acidosis. Assessing for pain relief and readjusting the monitor would have no effect on correcting the late decelerations.

 CN: Reduction of risk potential;  
CL: Synthesize

**39. 3.** The third maneuver involves grasping the lower portion of the abdomen just above the symphysis pubis between the thumb and index finger. This maneuver determines whether the fetal presenting part is engaged. The first maneuver involves facing the woman's head and using the tips of the fingers to palpate the uterine fundus. This maneuver is used to identify the part of the fetus that lies over the inlet to the pelvis. The second maneuver involves placing the palms of each hand on either side of the abdomen to locate the back of the fetus. The fourth maneuver involves placing fingers on both sides of the uterus and pressing downward and inward in the direction of the birth canal. This maneuver is done to determine fetal attitude and degree of extension and should only be done if the fetus is in the cephalic presentation.

 CN: Physiological adaptation; CL: Apply


**40. 1.** Leopold's maneuvers are performed to determine the presentation and position of the fetus. The third maneuver determines whether the fetal presenting part is engaged in the maternal pelvis. The first maneuver distinguishes between a breech and a cephalic presentation through palpation of the top of the fundus. The second maneuver locates the fetal back, arms, and legs. The fetal heart rate monitoring device should be placed near the fetal skull and back for optimal fetal heart rate monitoring. The fourth maneuver is done to locate the fetal cephalic prominence if the fetus is in a cephalic position.

 CN: Health promotion and maintenance;  
CL: Apply

**41. 4.** The priority nursing diagnosis at this time is *Pain* related to LOP position and prolonged fetal descent. When the fetus is in this position, the fetal head presses against the client's sacrum, causing marked discomfort during contractions. Labor is usually longer and more uncomfortable when the fetus remains in an occipitoposterior position. *Anxiety* would be an appropriate nursing diagnosis if the client had stated that she was nervous, apprehensive, afraid, fearful, or restless. *Ineffective coping* would be appropriate if the client exhibited a loss of control, screaming, crying, or thrashing around in the bed. *Urinary retention* might be a related nursing diagnosis; however, if the nurse is vigilant in assessment of the client's bladder status, the client should void at least every 2 hours or have a catheterization performed. A full bladder can impair fetal descent and prolong labor.


 CN: Health promotion and maintenance;  
CL: Analyze

**42. 3.** Small clots that are expressed during fundal examination in the immediate postpartum period are normal; however, large clots are indicative of retained placental tissue. A small trickle of bright red vaginal bleeding may indicate a laceration. The nurse should notify the physician immediately of these findings, because uterine atony may occur and the laceration, if present, needs to be repaired to prevent further blood loss. Continuing to monitor the client every 15 minutes is the standard of care for a postpartum client. Taking no action would indicate that the nurse thinks passage of clots and trickling of bright red blood is a normal situation, which it is not. Methylergonovine is a powerful drug that contracts the uterus, but it usually is not administered to a client with a blood pressure of 136/92 mm Hg because of its hypertensive effects. Changing the perineal pads every 15 minutes is not helpful if the client is experiencing a hemorrhage.

 CN: Health promotion and maintenance;  
CL: Synthesize

## The Multigravid Client in Labor

**43. 3.** The cause of variable decelerations is cord compression, which may be relieved by moving the client to one side or another. If the client is already on the left side, changing the client to the right side is appropriate. Performing a vaginal examination will let the nurse know how far dilated the client is but will not relieve the cord compression. If the decelerations are not relieved by position changes, oxygen should be initiated but the rate should be 8 to 10 L/minute. Notifying the physician should occur if turning the client and administering oxygen do not relieve the decelerations.

 CN: Management of care; CL: Synthesize

**44. 1, 2, 4, 5, 6.** Knowledge of how the fetus is tolerating contractions as well as the frequency, intensity, and duration of contractions, as indicated on the fetal monitor strip, are extremely important. The type of analgesia or anesthesia being used, the client's response, and her pain rating should be included as well. The amount of vaginal bleeding indicates whether this labor is in the normal range. Vaginal discharge indicates if membranes are ruptured and the color, odor, and amount of amniotic fluid. The support persons with the client are an integral part of the labor process and greatly influence how she manages labor emotionally and, commonly, physically. A complete change-of-shift report would include the client's name, age, gravida and parity, current and prior illnesses that may influence this hospitalization, prior labor and delivery history if applicable, last vaginal examination time and findings, vaginal bleeding, support persons with client, current I.V.s and other medications being used, and pertinent laboratory test results. Future plan for birth control would be the least important information to be given to the next shift because it will not impact the labor care plan.


 CN: Physiological adaptation; CL: Create

**45. 2.** The feeling of needing to have a bowel movement is commonly caused by pressure on the receptors low in the perineum when the fetal head is creating pressure on them. This feeling usually indicates advances in fetal station and that the client may be close to delivery. The nurse should respond initially to the client's signs and symptoms by checking to validate current effacement, dilation, and station. If the fetus is ready to be delivered, having the room ready for the delivery and having naloxone hydrochloride (Narcan) available are important. Narcan completely or partially reverses the effects of natural and synthetic opioids, including respiratory depression. Documenting pain relief takes time away from the vaginal examination, preparing for delivery, and obtaining Narcan. The delivery may be occurring rapidly. Being prepared for the delivery is a higher priority than documentation for this client.


 CN: Safety and infection control;  
CL: Synthesize

**46. 2.** Naloxone hydrochloride (Narcan) would not be used in a client who has a history of drug addiction. Narcan would abruptly withdraw this woman from the drug she is addicted to as well as the Nubain. The withdrawal would occur within a few minutes of injection and, if severe enough, could jeopardize the mother and fetus. Xylocaine is a local anesthetic and numbs, rather than decreases the effects of Narcan. The local anesthetic and the pudendal block are both appropriate for


this delivery but are used to numb the maternal perineum for delivery.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**47. 1.** When a client receives an epidural anesthetic, sympathetic nerves are blocked along with the pain nerves, possibly resulting in vasodilation and hypotension. Other adverse effects include bladder distention, prolonged second stage of labor, nausea and vomiting, pruritus, and delayed respiratory depression for up to 24 hours after administration. Diaphoresis and tremors are not usually associated with the administration of epidural anesthesia. Headache, a common adverse effect of many drugs, also is not associated with administration of epidural anesthesia.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**48. 4.** The fetal monitor strip shows late decelerations. The first intervention would be to turn off the Pitocin because the medication is causing the contractions. The stress caused by the contractions demonstrates that the fetus is not being perfused during the entire contraction (as shown by the late decelerations). There is no time to continue to observe in this situation; intervention is a priority. The client is attached to an internal fetal monitor, which would be possible only if her membranes had already ruptured. If the fetus continues to experience stress, fetal oximetry may be initiated.

 CN: Physiological adaptation;  
CL: Analyze

**49. 4.** After an emergency delivery, the nurse suggests that the mother begin breast-feeding to contract the uterus. Breast-feeding stimulates the natural production of oxytocin. In a multiparous client, uterine atony is a potential complication because of the stretching of the uterine fibers following each subsequent pregnancy. Although breast-feeding does help to begin the parental-infant bonding process, this is not the primary reason for the nurse to suggest breast-feeding. Prevention of neonatal hypothermia is accomplished by placing blankets on both the neonate and the mother. Although colostrum in breast milk provides the neonate with nutrients and immunoglobulins, the primary reason for breast-feeding is to stimulate the natural production of oxytocin to contract the uterus.

 CN: Reduction of risk potential;  
CL: Apply

**50. 3.** A chill shortly after delivery is a common, normal occurrence. Warm blankets can help provide comfort for the client. It has been suggested that the shivering response is caused by a difference between internal and external body temperatures.


A different theory proposes that the woman is reacting to fetal cells that have entered the maternal bloodstream through the placental site. Assessing the client's pulse rate will provide no further information about the chill. Decreasing the I.V. rate will not influence the length of time the client trembles. Assessing blood loss is a standard of care at this point postpartum but has no correlation to the chill.

 CN: Health promotion and maintenance;  
CL: Synthesize

**51. 2.** After an amniotomy, the nurse should plan to first assess the FHR for 1 full minute. One of the complications of amniotomy is cord compression and/or prolapsed cord, and a FHR of 100 bpm or less should be promptly reported to the physician. A cord prolapse requires prompt delivery by cesarean section. The client's contraction pattern should be monitored once labor has been established. The client's temperature, pulse, and respirations should be assessed every 2 to 4 hours after rupture of the membranes to detect an infection. The nurse should document the color, quantity, and odor of the amniotic fluid, but this can be done after the FHR is assessed and a reassuring pattern is present.

 CN: Health promotion and maintenance;  
CL: Synthesize

**52. 3.** The most appropriate diagnosis at this time is *Risk for injury* related to the effects of the epidural anesthesia because the client may have no sensation in her lower abdomen and legs for several hours postpartum. Care should be taken to avoid injury, and ambulation should be delayed until sensation has returned. No information is presented in the scenario to suggest *Pain* due to episiotomy and exhaustive pushing. Multiparous clients commonly have shortened labors and may not require an episiotomy. If the client did have an episiotomy and the epidural anesthetic has worn off, then this nursing diagnosis would be appropriate. *Anxiety* would apply if the client expressed feelings of anxiety or nervousness because of a problem with moving her legs or toes. *Excess fluid volume* would apply if the client received excessive amounts of intravenous fluid or complained of oliguria, an early sign of pulmonary edema.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**53. 1.** Caput succedaneum is common after the use of a vacuum extractor to assist the client's expulsion efforts. This edema may persist up to 7 days. Vacuum extraction is not associated with cephalohematoma. Maternal lacerations may occur, but they are more common when forceps are used. Neonatal intracranial hemorrhage is a risk with both vacuum

extraction and forceps deliveries, but it is not a common finding.

 CN: Health promotion and maintenance;  
CL: Analyze

**54. 1.** Breech presentations account for 5% of all births and the most common is frank breech. In frank breech, there is flexion of the fetal thighs and extension of the knees. The feet rest at the side of the fetal head. In complete breech, there is flexion of the fetal thighs and knees; the fetus appears to be squatting. Footling breech occurs when there is an extension of the fetal knees and one or both feet protrude through the cervix. Vertex presentation occurs in 95% of deliveries with the head is engaged in the pelvis.

 CN: Physiological adaptation; CL: Apply

**55. 4.** The nurse should assess the client's cervical dilation and station, because the client's symptoms are indicative of the transition phase of labor. Multiparous clients can proceed 5 to 9 cm per hour during the active phase of labor. Warming the temperature of the room is not helpful because the client will soon be ready to begin expulsive pushing. Increasing the intravenous fluid rate is not warranted unless the client is experiencing dehydration. Administration of an antiemetic at this point in labor is not warranted and may result in neonatal depression should a rapid delivery occur.

 CN: Health promotion and maintenance;  
CL: Synthesize

**56. 4.** To assess the frequency of the client's contractions, the nurse should assess the interval from the beginning of one contraction to the beginning of the next contraction. The duration of a contraction is the interval between the beginning and the end of a contraction. The acme identifies the peak of a contraction.

 CN: Health promotion and maintenance;  
CL: Analyze

**57. 3, 4, 5.** The range of fetal heart rate fluctuating too high and low could indicate fetal distress. The green peripad fluid indicates meconium, which could be associated with fetal distress. Increased fetal activity during labor may also indicate distress. The maternal vital signs noted and a perineal pad with blood and mucus are normal findings.


 CN: Reduction of risk potential;  
CL: Analyze

**58. 3.** After spontaneous rupture of the amniotic fluid, the gushing fluid may carry the umbilical cord out of the birth canal. Sudden deceleration of the fetal heart rate commonly signifies cord compression and/or prolapse of the cord, which would require immediate delivery. This client is


particularly at risk because the fetus is preterm and the fetal head may not be engaged. Turning the client to the right side is not a priority action. However, changing the client's position would be appropriate if variable decelerations are present. The nurse should assess the color, amount, and odor of the fluid, but this can be done once the fetal heart rate is assessed and no problems are detected. Cervical dilation should be checked but only after the fetal heart rate pattern is assessed.

 CN: Reduction of risk potential;  
CL: Synthesize

**59. 3, 6.** The pressure from the fetus descending into the birth canal can cause the client to feel she needs to move her bowels and could be near delivery. Failure to assess the stage of labor and degree of fetal descent before allowing the client to go to the bathroom may lead to progression of labor and could result in a delivery in the bathroom. Applying a fetal monitor may reassure the nurse that the fetus is doing well; however, it does not help to determine if the fetus is ready for delivery, which is the higher priority in this situation. Regardless of the client's prior experience with back labor pain, the fetal head moving lower into the birth canal causes pressure in the lower back area similar to the feeling of pressure with a bowel movement.


 CN: Safety and infection control;  
CL: Synthesize

**60. 2.** Spinal anesthesia is used less commonly today because of preference for epidural block anesthesia. One of the adverse effects of spinal anesthesia is a "spinal headache" caused by leakage of spinal fluid from the needle insertion. This can be treated by applying a cool cloth to the forehead, keeping the client in a flat position, or using a blood patch that can clot and seal off any further leakage of fluid. Spinal anesthesia is administered with the client in a sitting position. Another adverse effect of spinal anesthesia is hypotension caused by vasodilation. General anesthesia provides immediate anesthesia, whereas the full effects of spinal anesthesia may not be felt for 20 to 30 minutes. General anesthesia can be discontinued quickly when the anesthesiologist administers oxygen instead of nitrous oxide. Epidural anesthesia may take 1 to 2 hours to wear off.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**61. 1.** The drug of choice when hypotension occurs as a result of epidural anesthesia is ephedrine sulfate because it provides a quick reversal of the vasodilator effects of the anesthesia. Epinephrine is typically used to treat anaphylactic shock. Methylergonovine is a vasoconstrictor that is used for severe postpartum hemorrhage. Atropine sulfate


is used to dry the oral and respiratory secretions and may be used during operative procedures.

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 3.** Cimetidine (Tagamet) is ordered by some anesthesiologists who will be giving a general anesthetic to reduce the level of acid in the stomach contents, altering the pH to reduce the risk of complications should aspiration of vomitus occur. Aspiration of vomitus is the fifth most common cause of maternal mortality. Most anesthesiologists insert an endotracheal tube to reduce the incidence of aspiration. Isoproterenol (Isuprel) is used to decrease the incidence of bronchospasm. Atropine sulfate is administered to dry oral and nasal secretions. Although cimetidine is useful for gastric ulcer therapy, gastric ulcers are not a common effect associated with operative deliveries.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**63. 2.** Lumbar epidural anesthesia is usually administered with the client in a sitting or a left side-lying position with shoulders parallel and legs slightly flexed. These positions expose the vertebrae to the anesthesiologist. Paracervical and local anesthetics are usually administered with the client in the lithotomy position. The knee-to-chest and prone positions are not used for anesthesia administration.

 CN: Pharmacological and parenteral therapies; CL: Apply

**64. 2.** Anterior-posterior slit occurs as the perineum flattens and is followed by an oval opening. As labor progresses, the perineum takes on a circular shape. Crowning occurs when the fetal head is visible.

 CN: Physiological adaptation; CL: Apply


**65. 1.** A neonate in good condition needs to be kept warm. This reduces cold stress and potential respiratory problems. Cold stress causes the neonate to burn much-needed brown fat. The infant can be evaluated under a radiant warmer or wrapped in dry, warm blankets on the mother's abdomen. Instilling erythromycin ointment, weighing the neonate, and applying identification bracelets can be done once the neonate has been placed under a radiant warmer and the temperature has stabilized.

 CN: Health promotion and maintenance;  
CL: Synthesize


## The Labor Experience

**66. 3.** The expected outcome of magnesium sulfate administration is suppression of the contrac-


tions because the client is in preterm labor. Magnesium sulfate is a smooth muscle relaxant used to slow and stop contractions. Having contractions that lead to delivery is not the intended effect of this drug when used for preterm labor. Respirations lower than 12 breaths/minute may indicate magnesium sulfate toxicity. Another use of magnesium sulfate is to treat preeclampsia by preventing seizures and, secondarily, lowering maternal blood pressure. However, in this scenario, preterm labor—not preeclampsia—is being treated.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**67. 4.** Betamethasone is a corticosteroid that induces the production of surfactant. The pulmonary maturation that results causes the fetal lungs to mature more rapidly than normal. Because the lungs are mature, the risk of respiratory distress in the neonate is lowered but not eliminated. Betamethasone also decreases the surface tension within the alveoli. Betamethasone has no influence on contractions or carrying the fetus to full term.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**68. 1.** A Bishop score evaluates cervical readiness for labor based on five factors: cervical softness, cervical effacement, dilation, fetal position, and station. A Bishop score of 5 or greater in a multipara or a score of 8 or greater in a primipara indicate that a vaginal birth is likely to result from the induction process. The nurse should expect that labor will be induced using Pitocin because the Bishop score indicates that the client is 60% to 70% effaced, 3 to 4 cm dilated, and in an anterior position. The cervix is soft and the presenting part is at a -1 to 0 position. Prepidil, Cytotec, and Cervidil are all cervical ripening agents and the doses are accurate; however, cervical ripening has already taken place.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**69. 3.** Cervical ripening, or creating a cervix that is soft, anterior, and dilated to 2 to 3 cm, must occur before the cervix can efface and dilate with oxytocin (Pitocin). Drugs to accomplish this goal include dinoprostone (Cervidil), misoprostol (Cytotec), and prostaglandin E2 (PGE2). Nubain is a narcotic analgesic used in early labor and has no influence on the cervix. Betamethasone (Celestone) is a corticosteroid given to mature fetal lungs.

 CN: Pharmacological and parenteral therapies; CL: Apply

**70. 2.** Typically, a client will be able to have an epidural when she is 3 to 4 cm dilated or the active phase of labor has been established. Waiting until the cervix is dilated to this point ensures that the

client is in labor and the epidural is less likely to halt labor contractions. Nubain and Phenergan are used to provide relief until the client is about 7 cm dilated. If given after this time, narcotics may cause neonatal respiratory depression in the neonate. The majority of clients have an epidural or spinal for a cesarean section. The only time general anesthesia is used is for an emergency cesarean section.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**71. 1, 2, 3, 5.** The time of rupture; color, odor, amount, and clarity of amniotic fluid; and FHR and pattern before and after the procedure are all information that must be documented on the client's record. There is only one size for an amnio-hook.

 CN: Management of care; CL: Create

**72. 2.** The client is experiencing uterine hyperstimulation from the oxytocin (Pitocin). The first intervention should be to stop the oxytocin infusion, which may be the cause of the long, frequent contractions, elevated resting tone, and nonreassuring fetal heart patterns. Only after turning off the oxytocin, should the nurse turn the client to her left side to better perfuse the mother and fetus. Then she should increase the maintenance I.V. fluids to allow available oxygen to be carried to the mother and fetus. When all other interventions are initiated, she should notify the health care provider.

 CN: Management of care; CL: Synthesize

**73. 4.** Accelerations that are episodic and occur during fetal movement demonstrate fetal well-being. Turning the client to the left side, applying oxygen by face mask and notifying the health care provider are interventions used for late and variable decelerations indicating the fetus is not tolerating the induction process well.

 CN: Physiological adaptation; CL: Synthesize

**74. 1.** The client with PIH would be a candidate for the induction process because ending the pregnancy is the only way to cure PIH. A client with active herpes would be a candidate for a cesarean section to prevent the fetus from contracting the virus while passing through the birth canal. The woman with a face presentation will not be able to deliver vaginally due to the extended position of the neck. The client whose fetus exhibits late decelerations without oxytocin (Pitocin) would be at greater risk for fetal distress with use of this drug. Late decelerations indicate the fetus does not have enough placental reserves to remain oxygenated during the entire contraction. This client may require a cesarean section.

 CN: Management of care; CL: Evaluate


**75. 3.** The straight catheterization is within the scope of practice of a licensed practical nurse. An initial or continuing assessment is the responsibility of the registered nurse. Assessment must be complete before increasing the I.V. rate of Pitocin. The assessment and the increase in Pitocin rate are responsibilities for the nurse.

 CN: Management of care; CL: Evaluate

**76. 2.** Removing a fetal monitor from a client and assisting her to the bathroom are within the realm of practice of a nursing assistant. Performing a fundal check is an assessment, which is a responsibility of a registered nurse. A nursing assistant is not permitted to administer medication by any route. Education is also part of the professional nursing role. Although a nursing assistant can assist a mother with bottle feeding, the formal client education must be completed and validated by the nurse.

 CN: Management of care; CL: Evaluate

**77. 3.** When the fetal head is compressed, early decelerations are seen as a vagal response occurs and the fetal heart rate decelerates and inversely mirrors the contraction. This response commonly occurs when the client is 9 to 10 cm dilated or pushing. If communication cannot be facilitated, early decelerations are one indicator that delivery may be approaching. Late decelerations may occur at this time but indicate uteroplacental insufficiency rather than imminent birth. At any time during the labor process, the client may communicate with her family in her native language. The client's facial expressions may change at any point during labor and cannot be used as an indicator of imminent delivery.

 CN: Physiological adaptation;  
CL: Analyze

### The Intrapartal Client with Risk Factors

**78. 1, 2, 3.** With abruptio placentae, bleeding may occur vaginally, may be obstructed by the fetal head, or it may be hidden behind a portion of the placenta. Abdominal rigidity occurs, particularly with a concealed hemorrhage because the girth and fundal height increase. Abdominal pain is one of the classic symptoms of abruption. The pain may be intermittent, as in labor contractions, or continuous. The placenta with abruption is not larger than a normal placenta and the bleeding does not end spontaneously.

 CN: Physiological adaptation;  
CL: Analyze

**79. 1.** Clients who are pregnant with two (or more) fetuses are at greater risk for pregnancy-induced hypertension, hydramnios, placenta previa, preterm

labor, and anemia. During delivery, occasionally the placenta of the second twin separates before that twin is delivered, causing profound bleeding. Urinary tract infections and chorioamnionitis are not more common in clients with multifetal gestation compared with women with single-fetus pregnancies. Although multiparous women frequently deliver more quickly than a nullipara does, precipitous delivery is not more common with twin gestations.

 CN: Reduction of risk potential;  
CL: Analyze

**80. 3.** The multigravid client with class II heart disease has a slight limitation of physical activity and may become fatigued with ordinary physical activity. A side-lying or semi-Fowler's position with the head elevated helps to ensure cardiac emptying and adequate oxygenation. In addition, oxygen by mask, analgesics and sedatives, diuretics, prophylactic antibiotics, and digitalis may be warranted. Although breathing slowly during a contraction may assist with oxygenation, it would have no effect on cardiac emptying. It is essential that the laboring woman with cardiac disease be relieved of discomfort and anxiety. Effective intrapartum pain relief with analgesia and epidural anesthesia may reduce cardiac workload as much as 20%. Local anesthetics are effective only during the second stage of labor.


 CN: Reduction of risk potential;  
CL: Synthesize

**81. 4.** Assessing for signs and symptoms associated with cardiac decompensation is the priority. Class III heart disease during pregnancy has a 25% to 50% mortality. These clients are markedly compromised, with marked limitation of physical activity. They frequently experience fatigue, palpitations, dyspnea, or anginal pain. A pulse rate greater than 100 bpm or a respiratory rate greater than 25 breaths/minute may indicate cardiac decompensation that could result in cardiac arrest. Additional symptoms include dyspnea, peripheral edema, orthopnea, tachypnea, rales, and hemoptysis.


 CN: Reduction of risk potential;  
CL: Analyze

**82. 2.** Clients who have been diagnosed with class II heart disease and prosthetic valve replacement are most likely to have an order for antibiotic medications to prevent the development of bacterial endocarditis and bacteremia. Clients with valvular heart disease have a high susceptibility to subacute bacterial endocarditis. Anticoagulant therapy is usually discontinued during labor and delivery because of the potential for hemorrhage. Diuretic medications are generally not prescribed for clients with class I or class II heart disease. Diuretics usually are not necessary and may result in potassium depletion. Folic acid supplements are usually prescribed

for clients with megaloblastic anemia. Folic acid is also included in many prenatal vitamins and can help to prevent neural tube defects in the fetus.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**83. 1.** Before administering prostaglandin E2 gel, the nurse would assess the frequency and duration of any uterine contractions first, because prostaglandin E2 gel is contraindicated if the client is having contractions. If there are no contractions, the client should be placed in a semi-Fowler's position to allow for vaginal insertion of the gel. Although determining whether the client's membranes have ruptured is part of the assessment of any client in labor, it is not specifically related to the administration of prostaglandin E2 gel. If the membranes remain intact, an amniotomy may be performed once the client begins to dilate and the fetal head is engaged. However, it is not necessary for the nurse to prepare the client for this procedure at this time.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**84. 4.** One of the potential disadvantages of oxytocin induction is neonatal jaundice or hyperbilirubinemia. Oxytocin decreases the elimination of bilirubin from the neonate. Other adverse effects include maternal hypertension and frontal headache, which disappear when the drug is discontinued. The drug has antidiuretic properties that can lead to maternal water intoxication. Dangerous effects of this powerful drug include uterine hyperstimulation or tetanic contractions, which can result in abruptio placentae and uterine rupture. Urinary frequency, maternal hypoglycemia, and preterm birth are not associated with oxytocin administration. Ultrasound procedures are used to estimate gestational age to prevent preterm delivery. Clients who are diabetic commonly deliver before term because the placenta begins to deteriorate, which can result in stillbirth.

 CN: Pharmacological and parenteral therapies; CL: Create

**85. 4.** The highest priority nursing diagnosis for the client at this time is *Risk for injury, maternal or fetal* related to uterine hyperstimulation. Diabetic mothers have a higher incidence of pregnancy-induced hypertension, polyhydramnios, preterm birth, and larger-than-average fetuses and commonly have decreased placental perfusion. Infants of diabetic mothers may have polycythemia, congenital anomalies, and respiratory distress. Because of its antidiuretic properties, oxytocin infusion poses a risk of fluid overload, not fluid deficit. There is no information to support the diagnosis of *Pain* related to prolonged labor. For multigravid clients, labor is commonly shorter than for

primigravidas. A labor duration longer than 12 hours would indicate a prolonged labor. There is no indication that the client will require cesarean delivery at this time.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**86. 4.** A common sign of fetal distress related to an inadequate transfer of oxygen to the fetus is meconium-stained fluid. Because the fetus has suffered hypoxia, close fetal heart rate monitoring is necessary. In addition, all clients are monitored continuously after rupture of membranes for fetal distress caused by cord prolapse. If there are increasing signs of fetal distress (e.g., late decelerations), the physician should be notified immediately. A cesarean delivery may be performed for fetal distress. Increasing the rate of the oxytocin infusion could lead to further fetal distress. Turning the client to the left side, rather than a knee-chest position, improves placental perfusion. The physician may wish to determine the extent of cervical dilation to make a decision about whether a cesarean delivery is warranted, but continuous fetal heart rate monitoring is essential to determine fetal status.

 CN: Reduction of risk potential; CL: Synthesize

**87. 3.** Neonates born to mothers who smoke tend to have lower-than-average birth weights. Neonates born to mothers who smoke also are at higher risk for stillbirth, sudden infant death syndrome, bronchitis, allergies, delayed growth and development, and polycythemia. Maternal smoking is not related to higher neonatal hyperirritability, hyperbilirubinemia, or hypocalcemia. Rather, cocaine use during pregnancy is associated with neonatal hyperirritability and withdrawal symptoms. Hyperbilirubinemia is associated with Rh or ABO incompatibility or the administration of intravenous oxytocin during labor. Approximately 50% of neonates born to mothers with insulin-dependent diabetes experience hypocalcemia during the first 3 days of life.

 CN: Health promotion and maintenance; CL: Analyze

**88. 3.** The client should be urged to push with an open glottis to prevent the Valsalva maneuver. Pushing with a closed glottis increases intrathoracic pressure, preventing venous return. Blood pressure also falls, and cardiac output decreases. Pushing for at least 1 to 3 minutes is too long; prolonged pushing can lead to reduced blood flow and fatigue. Pushing for the duration of the contraction is sufficient. Pushing while holding the breath results in the Valsalva maneuver. Because the client has had an epidural anesthetic, she may not feel the urge to




push and may need coaching during the pushing phase.

 CN: Pharmacological and parenteral therapies; CL: Create

**89. 3.** The American College of Obstetricians and Gynecologists has classified forceps applications into three categories: outlet, low, or middle. When the fetal skull is on the perineum with the scalp visible at the perineal floor or vaginal opening, this is considered outlet forceps application. When the head is higher in the pelvis but engaged and its greatest diameter has passed the inlet, the operation is termed midforceps. Midforceps deliveries are not recommended because they are extremely dangerous for the mother and fetus because of the possibility of uterine rupture. If the head is not engaged, at -1 station, this is termed high forceps. High forceps deliveries also are exceedingly dangerous for both the mother and fetus because of the possibility of uterine rupture and are not recommended. Cesarean delivery is preferred in these situations. The fetal head at station +2 or lower is termed low forceps.

 CN: Reduction of risk potential;  
CL: Apply

**90. 1.** Oligohydramnios, or a decrease in the volume of amniotic fluid, is associated with variable fetal heart rate decelerations due to cord compression. Maintenance of an adequate amniotic fluid volume during labor provides protective cushioning of the umbilical cord and minimizes cord compression. Cord compression can result in fetal metabolic acidosis, not alkalosis. Amnioinfusion is used to minimize cord compression, not to increase the fetal heart rate accelerations during a contraction. The goal is to maintain the amniotic fluid index at 8 cm. This can be determined by ultrasound.

 CN: Reduction of risk potential;  
CL: Apply

**91. 4.** A primigravid client diagnosed with pregnancy-induced hypertension has the potential for developing seizures (eclampsia). This client should be in a room with the least amount of stimulation possible to reduce the risk of seizures and as close to the nurses' station as possible in case the client requires immediate assistance. Bright lighting and sunshine can be a stimulant, possibly increasing the risk of seizures, as can being in a semiprivate room with roommate, visitors, conversation, and noise.

 CN: Management of care; CL: Synthesize

**92. 4.** The client is experiencing a precipitous delivery. The nurse should remain calm during a precipitous delivery. Explaining to the client what is happening as the birth progresses and how she can assist is likely to help her remain calm and cooperative. Maintaining eye contact is also beneficial. Telling

the client that she is right and to just relax is inappropriate because the client may not be able to relax because of the strong urge to push the fetus out of the birth canal. Telling the client not to push because she may tear the cervix can instill fear, not cooperation. Saying that the physician will be there soon may not be an accurate statement and is not reassuring if the client is concerned about the delivery.

 CN: Psychosocial adaptation; CL: Apply


**93. 2.** During a precipitous delivery, after calling for assistance and helping the client lie down, the nurse should provide support to the fetal head to prevent it from coming out. It is not appropriate to tell the client to push between contractions because this may lead to lacerations. The shoulder should be delivered by applying downward traction until the anterior shoulder appears fully at the introitus, then upward pressure to lift out the other shoulder. Priority should be given to safe delivery of the infant over protecting the perineum by massage.

 CN: Reduction of risk potential;  
CL: Synthesize


**94. 2.** Because delivery occurs so rapidly and the fetus is propelled quickly through the birth canal, the major complication of a precipitous delivery is a boggy fundus, or uterine atony. The neonate should be put to the breast, if the mother permits, to allow for the release of natural oxytocin. In a hospital setting, the physician will probably order administration of oxytocin. The nurse should gently massage the fundus to ensure that it is firm. There is no relationship between a precipitous delivery and postpartum "blues" or intrauterine infection. Postpartum "blues" usually does not occur until about 3 days postpartum, and symptoms of postpartum infection usually occur after the first 24 hours. There is no relationship between a precipitous delivery and urinary tract infection even though the delivery has been accomplished under clean rather than sterile technique. Symptoms of urinary tract infection typically begin on the first or second postpartum day.

 CN: Reduction of risk potential;  
CL: Analyze

**95. 2.** The fetal heart rate of a multipara diagnosed with Rh sensitization and probable fetal hydrops and anemia will most likely demonstrate a sinusoidal pattern that resembles a sine wave. It has been hypothesized that this pattern reflects an absence of autonomic nervous control over the fetal heart rate resulting from severe hypoxia. This client will most likely require a cesarean delivery to improve the fetal outcome. Early decelerations are associated with head compression; variable decelerations are associated with cord compression; and late decelerations are associated with poor placental perfusion.

 CN: Reduction of risk potential;  
CL: Analyze

**96. 3.** Oxytocin, given postpartum to contract the uterus, should be administered after both twins and both placentas have been delivered. If oxytocin is given any earlier—after the first twin, after the first placenta, or after the second twin—the uterus will contract and make delivery of the placenta or placentas difficult.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**97. 1.** A priority assessment for the nurse to make is to determine the estimated date of delivery or probable gestational age of the fetus. If the gestation is less than 37 weeks, the neonatal team should be called to begin resuscitative efforts if needed. Amniotic fluid status is not important at this point, because if the fetal skull is crowning, delivery is imminent. Determination of gravida and parity is part of the normal nursing history, but the priority is the status of the fetus and safe delivery. Prenatal history is part of the nursing assessment, but this information is not especially relevant until the fetus is safely delivered and has been given immediate care.

 CN: Health promotion and maintenance; CL: Analyze

**98. 2.** It is important that the parents be allowed to touch, hold, and participate in care of the twins whenever they desire. Ideally, this will be on a daily basis, to promote parent-infant bonding. It is not appropriate to discuss how the couple will cope with twin infants at home until they are ready to take the infants home. They are too overwhelmed at this point and are focused on the well-being of their infants while hospitalized. Having the couple visit the twins to provide care on a 24-hour basis is not warranted. Identifying complications that may occur is not appropriate. If complications arise, the parents should be well informed and given opportunities for discussion related to the care provided.

 CN: Psychosocial adaptation; CL: Create


**99. 4.** The priority diagnosis is *Risk for infection* related to birth trauma and prolonged ruptured membranes. Infection can be a serious postpartum complication. Although the client may be fatigued, she should not be experiencing activity intolerance. Clients with heart disease may experience activity intolerance due to excessive cardiac workload. Although the client may be experiencing sleep deprivation, most clients are alert and awake after delivery of a newborn. *Situational low self-esteem* is not a priority diagnosis. Clients who undergo a cesarean delivery commonly feel a sense of failure because of not delivering vaginally, but this is not the case for this client.

 CN: Reduction of risk potential; CL: Analyze


**100. 2.** Postmature neonates commonly have difficulty maintaining adequate glucose reserves and usually develop hypoglycemia soon after birth. Other common problems include meconium aspiration syndrome, polycythemia, congenital anomalies, seizure activity, and cold stress. These complications result primarily from a combination of advanced gestational age, placental insufficiency, and continued exposure to amniotic fluid. Delayed meconium is not associated with post-term gestation. Hyperbilirubinemia occurs in term neonates as well as post-term neonates, but unless there is an Rh incompatibility it does not develop until after the first 24 hours of life.

 CN: Reduction of risk potential; CL: Analyze

**101. 4.** Polyhydramnios is an abnormally large amount of amniotic fluid in the uterus. The client has understood the instructions when the client states that polyhydramnios is associated with gastrointestinal disorders (e.g., tracheoesophageal fistula). Polyhydramnios is also associated with maternal illnesses such as diabetes and anemia. Other fetal/neonatal disorders associated with this condition include congenital anomalies of the central nervous system (e.g., anencephaly), upper gastrointestinal obstruction, and macrosomia. Polyhydramnios can lead to preterm labor, premature rupture of the membranes, and cord prolapse. Renal dysfunction and intrauterine growth retardation are associated with oligohydramnios, not polyhydramnios. Pulmonary hypoplasia (poorly developed lungs) is associated with prolonged oligohydramnios.

 CN: Reduction of risk potential; CL: Evaluate

**102. 1.** If a client has been in active labor and there is no change in cervical dilation after 2 hours, the nurse should suspect cephalopelvic disproportion. This may be caused by an inadequate pelvis size of the mother or by a large-for-gestational-age fetus. The physician should be notified about the client's lack of progress. If the fetus cannot descend, a cesarean delivery is warranted. The client is not experiencing a prolonged latent phase (0 to 3 cm dilation), because her cervix is dilated to 6 cm. She has not reached the transitional phase, characterized by a cervical dilation of 8 to 10 cm. With a hypotonic labor pattern, contractions are painful but far apart and not very intense. This client's contractions are of moderate intensity.


 CN: Reduction of risk potential; CL: Analyze

**103. 3.** Preparation for cesarean delivery is similar to preparation for any abdominal surgery. The client must give informed consent. Another person may


not sign for the client unless the client is unable to sign the form. If this is the case, only certain designated people can do so legally. The husband does not need to sign the form unless his wife is unable to do so. In an emergency, surgery may be performed without a written consent if it is done to save the life of the mother or the child, or both.

 CN: Management of care;  
CL: Synthesize

**104. 4.** Decreased variability may be seen in various conditions. However, it is most commonly caused by analgesic administration. Other factors that can cause decreased variability include anesthesia, deep fetal sleep, anencephaly, prematurity, hypoxia, tachycardia, brain damage, and arrhythmias. Maternal fatigue, fetal malposition, and small-for-gestational-age fetus are not commonly associated with decreased variability.

 CN: Health promotion and maintenance;  
CL: Apply

**105. 4.** It is not unusual for clients who undergo an emergency cesarean delivery to express thoughts of failure. Pain, hemorrhage, and anxiety may all occur, but the priority diagnosis at this time is *Situational low self-esteem*. In this situation, the nurse should be supportive and should allow the client to verbalize any feelings of failure, guilt, or anger. Nursing care should include reviewing the events that occurred and clearing up any questions or misconceptions.

 CN: Psychosocial adaptation;  
CL: Analyze

**106. 4.** Respiratory distress syndrome is more common in neonates delivered by cesarean section than in those delivered vaginally. During a vaginal delivery, pressure is exerted on the fetal chest, which aids in the fetal inhalation and exhalation of air and lung expansion. This pressure is not exerted on the fetus with a cesarean delivery. Congenital anomalies are not more common with cesarean delivery. Pulmonary hypertension occurs more commonly in infants with meconium aspiration syndrome, congenital diaphragmatic hernia, respiratory distress syndrome, or neonatal sepsis, not with cesarean delivery. Meconium aspiration syndrome occurs more commonly with vaginal delivery, post-term neonate, and prolonged labor, not with cesarean delivery.

 CN: Health promotion and maintenance are;  
CL: Apply

**107. 4.** Congenital anomalies are not related to maternal urinary tract infections. A multigravid client with acute pyelonephritis is susceptible to preterm labor, premature rupture of the membranes, maternal sepsis, intrauterine growth retardation, and

fetal loss. The most common organism responsible for the urinary tract infection is *Escherichia coli*.

 CN: Reduction of risk potential;  
CL: Evaluate


**108. 1.** Conjunctivitis is a common complication of neonates who are born to mothers with untreated chlamydial infection. Neonatal pneumonia is another condition associated with chlamydial infection of the mother. Untreated chlamydial infection is not associated with heart disease or brain damage. Exposure to rubella may lead to neonatal heart defects, and brain damage may occur as a result of prolonged shoulder dystocia or difficulty delivering the fetal head during a vaginal breech delivery. Occasionally, because of immature circulation, a neonate who has been lying on his or her side appears red on one side of the body. This “harlequin sign” is transient and is of no clinical significance. Presence of a harlequin sign is unrelated to untreated chlamydial infection.

 CN: Reduction of risk potential;  
CL: Apply

**109. 1.** The purpose of the RHIG is to provide passive antibody immunity and prevent Rh-positive sensitization with the next pregnancy. It should be given within 72 hours after delivery of an Rh-positive neonate. Clients who are Rh-negative and conceive an Rh-negative fetus do not need antibody protection. Rh-positive cells contribute to sensitization, not Rh-negative cells. The RHIG does not cross the placenta and destroy fetal Rh-positive cells.

 CN: Reduction of risk potential;  
CL: Apply

**110. 3.** Because magnesium sulfate is a central nervous system depressant, the nurse should plan to assess the client’s respiratory rate every hour. If the respiratory rate is less than 12 breaths/minute, the client may be experiencing magnesium sulfate overdose. Urinary output via an indwelling catheter should be assessed hourly and should be at least 30 mL/hour. Deep tendon reflexes and blood pressure should also be assessed every hour. At some institutions continuous electronic blood pressure monitoring will be performed.


 CN: Pharmacological and parenteral therapies;  
CL: Analyze

**111. 2.** For a client diagnosed with probable placenta previa, hypovolemic shock is a complication. Continuous blood pressure monitoring with an electronic cuff is the priority assessment after the client’s admission. Once the client is admitted, an ultrasound examination will be performed to determine the placement of the placenta. Whole blood replacement is not warranted at this time. However, it may be necessary if the client demonstrates signs

and symptoms of hemorrhage or shock. Internal fetal heart rate monitoring is contraindicated because the monitoring device may puncture the placenta and place both the mother and fetus in jeopardy. An immediate cesarean delivery is not necessary until there has been an assessment of the amount of bleeding and the location of the placenta previa.

 CN: Reduction of risk potential;  
CL: Apply


**112. 4.** Dramatic vasoconstriction occurs as a result of sniffing crack cocaine. This can lead to increased respiratory and cardiac rates and hypertension. It can severely compromise placental circulation, resulting in abruptio placentae and preterm labor and delivery. Infants of these women can experience intracranial hemorrhage and withdrawal symptoms of tremulousness, irritability, and rigidity. Placenta previa, ruptured uterus, and maternal hypotension are not associated with cocaine use. Placenta previa may be associated with grand multiparity. Ruptured uterus may be associated with a large-for-gestational-age fetus.

 CN: Reduction of risk potential;  
CL: Analyze

**113. 2.** Pregnant women who become infected with the rubella virus early in pregnancy risk having a neonate born with rubella syndrome. The symptoms include thrombocytopenia, cataracts, cardiac disorders, deafness, microcephaly, and motor and cognitive impairment. The most extensive neonatal effects occur when the mother is exposed during the first 2 to 6 weeks and up to 12 weeks' gestation, when critical organs are forming. Bulging fontanels are associated with increased intracranial pressure and meningitis, which can occur as the result of a b-hemolytic streptococcal infection.


 CN: Reduction of risk potential;  
CL: Analyze

**114. 3.** To stop the process of DIC, the underlying insult that began the phenomenon must be halted. Treatment includes fresh-frozen platelets or blood administration. The physician also may order heparin before the administration of blood products to restore the normal clotting mechanism. Immediate delivery of the fetus is essential. Magnesium sulfate is given for pregnancy-induced hypertension or preterm labor. Heparin, not warfarin sodium (Coumadin), is used to treat DIC. Meperidine hydrochloride (Demerol) is used for pain relief.


 CN: Pharmacological and parenteral therapies; CL: Apply

**115. 2.** The intended effect for this client is to decrease the number and frequency of contractions. Even though this client has chronic hypertension, the first goal is to prevent delivery of a 34 weeks' gestation client. If the blood pressure moves into the therapeutic


range, that is a benefit for the client but it is not the major goal. Magnesium sulfate may decrease the accelerations found in this fetus as it decreases the ability of the infant to respond, acting on the infant in the same way it does on the mother. Maternal respiratory rate may also decrease and a lower respiratory rate to 12 respirations per minute indicates that this level of magnesium sulfate is becoming toxic to this client.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**116. 1.** Although thioamides such as propylthiouracil and methimazole are considered teratogenic to the fetus and can lead to congenital hyperthyroidism (goiter) in the neonate, they still represent the treatment of choice. The client should be regulated on the lowest possible dose. Hyperthyroidism is associated with preterm labor and a low-birth-weight infant, so the client should contact the physician or health care provider if the contractions begin again. The client should not be urged to breast-feed, because medications such as propylthiouracil and methimazole are secreted in breast milk. Tachycardia (not bradycardia) is associated with thyroid storm, a medical emergency, and should be reported to the physician.

 CN: Pharmacological and parenteral therapies; CL: Apply

**117. 4.** The first action by the nurse should be to call for immediate assistance in the client's room, because this is an emergency. Throughout the seizure, the nurse should note the time and length of the seizure and continue to monitor the status of both client and fetus. The side rails should have been padded at the time of the client's admission to the hospital as part of seizure precautions. The client should be turned to her left side to improve placental perfusion. Inserting a tongue blade is not recommended because it can further obstruct the airway or cause injury to the client's teeth.


 CN: Safety and infection control;  
CL: Synthesize

**118. 3.** In an abusive situation, the client's safety is the priority. The nurse should refer the client to a social worker who can provide the client with options such as a safe shelter. Commonly clients who are battered feel powerless and fear that the batterer will kill them. As a result, they remain in the abusive situation. Telling the client to leave the boyfriend immediately is not helpful and reflects the values of the nurse. Although asking about fetal movement is important and is part of a routine assessment, a sonogram can be performed to confirm fetal well-being. The referral is more important at this time. Although it may be part of the unit's policies and procedures to report any incidents such as this one to the unit supervisor,

the client's immediate need for safety must be addressed first.

 CN: Management of care; CL: Apply

**119. 1.** The client's symptoms are indicative of amniotic fluid embolism, which is a medical emergency. After calling for assistance, the first action should be to administer oxygen by face mask or cannula to ensure adequate oxygenation of mother and fetus. If the client needs cardiopulmonary resuscitation, this can be started once oxygen has been administered. If the client survives, disseminated intravascular coagulation will probably develop, and the client will need intravenous fibrinogen and heparin. Oxytocin, a vasoconstrictor, is not warranted for amniotic fluid embolism.


 CN: Physiological adaptation;  
CL: Synthesize

### Managing Care Quality and Safety

**120. 4.** Delegation of duties and clients to ancillary personnel is commonly the responsibility of the registered nurse. The client who is a G 2, P 1, with a history of hyperemesis gravidarum, is the client with the least potential for labor complications. Hyperemesis gravidarum typically occurs and is treated in the first or second trimester of pregnancy and should be resolved by this point in the pregnancy. A G 4, P 3 client with a history of gestational diabetes may have cephalopelvic disproportion due to a large-for-gestational-age fetus requiring a cesarean section delivery. The G 3, P 1, Ab 1 client is preterm at 35 weeks' gestation and may require an intensive care neonatal team. In a G 1, P 0 client, leaking green amniotic fluid indicates that there has been fetal distress.

 CN: Management of care; CL: Synthesize


**121. 2.** The nurse will need to assess the client's ability to bear weight before taking her to the bathroom. If she cannot bear weight, she will be unable to ambulate. Asking the client to remain in bed until the assessments are complete sets the client up for increased post partum bleeding, as the bladder will displace the uterus. Encouraging the client to sit at the bedside is an excellent strategy to prevent orthostatic hypotension, but will not give the nurse an idea if the client can ambulate. Having a staff member with the client is also correct for the first ambulation of this client, but the ability to bear weight and walk will need to be completed first.

 CN: Reduction of risk potential;  
CL: Synthesize

**122. 1, 4, 5.** In most settings, the charge nurse coordinates and directs the activities of the unit. Prior to the change of shift, the nurse will review and update the status of each of the laboring clients on the unit to include any difficulties or unusual situations that may be occurring with each of them, including following up with a primary nurse after a delivery. A change of shift report with the oncoming charge nurse is among the last activities completed before ending the shift. Activities such as admitting a client in labor and completing the nursing responsibilities of the nurse who had to leave 30 minutes early can be delegated to staff members. In an emergency situation, the charge nurse could assume responsibility for client care.

 CN: Management of care; CL: Create

**123. 4.** The client at 42 weeks' is the greatest concern and the nurse should make rounds on this client first based on the length of the pregnancy and the green color of the amniotic fluid. Bloody show is a normal sign of impending labor as the cervix may be beginning to dilate. Not having contractions after rupture of membranes is not unusual within a 1-hour time frame. The green amniotic fluid indicates that fetal distress has recently occurred to the point that the fetus had a bowel movement in utero. Along with the 42-week gestation, this fetus is at greatest risk. The nurse can see the primipara in active labor at 5 cm dilation last; this client is in pain but nothing about her situation indicates anything but a normal labor process and as a primipara, her labor process will be slow. The client that is completely effaced, 8 cm dilated and at + 2 station as a primipara usually moves through labor at a slower pace than a multiparous client. She is experiencing nausea which is an expected situation as a laboring client enters transition. The client with no prenatal care is a cause for concern as the nurse knows nothing about her background. Her blood pressure is elevated, an indicator of mild preeclampsia, but there is no other indications of worsening preeclampsia, such as headache, visual disturbances, or epigastric pain.

 CN: Management of care; CL: Synthesize

**124. 1, 2, 3, 4.** Assuring the safety of this client is the top priority for this client. The nurse should place the client on the fetal and contraction monitor. Since the client is 8 cm dilated and a multi-gravid client, asking other staff members to set up the delivery table would be in order. This client is not a candidate for medication as this may have an influence on the baby. This client is past the point of offering an epidural as she may have delivered by the time the medication is in effect, but comfort measures such as warm or cool cloths, back rubs, etc. may be helpful. The support system is an

important aspect of the delivery process and is an easily settled situation. Preparing to give an early report to the oncoming nurse does not apply in this situation.

 CN: Management of care; CL: Create

**125. 3.** In emergency situations, verbal orders should be entered into the electronic medical record or chart and signed immediately after the emergency. The nurse taking this order and giving the medication needs to call the physician, explain the order and that the medication was administered per the verbal order, and request that the physician

write the correct order. If the nurse misunderstood the order and gave the medication by the wrong route, an incident report will need to be initiated. The charge nurse would become involved if an error has occurred, an incident report is needed, or there is difficulty between the nurse and physician that cannot be remediated. Rectifying this order is the responsibility of the implementing nurse. Waiting until the physician comes back to the hospital unit may not occur quickly enough to safely care for the client.

 CN: Management of care; CL: Synthesize

# TEST 4

## Postpartal Care

- The Postpartal Client with a Vaginal Birth
- The Postpartal Client Who Breast-Feeds
- The Postpartal Client Who Bottle-Feeds
- The Postpartal Client with a Cesarean Birth
- The Postpartal Client with Complications
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Postpartal Client with a Vaginal Birth

1. The nurse from the nursery is bringing a newborn to a mother's room. The nurse took care of the mother yesterday and knows the mother and baby well. The nurse should implement which of the following next to ensure the safest transition of the infant to the mother?

- 1. Assess whether the mother is able to ambulate to care for the infant.
- 2. Ask the mother if there is anything else she needs for the care of her baby.
- 3. Check the crib to determine if there are enough diapers and formula.
- 4. Complete the hospital identification procedure with mother and infant.

2. A client is in the first hour of her recovery after a vaginal delivery. During an assessment, the lochia is moderate, bright red, and is trickling from the vagina. The nurse locates the fundus at the umbilicus; it is firm and midline with no palpable bladder. The client's vital signs remain at their baseline. Based on this information, the nurse would implement which of the following actions?

- 1. Increase the I.V. rate.
- 2. Recheck the admission hematocrit and hemoglobin levels.
- 3. Report the findings to the health care provider.
- 4. Document the findings as normal.

3. The nurse is caring for a G 3, T 3, P 0, Ab 0, L 3 woman who is one day postpartum following a vaginal delivery. Which of the following indicates a need for further assessment?

- 1. Increased hematocrit and hemoglobin.
- 2. White blood cell (WBC) count of 15,000.
- 3. Pulse of 60.
- 4. Temperature of 100.8° F.

4. The nurse is caring for a postpartum client who delivered vaginally 4 hours ago and has not voided since delivery. Feeling has returned to her perineal area, and she has ambulated to the bathroom and attempted to void twice. She has ice on her edematous perineum. Her uterus is 3 fingerbreadths above the umbilicus, to the right of midline, and firm only with massage. What is the priority nursing action?

- 1. Evaluate the client with a bladder scan.
- 2. Insert a Foley catheter.
- 3. Medicate the client with a nonsteroidal anti-inflammatory drug (NSAID).
- 4. Massage the fundus until it is firm and perform a one-time catheterization on the client.

5. A client delivered vaginally 2 hours ago and has a third-degree laceration. There is ice in place on her perineum. However, her perineum is slightly edematous and the client is complaining of pain rated 6 on a scale of 1 to 10. Which nursing intervention would be the **most** appropriate at this time?

- 1. Begin sitz baths.
- 2. Administer pain medication per order.
- 3. Replace ice packs to the perineum.
- 4. Initiate anesthetic sprays to the perineum.

6. A client is in the fourth stage of labor. Which set of assessments is the highest priority at this time?

- 1. Assessment of the ability to push with contractions, hydration, and emotional stability.
- 2. Assessment of maternal vital signs, fetal heart tones, and the contraction pattern.
- 3. Assessment of maternal vital signs, the fundus, the bladder, and lochia.
- 4. Assessment of maternal emotional status, infant bonding, and feeding preferences.

7. A primigravid client delivered vaginally 2 hours ago with no complications. As the nurse plans care for this postpartum client, which postpartum goal would have the **highest** priority?

- 1. By discharge, the family will bond with the neonate.
- 2. The client will demonstrate self-care and infant care by the end of the shift.
- 3. The client will state instructions for discharge during the first postpartum day.
- 4. By the end of the shift, the client will describe a safe home environment.

8. In response to the nurse's question about how she is feeling, a postpartum client states that she is fine. She then begins talking to the baby, checking the diaper, and asking infant care questions. The nurse determines the client is in which postpartal phase of psychological adaptation?

- 1. Taking in.
- 2. Taking on.
- 3. Taking hold.
- 4. Letting go.

9. A client has admitted use of cocaine prior to beginning labor. After the infant is born, the nurse should anticipate the need to include which of the following actions in the infant's plan of care?

- 1. Urine toxicology screening.
- 2. Notifying hospital security.
- 3. Limiting contact with visitors.
- 4. Contacting local law enforcement.

10. The nurse is evaluating the client who delivered vaginally 2 hours ago and is experiencing postpartum pain rated 8 on scale of 1 to 10. The client is a G 4, P 4, breast-feeding mother who would like medication to decrease the pain in her uterus. Which of the medications listed on the orders sheet would be the most appropriate for this client?

- 1. Aspirin 1,000 mg P.O. q 4 to 6 hour p.r.n.
- 2. Ibuprofen 800 mg P.O. q 6 to 8 hour p.r.n.
- 3. Colace 100 mg P.O. b.i.d.
- 4. Vicodin 1 to 2 tabs P.O. q 4 to 6 hour p.r.n.

11. At which of the following locations would the nurse expect to palpate the fundus of a primiparous client immediately after delivery of a neonate?

- 1. Halfway between the umbilicus and the symphysis pubis.
- 2. At the level of the umbilicus.
- 3. Just below the level of the umbilicus.
- 4. Above the level of the umbilicus.

12. When instilling erythromycin ointment into the eyes of a neonate 1 hour old, the nurse would explain to the parents that the medication is used to prevent which of the following?

- 1. Chorioretinitis from cytomegalovirus.
- 2. Blindness secondary to gonorrhea.
- 3. Cataracts from beta-hemolytic streptococcus.
- 4. Strabismus resulting from neonatal maturation.

13. The physician orders an intramuscular injection of phytonadione (AquaMEPHYTON) for a term neonate. The nurse explains to the mother that this medication is used to prevent which of the following?

- 1. Hypoglycemia.
- 2. Hyperbilirubinemia.
- 3. Hemorrhage.
- 4. Polycythemia.

14. When developing the plan of care for a primiparous client during the first 12 hours after vaginal delivery, which of the following concerns of the client should be the nurse's primary focus of care?

- 1. The neonate.
- 2. The family.
- 3. The client's own comfort.
- 4. The client's significant other.

15. The nurse assesses a swollen ecchymosed area to the right of an episiotomy on a primiparous client 6 hours after a vaginal delivery. The nurse should next:

- 1. Apply an ice pack to the perineal area.
- 2. Assess the client's temperature.
- 3. Have the client take a warm sitz bath.
- 4. Contact the physician for orders for an antibiotic.

16. Two hours after vaginally delivering a viable male neonate under epidural anesthesia, the client with a midline episiotomy ambulates to the bathroom to void. After voiding, the nurse assesses the client's bladder, finding it distended. The nurse interprets this finding based on the understanding that the client's bladder distention is most likely caused by which of the following?

- 1. Prolonged first stage of labor.
- 2. Urinary tract infection.
- 3. Pressure of the uterus on the bladder.
- 4. Edema in the lower urinary tract area.

17. A primiparous client who is bottle-feeding her neonate at 12 hours after birth asks the nurse, "When will my menstrual cycle return?" Which of the following responses by the nurse would be **most** appropriate?

- 1. "Your menstrual cycle will return in 3 to 4 weeks."
- 2. "It will probably be 6 to 10 weeks before it starts again."
- 3. "You can expect your menses to start in 12 to 14 weeks."
- 4. "Your menses will return in 16 to 18 weeks."



**18.** While the nurse is preparing to assist the primiparous client to the bathroom to void 6 hours after a vaginal delivery under epidural anesthesia, the client says that she feels dizzy when sitting up on the side of the bed. The nurse explains that this is most likely caused by which of the following?

- 1. Effects of the anesthetic during labor.
- 2. Hemorrhage during the delivery process.
- 3. Effects of analgesics used during labor.
- 4. Decreased blood volume in the vascular system.

**19.** The nurse enlists the aid of an interpreter when caring for a primiparous client from Mexico who speaks very little English and delivered a viable term neonate 8 hours ago. When developing the postpartum dietary plan of care for the client, the nurse would encourage the client's intake of which of the following?

- 1. Tomatoes.
- 2. Potatoes.
- 3. Corn products.
- 4. Meat products.

**20.** Three hours postpartum, a primiparous client's fundus is firm and midline. On perineal inspection, the nurse observes a small, constant trickle of blood. Which of the following conditions should the nurse assess further?

- 1. Retained placental tissue.
- 2. Uterine inversion.
- 3. Bladder distention.
- 4. Perineal lacerations.

**21.** At a postpartum check up 11 days after delivery, the nurse asks the client about the color of her lochia. Which of the following colors is expected?

- 1. Dark red.
- 2. Pink.
- 3. Brown.
- 4. White.

**22.** After instructing a primiparous client about episiotomy care, which of the following client statements indicates successful teaching?

- 1. "I'll use hot, sudsy water to clean the episiotomy area."
- 2. "I wipe the area from front to back using a blotting motion."
- 3. "Before bedtime, I'll use a cold water sitz bath."
- 4. "I can use ice packs for 3 to 4 days after delivery."

**23.** After explaining the procedure for using a portable sitz bath to a primiparous client who delivered 30 hours ago, which of the following would the nurse do next?

- 1. Fill the collecting bag with water at a temperature of 107° F (41.25° C).
- 2. Spray the perineal area with the ordered analgesic spray.
- 3. Wash hands and don clean gloves for the procedure.
- 4. Assess the client's perineum for swelling and redness.

**24.** A primiparous client, 20 hours after delivery, asks the nurse about starting postpartum exercises. Which of the following would be **most** appropriate to include in the nurse's instructions?

- 1. Start in a sitting position, then lie back, and return to a sitting position, repeating this five times.
- 2. Assume a prone position, then do push-ups by using the arms to lift the upper body.
- 3. Flex the knees while supine, then inhale deeply and exhale while contracting the abdominal muscles.
- 4. Flex the knees while supine, then bring chin to chest while exhaling and reach for the knees by lifting the head and shoulders while inhaling.

**25.** A multiparous client whose fundus is firm and midline at the umbilicus 8 hours after a vaginal delivery tells the nurse that when she ambulated to the bathroom after sleeping for 4 hours, her dark red lochia seemed heavier. Which of the following would the nurse include when explaining to the client about the increased lochia on ambulation?

- 1. Her bleeding needs to be reported to the physician immediately.
- 2. The increased lochia occurs from lochia pooling in the vaginal vault.
- 3. The increase in lochia may be an early sign of postpartum hemorrhage.
- 4. This increase in lochia usually indicates retained placental fragments.

**26.** Four hours after delivering a viable neonate by spontaneous vaginal delivery under epidural anesthesia, the client states she needs to urinate. The nurse should next:

- 1. Catheterize the client to obtain an accurate measurement.
- 2. Palpate the bladder to determine distention.
- 3. Assess the fundus to see if it is at the midline.
- 4. Measure the first two voidings and record the amount.

**27.** A primiparous client who delivered vaginally 8 hours ago desires to take a shower. The nurse anticipates remaining nearby the client to assess for which of the following?

- 1. Fatigue.
- 2. Fainting.
- 3. Diuresis.
- 4. Hygiene needs.

**28.** A primiparous client who delivered 12 hours ago under epidural anesthesia with a midline episiotomy tells the nurse that she is experiencing a great deal of discomfort when she sits in a chair with the baby. Which of the following instructions would be **most** appropriate?

- 1. "Ask for some pain medication before you sit down."
- 2. "Squeeze your buttock muscles together before sitting down."
- 3. "Keep a relaxed posture before sitting down with your full weight."
- 4. "Ask the physician for some analgesic cream or spray."

**29.** Which of the following would the nurse include in the primiparous client's discharge teaching plan about measures to provide visual stimulation for the neonate?

- 1. Maintain eye contact while talking to the baby.
- 2. Paint the baby's room in bright colors accented with teddy bears.
- 3. Use brightly colored animals and cartoon figures on the wall.
- 4. Move a brightly colored rattle in front of the baby's eyes.

**30.** A primiparous client has just delivered a healthy male infant. The client and her husband are Muslim and the husband begins chanting a song in Arabic while holding the neonate. The nurse interprets the father's actions as indicative of which of the following?

- 1. Thanking Allah for giving him a male heir.
- 2. Singing to his son from the Koran in praise of Allah.
- 3. Expressing appreciation that his wife and son are healthy.
- 4. Performing a ritual similar to baptism in other religions.

**31.** An adolescent primiparous client 24 hours postpartum asks the nurse how often she can hold her baby without "spoiling" him. Which of the following responses would be **most** appropriate?

- 1. "Hold him when he is fussy or crying."
- 2. "Hold him as much as you want to hold him."
- 3. "Try to hold him infrequently to avoid overstimulation."
- 4. "You can hold him periodically throughout the day."

**32.** The nurse on the night shift finds a multiparous client, 8 hours postpartum, drenched in perspiration. The client's temperature is 99° F (36.8° C), the pulse is 68 bpm, and the blood pressure is 120/80 mm Hg. Which of the following nursing diagnoses is a priority?

- 1. *Risk for infection* (postpartum) related to birth trauma.
- 2. *Ineffective thermoregulation* related to hormonal changes.
- 3. *Ineffective tissue perfusion: Renal* related to the status of multiparity.
- 4. *Excess fluid volume* related to normal postpartal diuresis.

**33.** On the first postpartum day, the primiparous client reports perineal pain of 5 on a scale of 1 to 10 that was unrelieved by ibuprofen 800 mg given 2 hours ago. The nurse should further assess the client for:

- 1. Puerperal infection.
- 2. Vaginal lacerations.
- 3. History of drug abuse.
- 4. Perineal hematoma.

**34.** The nurse assigns an individual who is an unlicensed assistive personnel to care for a client who is one day postpartum. Which of the following would be appropriate to delegate to this person? Select all that apply.

- 1. Changing the perineal pad and reporting the drainage.
- 2. Assisting the mother to latch the infant onto the breast.
- 3. Checking the location of the fundus prior to ambulating the client.
- 4. Reinforcing good hygiene while assisting the client with washing the perineum.
- 5. Discussing postpartum depression with the client who is found crying.
- 6. Assisting the client with ambulation shortly after delivery.

**35.** While the nurse is caring for a primiparous client on the first postpartum day, the client asks, "How is that woman doing who lost her baby from prematurity? We were in labor together." Which of the following responses by the nurse would be most appropriate?

- 1. Ignore the client's question and continue with morning care.
- 2. Tell the client "I'm not sure how the other woman is doing today."
- 3. Tell the client "I need to ask the woman's permission before discussing her well-being."
- 4. Explain to the client that "Nurses are not allowed to discuss other clients on the unit."

**36.** A newly delivered primiparous client asks the nurse, “Can my baby see?” Which of the following statements about neonatal vision should the nurse include in the explanation?

- 1. Neonates primarily focus on moving objects.
- 2. They can see objects up to 12 inches away.
- 3. Usually they see clearly by about 2 days after birth.
- 4. Neonates primarily distinguish light from dark.

**37.** While assessing the fundus of a multiparous client 36 hours after delivery of a term neonate, the nurse notes a separation of the abdominal muscles. The nurse should tell the client:

- 1. She will have a surgical repair at 6 weeks postpartum.
- 2. To remain on bed rest until resolution occurs.
- 3. The separation will resolve on its own with the right posture and diet.
- 4. To perform exercises involving head and shoulder raising in a lying position.

**38.** A postpartum client delivered 6 hours ago without anesthesia and just voided 100 mL. The nurse palpates the fundus 2 fingerbreadths above the umbilicus and off to the right side. What should the nurse do **first**?

- 1. Administer ibuprofen (Motrin).
- 2. Reassess in 1 hour.
- 3. Catheterize the client.
- 4. Administer an I.V. bolus of 500 mL to rehydrate per policy.

**39.** While the nurse is assessing the fundus of a multiparous client who delivered 24 hours ago, the client asks, “What can I do to get rid of these stretch marks?” Which of the following responses would be **most** appropriate?

- 1. “As long as you don’t get pregnant again, the marks will disappear completely.”
- 2. “They usually fade to a silvery-white color over a period of time.”
- 3. “You’ll need to use a specially prescribed cream to help them disappear.”
- 4. “If you lose the weight you gained during pregnancy, the marks will fade to a pale pink.”

**40.** A primiparous client who delivered a viable neonate 8 hours ago tells the nurse that she gained 26 lb during pregnancy and asks how long it will take to return to her normal prepregnant weight. The nurse should tell the client that the usual time frame for returning to prepregnant weight is:

- 1. 4 weeks.
- 2. 6 weeks.
- 3. 8 weeks.
- 4. 12 weeks.

**41.** An adolescent primiparous client at 24 hours postpartum tells the nurse that she and her baby will be living with her boyfriend’s parents so that she can finish high school and go on to college. The client’s boyfriend and parents have been supportive of the client and neonate. Which of the following is an appropriate nursing diagnosis at this time?

- 1. *Anxiety* related to return to high school and peer pressure.
- 2. *Ineffective coping* related to inability to view motherhood realistically.
- 3. *Readiness for enhanced family coping*, related to the addition of a new family member.
- 4. *Deficient knowledge* related to the financial and emotional costs of childrearing.

**42.** A primiparous client who delivered a viable term neonate vaginally 48 hours ago has a midline episiotomy and repair of a third-degree laceration. When preparing the client for discharge, which of the following assessments would be **most** important?

- 1. Constipation.
- 2. Diarrhea.
- 3. Excessive bleeding.
- 4. Rectal fistulas.

**43.** In preparation for discharge, the nurse discusses sexual issues with a primiparous client who had a routine vaginal delivery with a midline episiotomy. The nurse should instruct the client that she can resume sexual intercourse:

- 1. In 6 weeks when the episiotomy is completely healed.
- 2. After a postpartum check by the health care provider.
- 3. Whenever the client is feeling amorous and desirable.
- 4. When lochia flow and episiotomy pain have stopped.

**44.** The physician orders docusate sodium (Colace) 100 mg at bedtime for a primiparous client after vaginal delivery of a term neonate after a midline episiotomy. The nurse instructs the client to expect which of the following results from taking the medication?

- 1. Relief from episiotomy pain.
- 2. Contraction of the uterus.
- 3. Softening of the stool.
- 4. Aid in sleeping.

**45.** While caring for a multiparous client 4 hours after vaginal delivery of a term neonate, the nurse notes that the mother's temperature is 99.8° F (37.2° C), the pulse is 66 bpm, and the respirations are 18 breaths/minute. Her fundus is firm, mid-line, and at the level of the umbilicus. The nurse should:

- 1. Continue to monitor the client's vital signs.
- 2. Assess the client's lochia for large clots.
- 3. Notify the client's physician about the findings.
- 4. Offer the mother an ice pack for her forehead.

**46.** While assessing the episiotomy site of a primiparous client on the first postpartum day, the nurse observes a fairly large hemorrhoid at the client's rectum. After instructing the client about measures to relieve hemorrhoid discomfort, which of the following client statements indicates the need for additional teaching?

- 1. "I should try to gently manually replace the hemorrhoid."
- 2. "Analgesic sprays and witch hazel pads can relieve the pain."
- 3. "I should lie on my back as much as possible to relieve the pain."
- 4. "I should drink lots of water and eat foods that have a lot of roughage."

**47.** A primiparous client is on a regular diet 24 hours postpartum. She is from Guatemala and speaks little English. The client's mother asks the nurse if she can bring her daughter some "special foods from home." The nurse responds, based on the understanding about which of the following?

- 1. Foods from home are generally discouraged on the postpartum unit.
- 2. The mother can bring the daughter any foods that she desires.
- 3. This is permissible as long as the foods are nutritious and high in iron.
- 4. The client's physician needs to give permission for the foods.

**48.** A primiparous client, 48 hours after a vaginal delivery, is to be discharged with a prescription for vitamins with iron because she is anemic. To maximize absorption of the iron, the nurse instructs the client to take the medication with which of the following?

- 1. Orange juice.
- 2. Herbal tea.
- 3. Milk.
- 4. Grape juice.

**49.** The nurse is completing discharge instructions with a new mother and is concerned about her safety. Which statement by the client indicates the client needs further instructions?

- 1. "I will need to be checked out by the doctor in a week."
- 2. "I need to wear a sports bra for a few days so I don't get milk."
- 3. "I can get pregnant now if I don't use birth control."
- 4. "I may feel sad for a few days but should be OK within a few days."

**50.** The nurse is caring for a multiparous client after vaginal delivery of a set of male twins 2 hours ago. The nurse should encourage the mother and husband to:

- 1. Bottle-feed the twins to prevent exhaustion and fatigue.
- 2. Plan for each parent to spend equal amounts of time with each twin.
- 3. Avoid assistance from other family members until attachment occurs.
- 4. Relate to each twin individually to enhance the attachment process.

**51.** Twelve hours after a vaginal delivery with epidural anesthesia, the nurse palpates the fundus of a primiparous client and finds it to be firm, above the umbilicus, and deviated to the right. Which of the following would the nurse do next?

- 1. Document this as a normal finding in the client's record.
- 2. Contact the physician for an order for methyl-ergonovine.
- 3. Encourage the client to ambulate to the bathroom and void.
- 4. Gently massage the fundus to expel the clots.

**52.** A nurse is discussing discharge instructions with a client. Which of the following statements indicate that the client understands the resources and information available if needed after discharge? Select all that apply.

- 1. "I know to wait 2 weeks before I start my birth control pills."
- 2. "I have the hospital phone number if I have any questions."
- 3. "If I have any breathing problems, chest pain, or pounding fast heart rate, I will seek medical assistance."
- 4. "My mother is coming to help for a month so I will be fine."
- 5. "I know if I get fever or chills or change in lochia to call the physician."
- 6. "I will continue my prenatal vitamins until my postpartum checkup or longer."

## The Postpartal Client Who Breast-Feeds

**53.** The nurse is reviewing discharge instructions with a postpartum breast-feeding client who is going home. She has chosen medroxyprogesterone (Depo-Provera) as birth control. Which statement by the client identifies that she needs further instruction concerning birth control?

- 1. "I will wait for my 6-week check up to get my first Depo-Provera shot."
- 2. "Depo-Provera injections last for 90 days."
- 3. "My milk supply should be well established before using Depo-Provera."
- 4. "You will give me my first Depo-Provera shot before I leave today."

**54.** A postpartum primiparous client is having difficulty breast-feeding her infant. The infant latches on to the breast but the mother's nipples are extremely sore during and after each feeding. The client needs further instruction about breast-feeding when she states:

- 1. "The baby needs to have as much of the nipple and areola in his mouth as possible to prevent sore and cracked nipples."
- 2. "I can put breast milk on my nipples to heal the sore areas."
- 3. "As long as some of my nipple is in the baby's mouth, the baby will receive enough milk."
- 4. "Feeding the baby for a half-hour on each side will not make my breasts sore."

**55.** The nurse is caring for a primipara who delivered her baby yesterday and has chosen to breast-feed her neonate. Which assessment finding is considered unusual for the client at this point postpartum?

- 1. Milk production.
- 2. Diaphoresis.
- 3. Constipation.
- 4. Diuresis.

**56.** The nurse is caring for several mother-baby couplets. In planning the care for each of the couplets, which mother would the nurse expect to have the most severe afterbirth pains?

- 1. G 4, P 1 client who is breast-feeding her infant.
- 2. G 3, P 3 client who is breast-feeding her infant.
- 3. G 2, P 2 cesarean client who is bottle-feeding her infant.
- 4. G 3, P 3 client who is bottle-feeding her infant.

**57.** A breast-feeding client is seen at home by the visiting nurse 10 days after a vaginal delivery. The client is complaining of a warm, red, painful breast; a temperature of 100° F; and flulike symptoms. What should the nurse do?

- 1. Encourage the client to breast-feed her infant using the unaffected breast.
- 2. Refer the woman to her primary health care provider.
- 3. Inform the client that she needs to discontinue breast-feeding.
- 4. Instruct the woman to apply warm compresses to the affected breast.

**58.** A diabetic postpartum client plans to breast-feed. The nurse determines that the client's understanding of breast-feeding instructions is sufficient when she states:

- 1. "Insulin will be transferred to the baby through breast milk."
- 2. "Breast-feeding is not recommended for diabetic mothers."
- 3. "Breast milk from diabetic mothers contains few antibodies."
- 4. "Breast-feeding will assist in lowering maternal blood glucose."

**59.** A primiparous client who delivered a viable neonate 48 hours ago experienced a third-degree laceration. In preparation for discharge, the nurse instructs the client, who is breast-feeding her neonate, about perineal care. Which of the following client statements indicates the need for further instructions?

- 1. "I can take acetaminophen every 3 to 4 hours or ibuprofen every 6 to 8 hours for the discomfort."
- 2. "Warm sitz baths three or four times a day for 20 minutes can offer relief."
- 3. "I should try to prevent constipation by drinking plenty of fluids."
- 4. "I can take an aspirin with codeine every 4 hours for the discomfort."

**60.** During the home visit, a breast-feeding client asks the nurse what contraception method she and her husband should use until she has her 6-week postpartal examination. Which of the following would be **most** appropriate for the nurse to suggest?

- 1. Condom with spermicide.
- 2. Oral contraceptives.
- 3. Rhythm method.
- 4. Abstinence.

**61.** A primiparous client who is beginning to breast-feed her neonate asks the nurse, "Is it important for my baby to get colostrum?" When instructing the client, the nurse would explain that colostrum provides the neonate with:

- 1. More fat than breast milk.
- 2. Vitamin K, which the neonate lacks.
- 3. Delayed meconium passage.
- 4. Passive immunity from maternal antibodies.

**62.** Which of the following forms the basis for the teaching plan about avoiding medication use unless prescribed for a primiparous client who is breast-feeding?

- 1. Breast milk quality and richness are decreased.
- 2. The mother's motivation to breast-feed is diminished.
- 3. Medications may be excreted in breast milk to the nursing neonate.
- 4. Medications interfere with the mother's let-down reflex.

**63.** A breast-feeding primiparous client with a midline episiotomy is prescribed ibuprofen 200 mg orally. The nurse instructs the client to take the medication:

- 1. Before going to bed.
- 2. Midway between feedings.
- 3. Immediately after a feeding.
- 4. When providing supplemental formula.

**64.** Which of the following would the nurse include in the teaching plan for a primiparous client about the frequency of breast-feeding the neonate during the first few days?

- 1. Feeding the neonate whenever he or she cries.
- 2. Restricting feedings to 1 to 2 minutes per side.
- 3. Feeding the neonate for at least 10 minutes per side.
- 4. Maintaining feeding for 20 to 30 minutes per side.

**65.** A multiparous client, 28 hours after cesarean delivery, who is breast-feeding complains of severe cramps or afterpains. The nurse explains that these are caused by which of the following?

- 1. Flatulence accumulation after a cesarean delivery.
- 2. Healing of the abdominal incision after cesarean delivery.
- 3. Adverse effects of the medications administered after delivery.
- 4. Release of oxytocin during the breast-feeding session.

**66.** After the nurse counsels a primiparous client who is breast-feeding her neonate about diet and nutritional needs during the lactation period, which of the following client statements indicates a need for additional teaching?

- 1. "I need to increase my intake of vitamin D."
- 2. "I should drink at least five glasses of fluid daily."
- 3. "I need to get an extra 500 calories per day."
- 4. "I need to make sure I have enough calcium in my diet."

**67.** The client is breast-feeding and asks the nurse about nutrition and diet. Which of the following statements by the client indicate understanding of dietary needs to promote successful breast-feeding? Select all that apply.

- 1. "I need to increase the number of meals I eat from three to five each day."
- 2. "I have to add about 500 more calories to my diet while I breast-feed."
- 3. "I need at least two servings of protein, like meat or eggs, with each meal."
- 4. "I need to double my fluids from my normal three to six glasses each day."
- 5. "I can include fats in my diet now."
- 6. "I can eat more cheese and drink orange juice with calcium to increase my calcium intake."

**68.** A breast-feeding primiparous client asks the nurse how breast milk differs from cow's milk. The nurse responds by saying that breast milk is higher in which of the following?

- 1. Fat.
- 2. Iron.
- 3. Sodium.
- 4. Calcium.

**69.** While assisting a primiparous client with her first breast-feeding session, which of the following actions should the nurse instruct the mother to do to stimulate the neonate to open the mouth and grasp the nipple?

- 1. Pull down gently on the neonate's chin and insert the nipple.
- 2. Squeeze both of the neonate's cheeks simultaneously.
- 3. Place the nipple into the neonate's mouth on top of the tongue.
- 4. Brush the neonate's lips lightly with the nipple.

**70.** A 25-year-old primiparous client who delivered a viable neonate 2 hours ago has decided to breast-feed her neonate. Which of the following instructions should the nurse address as the highest priority in the teaching plan about preventing nipple soreness?

- 1. Keeping plastic liners in the brassiere to keep the nipple drier.
- 2. Placing as much of the areola as possible into the baby's mouth.
- 3. Smoothly pulling the nipple out of the mouth after 10 minutes.
- 4. Removing any remaining milk left on the nipple with a soft washcloth.

**71.** Which of the following client statements indicates effective teaching about burping a breast-fed neonate?

- 1. "Breast-fed babies who are burped frequently will take more on each breast."
- 2. "If I supplement the baby with formula, I will rarely have to burp him."
- 3. "I'll breast-feed my baby every 3 hours so I won't have to burp him."
- 4. "When I switch to the other breast, I'll burp the baby."

**72.** After the nurse teaches a primiparous client planning to return to work in 6 weeks about storing breast milk, which of the following client statements indicates the need for further teaching?

- 1. "I can let the milk sit out in a bottle for up to 10 hours."
- 2. "I'll be sure to label the milk with the date, time, and amount."
- 3. "I can safely store the milk for 3 days in the refrigerator."
- 4. "I can keep the milk in a deep-freeze in clean glass bottles for up to 1 year."

**73.** During a home visit on the fourth postpartum day, a primiparous client tells the nurse that she is aware of a "let-down sensation" in her breasts and asks what causes it. The nurse explains that the let-down sensation is stimulated by which of the following?

- 1. Adrenalin.
- 2. Estrogen.
- 3. Prolactin.
- 4. Oxytocin.

**74.** During a home visit on the fourth postpartum day, a primiparous client tells the nurse that she has been experiencing breast engorgement. To relieve engorgement, the nurse teaches the client that before nursing her baby, the client should do which of the following?

- 1. Apply an ice cube to the nipples.
- 2. Rub her nipples gently with lanolin cream.
- 3. Express a small amount of breast milk.
- 4. Offer the neonate a small amount of formula.

**75.** A breast-feeding primiparous client who delivered 8 hours ago asks the nurse, "How will I know that my baby is getting enough to eat?" Which of the following guidelines should the nurse include in the teaching plan as evidence of adequate intake?

- 1. Six to eight wet diapers by the fifth day.
- 2. Three to four transitional stools on the fourth day.
- 3. Ability to fall asleep easily after feeding on the first day.
- 4. Regain of lost birth weight by the third day.

**76.** Which of the following should the nurse include in the teaching plan for a primiparous client who asks about weaning her neonate?

- 1. "Wait until you have breast-fed for at least 4 months."
- 2. "Eliminate the baby's favorite feeding times first."
- 3. "Plan to omit the daytime feedings last."
- 4. "Gradually eliminate one feeding at a time."

**77.** Two weeks after a breast-feeding primiparous client is discharged, she calls the birthing center and says that she is afraid she is "losing my breast milk. The baby had been nursing every 4 hours, but now she's crying to be fed every 2 hours." The nurse interprets the neonate's behavior as most likely caused by which of the following?

- 1. Lack of adequate intake to meet maternal nutritional needs.
- 2. The mother's fears about the baby's weight gain.
- 3. Preventing the neonate from sucking long enough with each feeding.
- 4. The neonate's temporary growth spurt, which requires more feedings.

**78.** During a home visit to a breast-feeding primiparous client at 1 week postpartum, the client tells the nurse that her nipples have become sore and cracked from the feedings. Which of the following should the nurse instruct the client to do?

- 1. Wipe off any lanolin creams from the nipple before each feeding.
- 2. Position the baby with the entire areola in the baby's mouth.
- 3. Feed the baby less often for the next several days.
- 4. Use a mild soap while in the shower to prevent an infection.

### The Postpartal Client Who Bottle-Feeds

**79.** The nurse is assessing a client at her postpartum checkup 6 weeks after a vaginal delivery. The mother is bottle feeding her baby. Which client finding indicates a problem at this time?

- 1. Firm fundus at the symphysis.
- 2. White, thick vaginal discharge.
- 3. Striae that are silver in color.
- 4. Soft breasts without milk.

**80.** A client delivered 2 days ago and has been given instructions on breast care for bottle-feeding mothers. Which of the following statements indicates that the nurse should reinforce the instructions to the client?

- 1. "I will wear a sports bra or a well fitting bra for several days."
- 2. "When showering, I'll direct water onto my shoulders."
- 3. "I will only use only water to clean my nipples."
- 4. "I will use a breast pump to remove any milk that may appear."

**81.** A nurse is giving a shift report about a client in labor. Which of the following information is the **least** important to include to complete the report at the change of shift?

- 1. Gravida, term, preterm, abortion, living.
- 2. Cervical effacement, dilation, station.
- 3. Support person with the client.
- 4. Bottle- or breast-feeding preference.

**82.** A 24-year-old primipara who has delivered a healthy neonate in the hospital's birthing center plans to bottle-feed her neonate. When developing the nutritional teaching plan for the mother about the neonate's daily calorie allotment, the nurse should determine that the number of calories required by the neonate each day per pound of body weight is which of the following?

- 1. 30 to 35.
- 2. 40 to 45.
- 3. 50 to 55.
- 4. 60 to 65.

**83.** A primiparous client with a neonate who is 36 hours old asks the nurse, "Why does my baby spit up a small amount of formula after feeding?" The nurse explains that the regurgitation is thought to result from which of the following?

- 1. An immature cardiac sphincter.
- 2. A defect in the gastrointestinal system.
- 3. Burping the infant too frequently.
- 4. Moving the infant during the feeding.

**84.** A primiparous client who will be bottle-feeding her neonate asks, "What is the best position for the baby after feeding?" Which of the following positions should the nurse recommend to aid digestion?

- 1. Supine position.
- 2. On the left side.
- 3. Prone without a pillow.
- 4. Sitting on the caregiver's lap for 20 minutes.

**85.** A primiparous client who is bottle-feeding her neonate asks, "When should I start giving the baby solid foods?" The nurse instructs the client to introduce solid foods no sooner than at which age?

- 1. 2 months.
- 2. 6 months.
- 3. 8 months.
- 4. 10 months.

**86.** After instructing a primiparous client who is bottle-feeding about burping, which of the following client statements indicates that the client needs further teaching?

- 1. "I'll burp him after 15 minutes of feeding him formula."
- 2. "After he takes one-half ounce of formula, I'll burp him."
- 3. "I'll burp him while he is in an upright position."
- 4. "I'll gently pat his back to get him to burp."

**87.** When teaching a primiparous client about the growth and development of the neonate, which of the following should the nurse include as the usual age at which most babies are able to drink from a cup independently?

- 1. 5 to 7 months.
- 2. 8 to 10 months.
- 3. 12 to 14 months.
- 4. 15 to 16 months.

**88.** When preparing for discharge a 15-year-old primipara who is bottle-feeding her neonate, the nurse instructs the client not to "prop" the bottle while feeding the neonate because this can lead to which of the following?

- 1. Overfeeding and obesity.
- 2. Aspiration of the formula.
- 3. Tooth decay in the formative months.
- 4. Sudden infant death syndrome (SIDS).

### The Postpartal Client with a Cesarean Birth

**89.** The nurse is assessing a cesarean section client who delivered 12 hours ago. Findings include a distended abdomen with faint bowel sounds  $\times$  1 quadrant, fundus firm at umbilicus, lochia scant, rubra, and pain rated 2 on a scale of 1 to 10. The I.V. and Foley catheter have been discontinued and the client received medication 3 hours ago for pain. The client can have pain medication every 3 to 4 hours. The nurse should **first**:

- 1. Give the client pain medication.
- 2. Have the client use the incentive spirometry.
- 3. Ambulate the client from the bed to the hallway and back.
- 4. Encourage the client to begin caring for her baby.



**90.** Carboprost (Hemabate) was injected into the uterus of a client to treat uterine atony during a cesarean section. In preparing to care for this client postpartum, the nurse should assess the client for which of the following common adverse effects of the medication?

- 1. Vertigo and confusion.
- 2. Nausea and diarrhea.
- 3. Restlessness and increased vaginal bleeding.
- 4. Headache and hypertension.

**91.** A 30-year-old woman, G 4, P 4, has delivered a healthy term female neonate by cesarean delivery due to a nonreassuring fetal heart rate tracing. At 2 hours postpartum, the nurse assesses the client's retention catheter and observes that the client's urine is slightly red tinged. Which of the following should the nurse do next?

- 1. Continue to monitor the client's input and output.
- 2. Palpate the client's fundus gently every 15 minutes.
- 3. Assess the placement of the retention catheter.
- 4. Contact the client's physician for further orders.

**92.** While changing the neonate's diaper, the client asks the nurse about some red-tinged drainage from the neonate's vagina. Which of the following responses would be **most** appropriate?

- 1. "It's of no concern because it is such a small amount."
- 2. "The cause is usually related to swallowing blood during the delivery."
- 3. "Sometimes baby girls have this from hormones received from the mother."
- 4. "This vaginal spotting is caused by hemorrhagic disease of the newborn."

**93.** Four hours after cesarean delivery of a neonate weighing 4,000 g (8 lb, 13 oz), the primiparous client asks, "If I get pregnant again, will I need to have a cesarean?" When responding to the client, the nurse should base the response to the client about vaginal birth after cesarean delivery (VBAC) on which of the following?

- 1. VBAC may be possible if the client has not had a classic uterine incision.
- 2. A history of rapid labor is a necessary criterion for VBAC.
- 3. A low transverse incision contraindicates the possibility for VBAC.
- 4. VBAC is not possible because the neonate was large for gestational age.

**94.** A client who had a cesarean delivery 24 hours ago complains of pain from abdominal distention. The client has been on nothing-by-mouth status for the past 36 hours. The nurse should:

- 1. Offer the client a carbonated beverage twice daily.
- 2. Tell the client to use a straw when drinking fluids.
- 3. Limit the client to a soft diet until more bowel sounds exist.
- 4. Encourage ambulation in the hallway.

**95.** A primiparous client who underwent a cesarean delivery 30 minutes ago is to receive Rho(D) immune globulin (RhoGAM). The nurse should administer the medication within which of the following time frames after delivery?

- 1. 8 hours.
- 2. 24 hours.
- 3. 72 hours.
- 4. 96 hours.

**96.** While the nurse is caring for a primiparous client with cephalopelvic disproportion 4 hours after a cesarean delivery, the client requests assistance in breast-feeding. To promote maximum maternal comfort, which of the following would be **most** appropriate for the nurse to suggest?

- 1. Football hold.
- 2. Scissors hold.
- 3. Cross-cradle hold.
- 4. Cradle hold.

### The Postpartal Client with Complications

**97.** While assessing the fundus of a multiparous client 36 hours after delivery of a term neonate, the nurse notes a separation of the abdominal muscles. What action should the nurse take based on this assessment?

- 1. Notify the health care provider of the separation.
- 2. Discuss with the client that no further action is needed.
- 3. Demonstrate exercises involving head and shoulder lifting.
- 4. Refer the client to a surgeon for surgical repair after 6 weeks postpartum.

**98.** A multiparous client at 24 hours postpartum demonstrates a positive Homan's sign with discomfort. The nurse should:

- 1. Place a cold pack on the client's perineal area.
- 2. Place the client in a semi-Fowler's position.
- 3. Notify the client's physician immediately.
- 4. Ask the client to ambulate around the room.

**99.** Prophylactic heparin therapy is ordered to treat thrombophlebitis in a multiparous client who delivered 24 hours ago. After instructing the client about the medication, the nurse determines that the client understands the instructions when she states which of the following as the purpose of the drug?

- 1. To thin the blood clots.
- 2. To increase the lochial flow.
- 3. To increase the perspiration for diuresis.
- 4. To prevent further blood clot formation.

**100.** While caring for a primipara diagnosed with deep vein thrombosis at 48 hours postpartum who is receiving treatment with bed rest and intravenous heparin therapy, the nurse should contact the client's physician immediately if the client exhibited which of the following?

- 1. Pain in her calf.
- 2. Dyspnea.
- 3. Hypertension.
- 4. Bradycardia.

**101.** A primiparous client 3 days postpartum is to be discharged on heparin therapy. After teaching her about possible adverse effects of heparin therapy, the nurse determines that the client needs further instruction when she states that the adverse effects include which of the following?

- 1. Epistaxis.
- 2. Bleeding gums.
- 3. Slow pulse.
- 4. Petechiae.

**102.** After being treated with heparin therapy for thrombophlebitis, a multiparous client who delivered 4 days ago is to be discharged on oral warfarin (Coumadin). After teaching the client about the medication and possible effects, which of the following client statements indicates successful teaching?

- 1. "I can take two aspirin if I get uterine cramps."
- 2. "Protamine sulfate should be available if I need it."
- 3. "I should use a soft toothbrush to brush my teeth."
- 4. "I can drink an occasional glass of wine if I desire."

**103.** A nurse is explaining basic principles of asepsis and infection control to a client who has a respiratory track infection following delivery. The nurse determines the client understands principles of infection control to follow when the client says:

- 1. "I must use barrier isolation."
- 2. "I must wear a gown and gloves."
- 3. "I must use individual client care equipment."
- 4. "I must practice frequent hand washing."

**104.** A postpartum multiparous client diagnosed with endometritis is to receive intravenous antibiotic therapy with ampicillin sodium (Polycillin). Before administering this drug, the nurse must do which of the following?

- 1. Ask the client if she has any drug allergies.
- 2. Assess the client's pulse rate.
- 3. Place the client in a side-lying position.
- 4. Check the client's perineal pad.

**105.** Which of the following would be most important for the nurse to encourage in a primiparous client diagnosed with endometritis who is receiving intravenous antibiotic therapy?

- 1. Ambulate to the bathroom frequently.
- 2. Discontinue breast-feeding temporarily.
- 3. Maintain bed rest in Fowler's position.
- 4. Restrict visitors to prevent contamination.

**106.** Which of the following measures would the nurse expect to include in the teaching plan for a multiparous client who delivered 24 hours ago and is receiving intravenous antibiotic therapy for cystitis?

- 1. Limiting fluid intake to 1 L daily to prevent overload.
- 2. Emptying the bladder every 2 to 4 hours while awake.
- 3. Washing the perineum with povidone iodine (Betadine) after voiding.
- 4. Avoiding the intake of acidic fruit juices until the treatment is discontinued.

**107.** A primiparous client diagnosed with cystitis at 48 hours postpartum who is receiving intravenous ampicillin asks the nurse, "Can I still continue to breast-feed my baby?" The nurse should tell the client:

- 1. "You can continue to breast-feed as long as you want to do so."
- 2. "Alternate your breast-feeding with formula feeding to help you rest."
- 3. "You'll need to discontinue breast-feeding until the antibiotic therapy is stopped."
- 4. "You'll need to modify your technique by manually pumping your breasts."

**108.** Four days after a vaginal delivery, the client visits the clinic complaining of excessive lochia rubra with clots. The physician orders methylergonovine maleate (Methergine), 0.2 mg intramuscularly. Before administering this drug, the nurse should assess:

- 1. Blood pressure.
- 2. Pulse rate.
- 3. Breath sounds.
- 4. Bowel sounds.

**109.** During the first hour after delivery, assessment of a multiparous client who delivered a neonate weighing 4,593 g (10 lb, 2 oz) by cesarean delivery reveals a soft fundus with excessive lochia rubra. The nurse should include which of the following in the client's plan of care?

- 1. Administration of intravenous oxytocin.
- 2. Placement of the client in a side-lying position.
- 3. Rigorous fundal massage every 5 minutes.
- 4. Preparation for an emergency hysteromyomectomy.

**110.** A primiparous client who was diagnosed with hydramnios and breech presentation while in early labor is diagnosed with early postpartum hemorrhage at 1 hour after a cesarean delivery. The client asks, "Why am I bleeding so much?" The nurse responds based on the understanding that the most likely cause of uterine atony in this client is which of the following?

- 1. Trauma during labor and delivery.
- 2. Moderate fundal massage after delivery.
- 3. Lengthy and prolonged second stage of labor.
- 4. Overdistention of the uterus from hydramnios.

**111.** Thirty-six hours after a vaginal delivery, a multiparous client is diagnosed with endometritis due to b-hemolytic streptococcus. When assessing the client, which of the following would the nurse expect to find?

- 1. Profuse amounts of lochia.
- 2. Abdominal distention.
- 3. Nausea and vomiting.
- 4. Odorless vaginal discharge.

**112.** A multiparous client visits the urgent care center 5 days after a vaginal delivery experiencing persistent lochia rubra in a moderate to heavy amount. The client asks the nurse, "Why am I continuing to bleed like this?" The nurse should instruct the client that this type of postpartum bleeding is usually caused by which of the following?

- 1. Uterine atony.
- 2. Cervical lacerations.
- 3. Vaginal lacerations.
- 4. Retained placental fragments.

**113.** A 26-year-old primiparous client is seen in the urgent care clinic 2 weeks after delivering a viable female neonate. The client, who is breast-feeding, is diagnosed with infectious mastitis of the right breast. The client asks the nurse, "Can I continue breast-feeding?" The nurse should tell the client:

- 1. "You can continue to breast-feed, feeding your baby more frequently."
- 2. "You can continue once your symptoms begin to decrease."
- 3. "You must discontinue breast-feeding until antibiotic therapy is completed."
- 4. "You must stop breast-feeding because the breast is contaminated."

**114.** A primiparous client who had a vaginal delivery 1 hour ago voices anxiety because she has a nephew with Down syndrome. After teaching the client about Down syndrome, which of the following client statements indicates the need for additional teaching?

- 1. "Down syndrome is an abnormality that can result from a missing chromosome."
- 2. "Down syndrome usually results in some degree of mental retardation."
- 3. "There are several methods available to determine whether my baby has Down syndrome."
- 4. "Older mothers are more likely to have a baby with chromosomal abnormalities."

**115.** A 15-year-old unmarried primiparous client is being cared for in the hospital's birthing center after vaginal delivery of a viable neonate. The neonate is being placed for adoption through a social service agency. Four hours postpartum, the client asks if she can feed her baby. Which of the following responses would be **most** appropriate?

- 1. "I'll bring the baby to you for feeding."
- 2. "I think we should ask your physician if this is a good idea."
- 3. "It's not a good idea for you to have any contact with the baby."
- 4. "I'll check with the social worker to see if the adopting parents will permit this."

**116.** After teaching a primiparous client about treatment and self-care of infectious mastitis of the right breast, the nurse determines that the client needs further instruction when she states which of the following?

- 1. "I can apply localized heat to the infected area."
- 2. "I should increase my fluid intake to 2,000 mL per day."
- 3. "I'll need to take antibiotics for 7 to 10 days before I am cured."
- 4. "I should begin breast-feeding on the right side to decrease the pain."

**117.** During a home visit to a primiparous client who delivered vaginally 14 days ago, the client says, "I've been crying a lot the last few days. I just feel so awful. I am a rotten mother. I just don't have any energy. Plus, my husband just got laid off from his job." The nurse observes that the client's appearance is disheveled. Which of the following would be the nurse's best response?

- 1. "These feelings commonly indicate symptoms of postpartum blues and are normal. They'll go away in a few days."
- 2. "I think you're probably overreacting to the labor and delivery process. You're doing the best you can as a mother."
- 3. "It's not unusual for some mothers to feel depressed after the birth of a baby. I think I should contact your doctor."
- 4. "This may be a symptom of a serious mental illness. I think you should probably go to the hospital."

### Managing Care Quality and Safety

**118.** The nurse is catheterizing a client who cannot void after a normal delivery 8 hours ago. The nurse begins the catheterization process and the client asks the nurse if Betadine was used to clean the meatus for the catheterization. The nurse realizes that the client is allergic to Betadine and the client is reacting to the cleansing agent. The nurse should take the following steps in order of priority from first to last.

1. Document incident.

2. Clean Betadine from client's vaginal area.

3. Notify physician ordering catheterization.

4. Ask client what her reaction is when exposed to Betadine.

5. File an incident report.

**119.** A nurse is walking down the hall in the main corridor of a hospital. The Code Pink infant security alert system sounds and a Code Pink alert is announced. The first responsibility of the nurse when this situation occurs is to do which of the following?

- 1. Move to the entrance of the hospital and check each person leaving.
- 2. Go to the obstetrics unit to determine if they need help with the situation.
- 3. Call the nursery to ask which baby is missing.
- 4. Observe individuals in the area for large bags or oversized coats.

**120.** The nurse on a mother-baby unit who is working on the night shift is revising the planning worksheet for the remaining 2 hours of the shift. The nurse has the following tasks and orders to complete prior to the 7 a.m. change of shift. Using the work plan below, how should the nurse organize the following tasks so that everything is completed by 7 a.m.?

- 1. Draw blood for the ordered laboratory tests (CBCs) on 3 postpartum clients with report on charts by shift change.
- 2. Start IV of D5 ½ NS at keep vein open (KVO) rate on postpartum client just prior to change of shift.
- 3. Complete admission assessment of newborn turned over to nurse at 5 a.m.
- 4. Draw newborn bilirubin level at 6 a.m.

#### Nurse Worksheet

5:00	
5:30	
6:00	
6:30	

**121.** The nurse on the postpartum mother-baby unit is assigned to take care of four couplets and a new couplet will be admitted within the next 30 minutes. All assessments are complete. The nurse can delegate care for which couplet to the unlicensed nursing personnel?

- 1. A G1 P1 with gestational diabetes who is 12 hours postpartum and who still requires insulin.
- 2. A G4 P4 who is breast-feeding an 8 lb infant without difficulty.
- 3. A G3 P3 postpartum client who is receiving Magnesium Sulfate and whose infant has a respiratory rate of 20.
- 4. A G2 P2 who delivered vaginally 2 days ago with an infant having low blood glucose levels the first 24 hours post delivery.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Postpartal Client with a Vaginal Birth

**1. 4.** The hospital identification procedures for mothers and infants needs to be completed each time a newborn is returned to a family's room. It does not matter how well the nurse knows the mother and infant, this validation is a standard of care in an obstetrical setting. Assessing the mother's ability to ambulate, asking the mother if there is anything else she needs to care for the infant, and checking the crib to determine if there are enough supplies are important steps that are part of the process of transferring a baby to the mother, but identification verification is a safety measure that must occur first.

🔑 CN: Safety and infection control;  
CL: Create

**2. 3.** At any point in the postpartum period, the lochia should be dark in color, rather than bright red. The volume should not be great enough to trickle or run from the vagina. The information provided states the fundus is firm, midline, and at the umbilicus, which are the expected outcomes at this point postpartum. These findings would indicate to the nurse that the bleeding is not coming from the uterus or from uterine atony. The bladder is not palpable, which indicates that the bleeding is not related to a full bladder, which is further validated by the fundus being at the umbilicus. The most likely etiology is cervical or vaginal lacerations or tears. The nurse is unable to do anything to stop this type of bleeding and must notify the health care provider. Increasing the I.V. rate will not decrease the amount or type of vaginal bleeding. Rechecking the hematocrit and hemoglobin will only provide background information for the nurse and identify the beginning levels for this mother, rather than where she is now. It will do nothing to stop the bleeding. The bleeding level and color is not normal and documenting such findings as normal is incorrect.

🔑 CN: Management of care; CL: Synthesize

**3. 4.** Within the first 24 hours postpartum, the maternal temperature may increase to 100.4°F, a normal postpartum finding attributed to dehydration. A temperature higher than 100.4°F after the first 24 hours indicates a potential for infection. Hemoconcentration is a normal finding postpartum due to the remobilization and rapid loss of excess body fluids. WBC count is normally elevated as a response to the inflammation, pain, and stress of the birthing process. A pulse rate of 60 bpm is normal at this period and results from an increased cardiac output (mobilization of excess extracellular fluid into the vascular bed, decreased pressure from the uterus on vessels, blood flow back to the heart from the uterus returning to the central circulation) and alteration in stroke volume.

🔑 CN: Physiological adaptation;  
CL: Analyze

**4. 4.** Uterine massage enables immediate contraction of the uterus to prevent bleeding. In-and-out catheterization relieves bladder distention, eliminates displacement, firms the uterus, and prevents uterine bleeding. A bladder scan is not necessary because the nurse is able to palpate the full bladder. The positioning of the uterus indicates a full bladder. An indwelling urinary catheter is not necessary because most clients spontaneously void within 12 hours. The use of an NSAID will help reduce the inflammation that may be present but its action is not immediate and the status of the fundus needs more immediate interventions because of the risk of postpartum hemorrhage associated with a full bladder.

🔑 CN: Management of care; CL: Synthesize

**5. 2.** Pain medication is the first strategy to initiate at this pain level. When trauma has occurred to any area, the usual intervention is ice for the first 24 hours and heat after the first 24 hours. Sitz baths are initiated at the conclusion of ice therapy. Ice has already been initiated and will prevent further edema to the rectal sphincter and perineum and continue to reduce some of the pain. Anesthetic sprays can also be utilized for the perineal area when pain is involved but would not lower the pain to a level that the client considers tolerable.

🔑 CN: Physiological adaptation;  
CL: Synthesize

**6. 3.** Stage four is the first 2 to 4 hours postpartum. At this time, the nurse should frequently assess maternal vital signs, the fundus, bladder status, and lochia. The vital signs indicate the ability of the client to transition from pregnancy to postpartum and the physical status of the mother. The maternal fundus should remain firm, midline, and at the umbilicus or lower. A bladder that is distended


may displace the normally firm uterus and cause hemorrhage. The lochia is assessed for color, odor, and amount postpartum. Assessment of the mother's ability to push, hydration, emotional stability, contraction patterns, and fetal heart tones is important in stages one and two. Maternal vital signs will be assessed during all stages of labor. Maternal emotional status and infant bonding and feeding preferences are lower priorities than the physical well-being of the mother.

 CN: Reduction of risk potential;  
CL: Analyze

**7. 2.** Educating the client about caring for herself and her infant are the two highest priority goals. Following delivery, all mothers, especially the primigravida, require instructions regarding self-care and infant care. Learning needs should be assessed in order to meet the specific needs of each client. Bonding is significant, but is only one aspect of the needs of this client and the bonding process would have been implemented immediately postpartum, rather than waiting 2 hours. Planning the discharge occurs after the initial education has taken place for mother and infant and the nurse is aware of any need for referrals. Safety is an aspect of education taught continuously by the nurse and should include maternal as well as newborn safety.


 CN: Management of care; CL: Create

**8. 3.** The client is in the taking hold phase with a demonstrated focus on the neonate and learning about and fulfilling infant care and needs. The taking in phase is the first period after delivery where there is emphasis on reviewing and reliving the labor and delivery process, concern with self and needing to be mothered. Eating and sleep are high priorities during this phase. Taking on is not a phase of postpartum psychological adaptation. Letting go is the process beginning about 6 weeks postpartum when the mother may be preparing to go back to work. During this time, she can have other individuals assume care of the infant and begins the separation process.


 CN: Psychosocial adaptation;  
CL: Analyze

**9. 1.** A urine toxicology screening will be collected to document that the infant has been exposed to illegal drug use. This documentation will be the basis for legal action for the protection of this infant. If the infant tests positive for cocaine, the legal system will be activated to provide and ensure protective custody for this child. Hospital security would not become involved unless the mother is obtaining or using drugs on hospital premises. The mother and infant have the same privileges as any hospitalized clients unless the safety of the infant is jeopardized, thus limiting contact with visitors would


not be appropriate. Local law enforcement agencies would be contacted only if the mother initiates use of the drugs on hospital premises and such contact would be made through the hospital security system.

 CN: Physiological adaptation;  
CL: Synthesize


**10. 4.** Acetaminophen and hydrocodone (Vicodin) would be the drug of choice for this situation because the pain level is so high. Aspirin is not usually used because of the bleeding risk associated with its use. Although ibuprofen would typically be a good choice because it inhibits the prostaglandin synthesis associated with a multiparous client breast-feeding, the pain level is too high for this drug to have an acceptable effect. Docusate (Colace) is used as a stool softener postpartum but does not provide pain relief.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**11. 1.** Immediately after delivery of the placenta, the nurse would expect to palpate the fundus halfway between the umbilicus and the symphysis pubis. Within 2 hours postpartum, the fundus should be palpated at the level of the umbilicus. The fundus remains at this level or may rise slightly above the umbilicus for approximately 12 hours. After the first 12 hours, the fundus should decrease one fingerbreadth (1 cm) per day in size. By the ninth or tenth day, the fundus usually is no longer palpable.

 CN: Health promotion and maintenance;  
CL: Apply

**12. 2.** The instillation of erythromycin into the neonate's eyes provides prophylaxis for ophthalmia neonatorum, or neonatal blindness caused by gonorrhea in the mother. Erythromycin is also effective in the prevention of infection and conjunctivitis from *Chlamydia trachomatis*. The medication may result in redness of the neonate's eyes, but this redness will eventually disappear. Erythromycin ointment is not effective in treating neonatal chorioretinitis from cytomegalovirus. No effective treatment is available for a mother with cytomegalovirus. Erythromycin ointment is not effective in preventing cataracts. Additionally, neonatal infection with beta-hemolytic streptococcus results in pneumonia, bacterial meningitis, or death. Cataracts in the neonate may be congenital or may result from maternal exposure to rubella. Erythromycin ointment is also not effective for preventing and treating strabismus (crossed eyes). Infants may exhibit intermittent strabismus until 6 months of age.

 CN: Pharmacological and parenteral therapies; CL: Apply


**13. 3.** Phytonadione (vitamin K or AquaMEPHY-TON) acts as a preventive measure against neonatal hemorrhagic disease. At birth, the neonate does not have the intestinal flora to produce vitamin K, which is necessary for coagulation. Hypoglycemia is prevented and treated by feeding the infant. Hyperbilirubinemia severity can be decreased by early feeding and passage of meconium to excrete the bilirubin. Hyperbilirubinemia is treated with phototherapy. Polycythemia may occur in neonates who are large for gestational age or post-term. Clamping of the umbilical cord before pulsations cease reduces the incidence of polycythemia. Generally, polycythemia is not treated unless it is extremely severe.

 CN: Pharmacological and parenteral therapies; CL: Apply

**14. 3.** The first 12 hours after delivery are part of the taking-in phase of maternal postpartum adjustment, which typically lasts from 1 to 3 days. During the taking-in phase, the client is primarily concerned with her own needs. After the first 1 to 3 days postpartum, the client is in the taking-hold phase and can focus more on the needs of the neonate. Although the family is an important unit of care and the significant other is important for the mother's emotional support, during the taking-in phase the mother is focused on herself.

 CN: Health promotion and maintenance; CL: Analyze

**15. 1.** The client has a hematoma. During the first 24 hours postpartum, ice packs can be applied to the perineal area to reduce swelling and discomfort. Ice packs usually are not effective after the first 24 hours. Although vital signs, including temperature, are important assessments, taking the client's temperature is unrelated to the hematoma and would provide no additional information about swelling. After 24 hours, the client may obtain more relief by taking a warm sitz bath. This moist heat is an effective way to increase circulation to the perineum and provide comfort. Usually, hematomas resolve without further treatment within 6 weeks. Additionally, the nurse should measure the hematoma to provide a baseline for subsequent measurements and should notify the physician of its presence. An antibiotic is not warranted at this point because the client is not exhibiting any signs or symptoms of infection.

 CN: Health promotion and maintenance; CL: Synthesize

**16. 4.** Urinary retention soon after delivery is usually caused by edema and trauma of the lower urinary tract; this commonly results in difficulty with initiating voiding. Hyperemia of the bladder mucosa also commonly occurs. The combination of hyperemia and edema predisposes to decreased sensation to void, overdistention of the bladder, and incomplete

bladder emptying. A prolonged first stage of labor can contribute to exhaustion and uterine atony, not urinary retention. If the client had a urinary tract infection, she would exhibit symptoms such as dysuria and a burning sensation. After delivery, the uterus is contracting, which leads to less pressure on the bladder. Pressure of the uterus on the bladder occurs during labor.

 CN: Health promotion and maintenance; CL: Analyze

**17. 2.** For clients who are bottle-feeding, the menstrual flow should return in 6 to 10 weeks, after a rise in the production of follicle-stimulating hormone by the pituitary gland. Nonlactating mothers rarely ovulate before 4 to 6 weeks postpartum. Therefore, 3 to 4 weeks is too early for the menstrual cycle to resume. For women who are breast-feeding, the menstrual flow may not return for 3 to 4 months (12 to 16 weeks) or, in some women, for the entire period of lactation, because ovulation is suppressed.

 CN: Health promotion and maintenance; CL: Apply

**18. 4.** The client's dizziness is most likely caused by orthostatic hypotension secondary to the decreased volume of blood in the vascular system resulting from the physiologic changes occurring in the mother after delivery. The client is experiencing dizziness because not enough blood volume is available to perfuse the brain. The nurse should first allow the client to "dangle" on the side of the bed for a few minutes before attempting to ambulate. By 6 hours postpartum, the effects of the anesthesia should be worn off completely. Typically, the effects of epidural anesthesia wear off by 1 to 2 hours postpartum, and the effects of local anesthesia usually disappear by 1 hour. The client scenario provides no information to indicate that the client experienced any postpartum hemorrhage. Normal blood loss during delivery should not exceed 500 mL.

 CN: Health promotion and maintenance; CL: Apply

**19. 4.** Because the diet of Hispanic Americans from Mexico and Central America commonly includes beans, corn products, tomatoes, chili peppers, potatoes, milk, cheeses, and eggs, the nurse needs to encourage an intake of meats, dark green leafy vegetables, and other high-protein products that are rich in iron. Doing so helps to compensate for the significant blood loss and subsequent iron loss that occurs during the postpartum period. Additionally, fresh fruits, meats, and green leafy vegetables may be scarce, possibly resulting in deficiencies of vitamin A, vitamin D, and iron. Tomatoes are high in vitamin C, potatoes are good sources of carbohydrates and vitamin C, and corn products are high in thiamine, but these are not rich sources of iron.

 CN: Health promotion and maintenance; CL: Create

**20. 4.** A small, constant trickle of blood and a firm fundus are usually indicative of a vaginal tear or cervical laceration. If the client had retained placental tissue, the fundus would fail to contract fully (uterine atony), exhibiting as a soft or boggy fundus. Also, vaginal bleeding would be evident. Uterine inversion occurs when the uterus is displaced outside of the vagina and is obvious on inspection. Bladder distention may result in uterine atony because the pressure of the bladder displaces the fundus, preventing it from fully contracting. In this case the fundus would be soft, possibly boggy, and displaced from midline.

 CN: Reduction of risk potential;  
CL: Analyze


**21. 4.** On about the eleventh postpartum day, the lochia should be lochia alba, clear or white in color. Lochia rubra, which is dark red to red, may persist for the first 2 to 3 days postpartum. From day 3 to about day 10, lochia serosa, which is pink or brown, is normal.

 CN: Health promotion and maintenance;  
CL: Evaluate

**22. 2.** The nurse should instruct the client to cleanse the perineal area with warm water and to wipe from front to back with a blotting motion. Warm water is soothing to the tender tissue, and wiping from front to back reduces the risk of contamination. Hot, sudsy water may increase the client's discomfort and may even burn the client in a very tender area. After the first 24 hours, warm water sitz baths taken three or four times a day for 20 minutes can help increase circulation to the area. Ice packs are helpful for the first 24 hours.

 CN: Health promotion and maintenance;  
CL: Evaluate

**23. 3.** After explaining the procedure to the client, the nurse should wash hands and don clean gloves for the procedure. Washing the hands prevents the spread of infection. Standard precautions are necessary to protect both the client and the nurse. The temperature of the water should be between 100° and 105° F (37.4° and 40° C) to prevent burns. Spraying the perineal area with the ordered analgesic spray is done after the sitz bath to provide the greatest pain relief. Assessing the client's perineum for swelling and redness is part of the nursing assessment and needs to be done after hand washing and donning clean gloves. Also, the assessment would be done before the nurse explains the procedure.

 CN: Safety and infection control;  
CL: Synthesize

**24. 3.** After an uncomplicated delivery, postpartum exercises may begin on the first postpartum day with exercises to strengthen the abdominal muscles. These are done in the supine position with the knees flexed, inhaling deeply while allowing the abdomen to expand and then exhaling while contracting the abdominal muscles. Exercises such as sit-ups (sitting, then lying back, and returning to a sitting position) and push-ups or exercises involving reaching for the knees are ordinarily too strenuous for the first postpartum day. Sit-ups may be done later in the postpartum period, after approximately 3 to 6 weeks.

 CN: Health promotion and maintenance;  
CL: Apply

**25. 2.** Lochia can be expected to increase when the client first ambulates. Lochia tends to pool in the uterus and vagina when the client is recumbent and flows out when the client arises. If the client had reported that her lochia was bright red, the nurse would suspect bleeding. In this situation, the client would be put back in bed and the physician would be notified. Early postpartum hemorrhage occurs during the first 24 hours, but typically the fundus is soft or "boggy." The client's fundus here is firm and midline. Late postpartal hemorrhage, occurring after the first 24 hours, is usually caused by retained placental fragments or abnormal involution of the placental site.

 CN: Health promotion and maintenance;  
CL: Synthesize

**26. 4.** After delivery, the nurse should plan to measure the client's first two voidings and record the amount to make sure that the client is emptying the bladder. Frequent voidings of less than 150 mL suggest that the client is experiencing urinary retention. In addition, if urinary retention is occurring, the bladder may be palpable and the fundus may be displaced from midline. The client does not need to be catheterized unless there is evidence of urinary retention. Palpation of the bladder before voiding is unnecessary. However, if the client has difficulty voiding or exhibits signs of urinary retention, then bladder palpation is indicated. The fundus can be displaced by a full bladder and should be assessed after the client voids.

 CN: Health promotion and maintenance;  
CL: Synthesize

**27. 2.** Clients sometimes feel faint or dizzy when taking a shower for the first time after delivery because of the sudden change in blood volume in the body. Primarily for this reason, the nurse remains nearby while the client takes her first shower after delivery. If the client becomes dizzy or expresses symptoms of feeling faint, the nurse should get the client back to bed as soon as possible. If the client



faints while in the shower, the nurse should cover the client to protect her privacy, stay with the client, and call for assistance. Fatigue postpartum is common and will precede taking a shower. Diuresis is a normal physiologic response during the postpartum period and not associated with showering. Hygiene needs also precede the shower.

 CN: Safety and infection control;  
CL: Analyze

**28. 2.** The nurse should instruct the client to squeeze or contract the muscles of the buttocks together before sitting down in the chair; this contracts the pelvic floor muscles, which reduces the tension on the tender perineal area. Then the client should put her full weight slowly down on the chair. Pain medication may only be ordered for every 3 to 4 hours, so the client may not be able to receive pain medication every time she desires to sit in the chair. The episiotomy pain usually fades by the fifth or sixth postpartum day. Maintaining a relaxed posture before sitting does not contract the pelvic floor muscles. Most physicians order an analgesic cream or spray when a client has an episiotomy, but they provide only temporary relief.

 CN: Health promotion and maintenance;  
CL: Synthesize

**29. 1.** Neonates like to look at eyes, and eye-to-eye contact is a highly effective way to provide visual stimulation. The parent's eyes are circular, move from side to side, and become larger and smaller. Neonates have been observed to fix on them. In general, neonates prefer circular objects of darkness against a white background. Sharp black and white images of geometric figures are appropriate. Use of bright colors on the walls and moving a colorful rattle do not provide as much visual stimulation as eye-to-eye contact with talking. Brightly colored animals and cartoon figures are more appropriate at approximately 1 year of age.

 CN: Health promotion and maintenance;  
CL: Create

**30. 2.** The father is praying to Allah because of the Muslim belief that the first sounds a child hears should be from the Koran in praise of and supplication to Allah. Although male children are revered in this culture, this practice is performed by Muslims whether the child is male or female. The father's actions are unrelated to his wife and son's being healthy. The nurse should allow the practice because doing so demonstrates cultural sensitivity and builds a trusting relationship with the family. The Muslim faith does not have a baptism rite whereby the child becomes a member of the faith.

 CN: Health promotion and maintenance;  
CL: Analyze

**31. 2.** According to Erikson, infants are in the trust versus mistrust stage. Holding, talking to, singing to, and patting neonates helps them develop trust in caregivers. Tactile stimulation is important and should be encouraged. Holding neonates often is unlikely to spoil them because they are totally dependent on other human beings to meet their needs. Being held makes infants feel loved and cared for and should be encouraged. The mother can hold the neonate as often as she wants, not just when the baby is crying or fussy. Overstimulation typically does not result from holding an infant.

 CN: Health promotion and maintenance;  
CL: Synthesize

**32. 4.** Excessive perspiration and diuresis is common during the puerperium as the body attempts to return to its prepregnant state. The most appropriate nursing diagnosis is *Excess fluid volume* related to normal postpartal diuresis. A temperature of 99° F (37.2° C) is normal during the first 24 hours postpartum. Foul-smelling lochia and a temperature higher than 100.4° F (38° C) would suggest an infection. Although hormonal shifts occur during the postpartum period, the client's diaphoresis is related to diuresis, not to a problem with thermoregulation caused by hormonal changes. No evidence is presented to suggest altered renal tissue perfusion related to the client's multiparity status. Clients with renal disease or renal failure may exhibit painful urination, flank pain, or lack of urinary output.

 CN: Health promotion and maintenance;  
CL: Analyze

**33. 4.** If the client continues to complain of perineal pain after an analgesic medication has been given, the nurse should inspect the client's perineum for a hematoma, because this is the usual cause of such discomfort. Ibuprofen is a nonsteroidal anti-inflammatory medication used to relieve mild pain. Pain from a perineal hematoma can be moderate to severe, possibly requiring a stronger analgesic, such as acetaminophen with codeine (Tylenol with Codeine). Ice applied to the perineum during the first 24 hours postpartum may decrease the severity of hematoma formation. Application of warm heat, such as a sitz bath three times daily for 20 minutes, also can help to relieve the discomfort when implemented after the first 24 hours. Typically hematomas resolve themselves within 6 weeks. A puerperal infection would be indicated if the client's temperature were 100.4° F (41° C) or higher. Also, lochia most likely would be foul smelling. A continuous trickle of lochia rubra would suggest a possible vaginal laceration. No evidence is presented to suggest a history of drug abuse.

 CN: Reduction of risk potential;  
CL: Analyze

**34. 1, 4, 6.** Delegating care to unlicensed assistive personnel requires that the nurse knows which tasks are within their capability. Changing the perineal pad and reporting drainage, reinforcing hygiene with perineal care, and assisting with ambulation are within the individual's capacity. Unlicensed assistive personnel should never be asked to complete any assessments, such as checking fundal location or performing skilled procedures on a client. In addition, it would be above the scope for unlicensed assistive personnel to assist the mother with latching on and discussing postpartum depression with the client. State boards of nursing list the procedures and tasks that unlicensed assistive personnel can complete when directed.

 CN: Management of care; CL: Synthesize

**35. 4.** The Health Information Portability and Accountability Act (HIPAA) regulations and ethical decision making require that the nurse maintain confidentiality at all times. The nurse's best response is to explain to the client that nurses are not allowed to discuss other clients on the unit. Ignoring the client's question is inappropriate because doing so would interfere with the development of a trusting nurse-client relationship. Confidentiality must be maintained at all times. Telling the client that the nurse isn't sure may imply that the nurse will find out and then tell the client about the other woman. Asking the other woman's permission to discuss her with another client is inappropriate because confidentiality must be maintained at all times.

 CN: Management of care; CL: Apply

**36. 2.** The neonate has immature oculomotor coordination, an inability to accommodate for distance, and poorly developed eyes, visual nerves, and brain. However, the normal neonate can see objects clearly within a range of 9 to 12 inches, whether or not they are moving. Visual acuity at birth is 20/100 to 20/150, but it improves rapidly during infancy and toddlerhood. Newborns can distinguish colors as well as light from dark.

 CN: Health promotion and maintenance; CL: Apply

**37. 4.** The client is experiencing diastasis recti, a separation of the longitudinal muscles (recti) of the abdomen that is usually palpable on the third postpartum day. An exercise involving raising the head and shoulders about 8 inches with the client lying on her back with knees bent and hands crossed over the abdomen is preferred. This exercise helps to pull the abdominal muscles together and the client gradually works up to performing this exercise 50 times per day. However, until the diastasis has

closed, the client should avoid exercises that rotate the trunk, twist the hips, or bend the trunk to one side, because further separation may occur. The condition does not need a surgical repair, and limited activity and bed rest are not necessary. Correct posture and adequate diet assist the body to return to its prepregnancy state more quickly but do not resolve the separation of abdominal muscles.

 CN: Reduction of risk potential; CL: Synthesize


**38. 4.** A uterine fundus located off to one side and above the level of the umbilicus is commonly the result of a full bladder. Although the client had voided, the client may be experiencing urinary retention with overflow. If anesthesia has been used for delivery, the inability to void may be related to the lingering effects of anesthesia; however, that is not the case here. Physicians commonly write a one-time order for catheterization. After which, typically, enough edema has subsided making it easier and less painful for the client to void and completely empty her bladder. Administering ibuprofen would have no effect on the uterine fundus. Waiting to reassess in 1 hour could be detrimental since the client's distended bladder is interfering with uterine involution, predisposing her to possible hemorrhage. Administering a bolus of fluid would be inappropriate because it would only add to the client's full bladder.

 CN: Reduction of risk potential; CL: Synthesize


**39. 2.** Stretch marks, or *striae gravidarum*, are caused by stretching of the tissues, particularly over the abdomen. After delivery, the tissues atrophy, leaving silver scars. These skin pigmentations will not disappear completely. The striae gravidarum may reappear as pink streaks if the client becomes pregnant again. Special creams are not warranted because they are not helpful and may be expensive. Weight loss does not make the marks disappear. Striae gravidarum tend to run in families.

 CN: Health promotion and maintenance; CL: Synthesize

**40. 2.** In most cases, unless complications develop or the client has gained excessive weight during the antepartal period, she can expect to return to her prepregnant weight by 6 weeks. Many clients lose 14 to 20 lb by 2 weeks postpartum, primarily because of the birth of the fetus, the placenta, and fluid losses. Diet and exercise can help the client return to her prepregnant weight.

 CN: Health promotion and maintenance; CL: Apply

**41. 3.** The most appropriate nursing diagnosis based on the information provided is *Readiness for enhanced family coping*, related to the addition of a new family member. Based on the scenario, the client has the support of the boyfriend and his parents. A nursing diagnosis of *Anxiety* would be appropriate if the client verbalized anxious thoughts or feelings or worries about the situation. A nursing diagnosis of *Ineffective coping* would be appropriate if the client showed little interest in the neonate or in mothering behaviors. A nursing diagnosis of *Deficient knowledge* would be appropriate if the client expressed concerns about the financial and emotional costs of child rearing or questions about caring for the child.

 CN: Psychosocial adaptation;  
CL: Analyze


**42. 1.** The client with a third-degree laceration should be assessed for constipation, because a third-degree laceration extends into a portion of the anal sphincter. Constipation, not diarrhea, is more likely because this condition is extremely painful, possibly causing the client to be reluctant to have a bowel movement. The laceration has been sutured and should not be bleeding at 48 hours postpartum. Rectal fistulas may develop at a later time, but not at 48 hours postpartum.

 CN: Reduction of risk potential;  
CL: Create

**43. 4.** For most clients, sexual intercourse can be resumed when the lochia has stopped flowing and episiotomy pain has ceased, usually about 3 weeks postpartum. Sexual intercourse may be painful until the episiotomy has healed. The client also needs instructions about the possibility that pregnancy may occur before the return of the client's menstrual flow. The postpartum check by the health care provider typically occurs 4 to 6 weeks after delivery and most women have already had intercourse by this time. Typically, new mothers are exhausted and may not feel amorous or desirable for quite a while. In addition, the mother's physiologic responses may be diminished because of low hormonal levels, adjustments to the maternal role, and fatigue due to lack of rest and sleep.

 CN: Health promotion and maintenance;  
CL: Synthesize

**44. 3.** Docusate sodium (Colace) is a stool softener, used to assist in bowel elimination. The client is at risk for constipation because of decreased food and fluid intake and pain from the episiotomy. Numerous analgesics, such as ibuprofen (Motrin) or acetaminophen (Tylenol), could be used to treat episiotomy pain, helping the client achieve comfort and thus fall asleep. Oxytocin is used to contract the uterus.

 CN: Pharmacological and parenteral therapies; CL: Apply


**45. 1.** The nurse needs to continue to monitor the client's vital signs. During the first 24 hours postpartum it is normal for the mother to have a slight temperature elevation because of dehydration. A temperature of 100.4° F (38° C) that persists after the first 24 hours may indicate an infection. Bradycardia during the first week postpartum is normal because of decreased blood volume, diuresis, and diaphoresis. The client's respiratory rate is within normal limits. Large clots are indicative of hemorrhage. However, the client's vital signs are within normal limits and her fundus is firm and midline. Therefore, large clots and possible hemorrhage can be ruled out. The physician does not need to be notified at this time. An ice pack is not necessary because the client's temperature is within normal limits.

 CN: Health promotion and maintenance;  
CL: Synthesize


**46. 3.** The client needs more teaching when she states, "I should lie on my back as much as possible to relieve the pain." Instead, the client should lie in the Sims position as much as possible to aid venous return to the rectal area and to reduce discomfort. Gentle manual replacement of the hemorrhoid is an appropriate measure to help relieve the discomfort and prevent enlargement. Analgesic sprays and witch hazel pads are helpful in reducing the discomfort of hemorrhoids. Drinking lots of water and eating roughage aid in bowel elimination, minimizing the risk of straining and subsequent hemorrhoidal development or enlargement.

 CN: Basic care and comfort; CL: Evaluate

**47. 2.** On most postpartum units, clients on regular diets are allowed to eat whatever kinds of food they desire. Generally, foods from home are not discouraged. The nurse does not need to obtain the physician's permission. Although it is preferred, the foods do not necessarily have to be high in iron. In many Latino cultures, there is a belief in the "hot-cold" theory of disease; certain foods (hot) are preferred during the postpartum period, and other foods (cold) are avoided. Therefore, the nurse should allow the mother to bring her daughter "special foods from home." Doing so demonstrates cultural sensitivity and aids in developing a trusting relationship.

 CN: Basic care and comfort;  
CL: Synthesize


**48. 1.** Iron is best absorbed in an acid environment or with vitamin C. For maximum iron absorption, the client should take the medication with orange juice or a vitamin C supplement. Herbal tea has no effect on iron absorption. Milk decreases iron absorption. Grape juice is not acidic and therefore would have no effect on iron absorption.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**49. 1.** The client will need a 4 to 6 week postpartum checkup to assure that she has returned to a pre-pregnancy state rather than 1 week postpartum. A sports bra will provide support to the breasts and decrease the chance that her milk will come in, or will provide support if she is breast-feeding. Some postpartum clients ovulate shortly after delivery and can become pregnant before having a first period. Postpartum blues occurs within the first 4 to 5 days postpartum and usually improves within 10 days postpartum, but the nurse should instruct the client to report any signs of feeling depressed to her health care provider.

 CN: Health promotion and maintenance;  
CL: Evaluate

**50. 4.** It is believed that the process of attachment is structured so that the parents become attached to only one infant at a time. Therefore, the nurse should encourage the parents to relate to each twin individually, rather than as a unit, to enhance the attachment process. Mothers of twins are usually able to breast-feed successfully because the milk supply increases on demand. However, possible fatigue and exhaustion require that the mother rest whenever possible. It would be highly unlikely and unrealistic that each parent would be able to spend equal amounts of time with both twins. Other responsibilities, such as employment, may prevent this. The parents should try to engage assistance from family and friends, because caring for twins or other multiple births (e.g., triplets) can be exhausting for the family.

 CN: Psychosocial adaptation;  
CL: Synthesize

**51. 3.** At 12 hours postpartum, the fundus normally should be in the midline and at the level of the umbilicus. When the fundus is firm yet above the umbilicus, and deviated to the right rather than in the midline, the client's bladder is most likely distended. The client should be encouraged to ambulate to the bathroom and attempt to void, because a full bladder can prevent normal involution. A firm but deviated fundus above the level of the umbilicus is not a normal finding and if voiding does not return it to midline, it should be reported to the physician. Methylergonovine (Methergine) is used to treat uterine atony. This client's fundus is firm, not boggy or soft, which would suggest atony. Gentle massage is not necessary because there is no evidence of atony or clots.

 CN: Reduction of risk potential;  
CL: Synthesize


**52. 2, 3, 5, 6.** The nurse is responsible for providing discharge instructions that include signs and symptoms that need to be reported to the physician as well as resources and follow-up for home care

if needed. Phone numbers and health practices to promote healing, such as the use of prenatal vitamins, are also essential pieces of information. The use of birth control pills needs to be discussed with the physician. A progesterone-only pill is used if the client is breast-feeding. Oral contraceptives should be initiated according to the physician's advice. Although the client's mother may be helpful, the client's statement that she will be fine because her mother is coming indicates that she is unaware or ignoring information about valuable information and resources.

 CN: Reduction of risk potential;  
CL: Evaluate

### The Postpartal Client Who Breast-Feeds


**53. 4.** Depo-Provera is a progestin contraceptive that can reduce the initial production of breast milk. It is given to a breast-feeding woman when she returns for the 6-week postpartum check up. By this time, the milk supply is well established and will remain at that level. Depo-Provera is effective as a contraceptive for 90 days. Clients who are bottle-feeding may be given Depo-Provera prior to discharge from the hospital.

 CN: Pharmacological and parenteral therapies;  
CL: Evaluate


**54. 3.** As much of the mother's nipple and areola need to be in the infant's mouth in order to establish a latch that does not cause nipple cracks or fissures. Having the nipple and the areola deep in the infant's mouth decreases the stress on the end of the nipple, therefore decreasing pain, cracking and fissures. Breast milk has been found to heal nipples when placed on the nipple at the completion of a feeding. The length of time the baby feeds on each nipple is not a factor as long as the nipple is correctly placed in the infant's mouth.

 CN: Health promotion and maintenance;  
CL: Evaluate

**55. 1.** New mothers usually begin to produce milk at about the third day postpartum and colostrum is produced until that time. For clients who have breast-fed another infant during pregnancy, having milk shortly after delivery is not unusual. Diaphoresis and diuresis are considered normal during this time as the body excretes the additional fluids that are no longer needed after the pregnancy. Constipation may continue for several days as a result of progesterone remaining in the system, the consumption of iron, and trauma to the perineum.

 CN: Physiological adaptation;  
CL: Analyze

**56. 2.** The major reasons for afterbirth pains are breast-feeding, high parity, overdistended uterus during pregnancy, and a uterus filled with blood clots. Physiologically, afterbirth pains are caused by intermittent contraction and relaxation of the uterus. These contractions are stronger in multigravidas in order to maintain a contracted uterus. The release of oxytocin when breast-feeding also stimulates uterine contractions. There is no data to suggest any of these clients has had an overdistended uterus or currently has clots within the uterus. The G 3, P 3 client who is breast-feeding has the highest parity of the clients listed, which—in addition to breast-feeding—places her most at risk for afterbirth pains. The G 2, P 2 postcesarean client may have cramping but it should be less than the G 3, P 3 client. The G 3, P 3 client who is bottle-feeding would be at risk for afterbirth pains because she has delivered several children, but her choice to bottle-feed reduces her risk of pain.

 CN: Physiological adaptation;  
CL: Evaluate

**57. 2.** The client is exhibiting signs and symptoms of a breast infection (mastitis). The nurse should instruct her to contact her health care provider, who will likely order a prescription for antibiotics. She should continue to breast-feed the infant from both breasts. Frequent breast-feeding is encouraged rather than discontinuing the process for anyone having a breast infection. Applying warm compresses may relieve pain. However, the underlying infection indicated by the elevated temperature indicates that additional treatment with antibiotics will be needed.

 CN: Management of care; CL: Synthesize

**58. 4.** Breast-feeding consumes maternal calories and requires energy which increases the maternal basal metabolic rate and assists in lowering the maternal blood glucose level. Insulin is not transferred to the infant through breast milk. Breast-feeding is recommended for diabetic mothers because it does lower blood glucose levels. The number of antibodies in breast milk is not altered by maternal diabetes.

 CN: Physiological adaptation;  
CL: Evaluate

**59. 4.** Postpartum clients who are breast-feeding need to be cautioned about taking various medications, many of which can be passed to the infant via breast milk. Aspirin and codeine products should be avoided because the drug can increase bleeding or cause sleepiness in the infant. Medications such as ibuprofen or acetaminophen can be used to help to relieve the discomfort without causing any apparent harm to the neonate. Warm sitz baths three to four times a day for 20 minutes can be helpful in relieving the client's discomfort. Application of moist heat is soothing and increases


perineal circulation. Increased fluid (and fiber) intake promotes bowel elimination, thus preventing constipation, which can increase the client's discomfort.

 CN: Health promotion and maintenance;  
CL: Evaluate

**60. 1.** If not contraindicated for moral, cultural, or religious reasons, a condom with spermicide is commonly recommended for contraception after delivery until the client's 6-week postpartal examination. This method has no effect on the neonate who is breast-feeding. Oral contraceptives containing estrogen are not advised for women who are breast-feeding because the hormones decrease the production of breast milk. Women who are not breast-feeding may use oral contraceptive agents. The rhythm method is not effective because the client is unlikely to be able to determine when ovulation has occurred until her menstrual cycle returns. Although breast-feeding is not considered an effective form of contraception, breast-feeding usually delays the return of both ovulation and menstruation. The length of the delay varies with the duration of lactation and the frequency of breast-feeding. While abstinence is one form of birth control and safe while breast-feeding, it may not be acceptable to this couple who is asking about a method that will allow them to resume sexual relations.

 CN: Health promotion and maintenance;  
CL: Synthesize


**61. 4.** Colostrum is a thin, watery, yellow fluid composed of protein, sugar, fat, water, minerals, vitamins, and maternal antibodies (e.g., immunoglobulin A). It is important for the neonate to receive colostrum for passive immunity. Colostrum is lower in fat and lactose than mature breast milk. Colostrum does not contain vitamin K. The neonate will produce vitamin K once a feeding pattern is established. Colostrum may speed, rather than delay, the passage of meconium.

 CN: Health promotion and maintenance;  
CL: Apply

**62. 3.** Various medications can be excreted in the breast milk and affect the nursing neonate. The client should avoid all nonprescribed medications (such as acetaminophen) unless approved by the physician. Medications typically do not affect the quality of the mother's breast milk. Medications usually do not interfere with or diminish the mother's motivation to breast-feed, nor do they interfere with the mother's let-down reflex.

 CN: Health promotion and maintenance;  
CL: Apply

**63. 3.** Taking ibuprofen 200 mg orally immediately after breast-feeding helps minimize the neonate's exposure to the drug because drugs are most highly concentrated in the body soon after they are taken. Most mothers breast-feed on demand or every 2 to 3 hours, so the effects of the ibuprofen should be decreased by the next breast-feeding session. Taking the medication before going to bed is inappropriate because, although the mother may go to bed at a certain time, the neonate may wish to breast-feed soon after the mother goes to bed. If the mother takes the medication midway between feedings, then its peak action may occur midway between feedings. Breast milk is sufficient for the neonate's nutritional needs. Most breast-feeding mothers should not be encouraged to provide supplemental feedings to the infant because this may result in nipple confusion.

 CN: Pharmacological and parenteral therapies; CL: Apply

**64. 3.** During the first few days postpartum, the mother should be encouraged to nurse frequently. Breast-feeding for at least 10 minutes per side is recommended for the let-down reflex to begin. Feeding the infant whenever the infant cries is not appropriate and can lead to maternal exhaustion. Feeding for 1 to 2 minutes per side is insufficient for the let-down reflex. Also, this short period of time prevents the neonate from latching on and obtaining the needed nutrition. Initially, feeding for 10 minutes per side is sufficient until the infant becomes more comfortable with breast-feeding. Then the mother can increase the breast-feeding time gradually to 20 to 30 minutes.

 CN: Health promotion and maintenance; CL: Apply

**65. 4.** Breast-feeding stimulates oxytocin secretion, which causes the uterine muscles to contract. These contractions account for the discomfort associated with afterpains. Flatulence may occur after a cesarean delivery. However, the mother typically would complain of abdominal distention and a bloating feeling, not a "cramplike" feeling. Stretching of the tissues or healing may cause slight tenderness or itching, not cramping feelings of discomfort. Medications such as mild analgesics or stool softeners, commonly administered postpartum, typically do not cause cramping.

 CN: Health promotion and maintenance; CL: Apply

**66. 2.** For the breast-feeding client, drinking at least 8 to 10 glasses of fluid a day is recommended. Breast-feeding women need an increased intake of vitamin D for calcium absorption. A breast-feeding woman requires an extra 500 calories per day above

the recommended nonpregnancy intake to produce quality breast milk. Breast-feeding women need adequate calcium for blood clotting and strong bones and teeth.

 CN: Basic care and comfort; CL: Evaluate

**67. 2, 3, 4, 5, 6.** To maintain adequate milk supply, lactating women need to increase their calories by 500. They also need to increase protein (to 7 servings daily), fluid (4 to 5 glasses of milk plus 2 additional glasses), fat (from sparing use prepregnancy to 5 daily servings), and calcium intake (1,000 to 1,200 mg daily).

 CN: Health promotion and maintenance; CL: Evaluate

**68. 1.** Breast milk has a higher fat content than cow's milk. Thirty percent to fifty five percent of the calories in breast milk are from fat. Breast milk contains less iron than cow's milk does. However, the iron absorption from breast milk is greater in the neonate than with cow's milk. Breast milk contains less sodium and calcium than cow's milk.

 CN: Basic care and comfort; CL: Apply

**69. 4.** Lightly brushing the neonate's lips with the nipple causes the neonate to open the mouth and begin sucking. The neonate should be taught to open the mouth and grasp the nipple on his or her own. The neonate should not be forced to nurse.

 CN: Health promotion and maintenance; CL: Apply

**70. 2.** Several methods can be used to prevent nipple soreness. Placing as much of the areola as possible into the neonate's mouth is one method. This action prevents compression of the nipple between the neonate's gums, which can cause nipple soreness. Other methods include changing position with each feeding, avoiding breast engorgement, nursing more frequently, and feeding on demand. Plastic liners are not helpful because they prevent air circulation, thus promoting nipple soreness. Instead, air drying is recommended. Pulling the baby's mouth out smoothly after only 10 minutes may prevent the baby from getting the entire feeding and increases nipple soreness. Any breast milk remaining on the nipples should not be wiped off, because the milk has healing properties.

 CN: Health promotion and maintenance; CL: Synthesize

**71. 4.** Breast-fed neonates do not swallow as much air as bottle-fed neonates, but they still need to be burped. Good times to burp the neonate are when the mother switches from one breast to the other and at the end of the breast-feeding session. Neonates do not eat more if they are burped

frequently. Breast-feeding mothers are advised not to supplement the feedings with formula because this may cause nipple confusion and decrease milk production. If supplements are given, the baby still needs to be burped. Neonates who are fed every 3 hours still need to be burped.

 CN: Health promotion and maintenance;  
CL: Evaluate

**72. 3.** Stored breast milk can be safely kept in the refrigerator for up to 7 days or in a deep-freeze at 0° F (–18° C) for 12 months. Breast milk should be stored in glass containers because immunoglobulin tends to stick to plastic bottles. Breast milk can remain without refrigeration or loss of nutrients for up to 10 hours. The containers should be labeled with date, time, and amount to prevent inadvertent administration of spoiled milk. Frozen breast milk should be thawed in the refrigerator for a few hours, placed under warm tap water, then shaken.

 CN: Health promotion and maintenance;  
CL: Evaluate

**73. 4.** Oxytocin stimulates the let-down reflex when milk is carried to the nipples. A lactating mother can experience the let-down reflex suddenly when she hears her baby cry or when she anticipates a feeding. Some mothers have reported feeling the let-down reflex just by thinking about the baby. Adrenalin may increase if the mother is excited, but this hormone has no direct influence on breast-feeding. Estrogen influences development of female secondary sex characteristics and controls menstruation. Prolactin stimulates milk production.

 CN: Health promotion and maintenance;  
CL: Apply

**74. 3.** Expressing a little milk before nursing, massaging the breasts gently, or taking a warm shower before feeding also may help to improve milk flow. Although various measures such as ice, heat, and massage may be tried to relieve breast engorgement, prevention of breast engorgement by frequent feedings is the method of choice. Applying ice to the nipples does not relieve breast engorgement. However, it may temporarily relieve the discomfort associated with breast engorgement. Using lanolin on the nipples does not relieve breast engorgement and is unnecessary. Use of lanolin may cause sensitivity and irritation. Having frequent breast-feeding sessions, rather than offering the neonate a small amount of formula, is the method of choice for preventing and relieving breast engorgement. In addition, offering the neonate small amounts of formula may result in nipple confusion.

 CN: Health promotion and maintenance;  
CL: Apply

**75. 1.** The nurse should instruct the client that the baby is getting enough to eat when there are six to eight wet diapers by the fifth day of age. Other signs include good suckling sounds during feeding, dripping breast milk at the mouth, and quiet rest or sleep after the feeding. By the fourth day of age, the infant should have soft yellow stools, not transitional (greenish) stools. Falling asleep easily after feeding on the first day is not a good indicator because most infants are sleepy during the first 24 hours. Most infants regain their lost birth weight in 7 to 10 days after birth. An infant who has gained weight during the first well-baby checkup (usually at 2 weeks) is getting sufficient breast milk at feedings.

 CN: Health promotion and maintenance;  
CL: Apply

**76. 4.** The client should wean the infant gradually, eliminating one feeding at a time. The baby can be weaned to a bottle (formula) anytime the mother desires; she does not have to breast-feed for 4 months. Most infants (and mothers) develop a “favorite feeding time,” so this feeding session should be eliminated last. The client may wish to begin weaning with daytime feedings when the infant is busy.

 CN: Health promotion and maintenance;  
CL: Create

**77. 4.** Neonates normally increase breast-feeding during periods of rapid growth (growth spurts). These can be expected at age 10 to 14 days, 5 to 6 weeks, 2.5 to 3 months, and 4.5 to 6 months. Each growth spurt is usually followed by a regular feeding pattern. Lack of adequate intake to meet maternal nutritional needs is not associated with the neonate’s desire for more frequent breast-feeding sessions. However, an intake of adequate calories is necessary to produce quality breast milk. The mother’s fears about weight gain and preventing the neonate from sucking long enough are not associated with the desire for more frequent breast-feeding sessions.

 CN: Health promotion and maintenance;  
CL: Analyze


**78. 2.** Even if the nipples are sore and cracked, the mother should position the baby with the entire areola in the baby’s mouth so that the nipple is not compressed between the baby’s gums during feeding. The best method is to prevent cracked nipples before they occur. This can be done by feeding frequently and using proper positioning. Warm, moist tea bags can soothe cracked nipples because of tannic acid in the tea. Creams on the nipples should be avoided; wiping off any lanolin creams from the nipple before each feeding can cause further soreness. Feeding the baby less often for the next few days will cause engorgement (and possible neonatal weight loss),

leading to additional problems. Soap use while in the shower should be avoided to prevent drying and removal of protective oils.

 CN: Reduction of risk potential;  
CL: Synthesize

### The Postpartal Client Who Bottle-Feeds

**79. 1.** By 4 to 6 weeks postpartum, the fundus should be deep in the pelvis and the size of a non-pregnant uterus. Subinvolution, caused by infection or retained placental fragments, is a problem associated with a uterus that is larger than expected at this time. Normal expectations include a white, thick vaginal discharge, striae that are beginning to fade to silver, and breasts that are soft without evidence of milk production (in a bottle-feeding mother).

 CN: Physiological adaptation;  
CL: Analyze

**80. 4.** The use of a breast pump to remove milk is contraindicated in bottle-feeding mothers. Nipple and breast stimulation and emptying of the breasts produce milk, rather than eliminate milk production. The bottle-feeding client is discouraged from stimulating the breasts in any way. A sports bra that is well fitting provides support and decreases stimulation. (Binders are not suggested.) Having the water in a shower land on the shoulders of the mother rather than the breasts also decreases stimulation. Only water is necessary to clean nipples when breast or bottle-feeding.

 CN: Basic care and comfort; CL: Evaluate

**81. 4.** The bottle- or breast-feeding preference is the least important information to be reported to the oncoming shift. The bottle- or breast-feeding plans will be important after delivery as many mothers breast-feed within an hour after delivery. The client's obstetrical history is a higher priority because it provides information about previous birthing experience. Information on cervical effacement, dilation, and station indicates the current state of labor and is essential for planning continuity of care for this client. Nurses on the incoming shift should also know the extent of support the client will need and who is currently providing that support.

 CN: Physiological adaptation; CL: Create

**82. 3.** As a general rule, most neonates require 50 to 55 calories per pound of body weight, or about 117 calories per kilogram of weight, each day. If the neonate receives less than this amount, malnutrition may occur. More than this amount can lead to obesity.

 CN: Basic care and comfort; CL: Apply

**83. 1.** Initial regurgitation in the neonate during the first 12 to 24 hours may be caused by excessive mucus and gastric irritation from foreign substances in the stomach. After the first 24 hours, regurgitation is thought to be caused by the neonate's immature cardiac sphincter. It represents an overflow of stomach contents and is probably a result of feeding the neonate too fast or too much. A defect in the gastrointestinal system usually results in more severe symptoms. A small amount of regurgitation is normal, but vomiting or forceful fluid expulsion is not. Burping the infant often during a feeding can decrease the amount of air in the stomach from swallowing. However, burping too often can lead the neonate to become tired or fussy. Moving the infant usually does not result in regurgitation.

 CN: Health promotion and maintenance;  
CL: Apply

**84. 1.** To aid digestion, the neonate should be placed in a supine position or on the right side propped with a small blanket roll after a feeding. Placing the neonate on the right side promotes gastric emptying and digestion. Placing the neonate in a prone position has been associated with sudden infant death syndrome. Although the mother may desire to hold the infant in her lap after feeding, this is not necessary for the neonate's digestion.

 CN: Health promotion and maintenance;  
CL: Apply


**85. 2.** Pediatricians recommend that infants be given either breast milk or formula until at least 6 months of age because of the neonate's difficulty digesting solid foods. Giving solid foods too early can lead to food allergies. Because chewing movements do not begin until 7 to 9 months of age, foods requiring chewing should be delayed until this time.

 CN: Health promotion and maintenance;  
CL: Apply

**86. 1.** The client needs further instruction when she says burping should be done after 15 minutes of formula feeding. The entire feeding should take only 15 to 20 minutes, and the neonate should be burped before that time. During initial feedings, the burping should be done after each half-ounce of formula with the neonate in an upright position, patting the neonate gently on the back.

 CN: Health promotion and maintenance;  
CL: Evaluate

**87. 2.** Most babies are developmentally ready to drink independently from a cup by the age of 8 to 10 months. If the child has not mastered drinking from a cup by this time, there may be a problem with motor development that requires further investigation.

 CN: Health promotion and maintenance;  
CL: Apply




**88. 2.** Bottle “propping” is not recommended because it can lead to aspiration, delayed bonding, feelings of mistrust (Erikson), and possible otitis media. The neonate will not be overfed during bottle propping but may suck too quickly, possibly resulting in aspiration of the formula. Putting the neonate to bed with a bottle can lead to tooth decay later in the formative years, but an infant cannot hold the bottle. The cause of SIDS has not been determined. However, it is associated with placing the infant in a prone position after eating.


 CN: Reduction of risk potential;  
CL: Synthesize

### The Postpartal Client with a Cesarean Birth

**89. 3.** The client should have more active bowel sounds by this time postpartum. Ambulation will encourage passing flatus and begin peristaltic action in the gastrointestinal track. Medicating the client should be evaluated prior to ambulating but it is probably too soon because the last dose was 3 hours ago and her pain assessment rating is fairly low. Pain medications should not have codeine as a component as it decreases peristaltic activity. Incentive spirometry or asking the client to turn, cough and deep breathe are appropriate to encourage good oxygen exchange in the lungs prior to ambulation, and walking can be used concurrently with these intervention. Participating in infant care is another way to encourage the mother to move about but the primary goal would be to have her walk on the unit, a more purposeful activity.

 CN: Physiological adaptation;  
CL: Synthesize

**90. 2.** Hemabate is an oxytocic prostaglandin that causes uterine contraction in women who are bleeding heavily. Nausea, vomiting, diarrhea, and fever are common adverse effects of prostaglandin administration. Vertigo and confusion are not associated with this drug. Vaginal bleeding may occur with inadequate amounts of Hemabate if the client continues to bleed. Restlessness may result if inadequate amounts of Hemabate are used and the woman continues to bleed and goes into shock. If too large a dose is given, the client may experience headache and hypertension because Hemabate does contract smooth muscles.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**91. 4.** Slightly red-tinged urine may indicate that the bladder was accidentally cut during the cesarean delivery. The nurse should notify the physician as soon as possible about the urine color. Continuing

to monitor the client’s input and output should be done after the physician is contacted. Palpating the fundus every 15 minutes is not necessary unless the client’s fundus becomes soft or “boggy.” Assessment of the retention catheter is a normal part of the elimination assessment by the nurse, but displacement is not the cause of the red-tinged urine.

 CN: Reduction of risk potential;  
CL: Synthesize


**92. 3.** The most appropriate response would be to explain that the vaginal spotting in female neonates is associated with hormones received from the mother. Estrogen is believed to cause slight vaginal bleeding or spotting in the female neonate. The condition disappears spontaneously, so there is no need for concern. Telling the mother that it is of no concern does not allay the mother’s worry. The vaginal spotting is related to hormones received from the mother, not to swallowing blood during the delivery or hemorrhagic disease of the neonate. Anemia is associated with hemorrhagic disease.

 CN: Health promotion and maintenance;  
CL: Synthesize

**93. 1.** VBAC can be attempted if the client has not had a classic uterine incision. This type of incision carries a danger of uterine rupture. A physician must be available, and a cesarean delivery must be possible within 30 minutes. A history of rapid labor is not a criterion for VBAC. A low transverse incision is not a contraindication for VBAC. A classic (vertical) incision is a contraindication because the client has a greater possibility for uterine rupture. Estimated fetal weight greater than 4,000 g by itself is not a contraindication if the mother is not diabetic.


 CN: Health promotion and maintenance;  
CL: Apply

**94. 4.** Abdominal distention, a major source of discomfort for the postoperative client, is best relieved by having the client ambulate more frequently. Ambulation stimulates circulation and peristalsis, thereby promoting the passage of flatus. Carbonated beverages contribute to additional gas formation, as can drinking through a straw, and should be avoided. The client can progress from full liquids to soft foods and then to a regular diet, once bowel sounds are present. The client does not need to limit her diet to soft foods, but she may wish to avoid foods that increase intestinal gas, such as beans or brussel sprouts.


 CN: Basic care and comfort;  
CL: Synthesize

**95. 3.** For maximum effectiveness, RhoGAM should be administered within 72 hours postpartum. Most Rh-negative clients also receive RhoGAM during the prenatal period at 28 weeks’ gestation

and then again after delivery. The drug is given to Rh-negative mothers who have a negative Coombs test and deliver Rh-positive neonates. If there is doubt about the fetus's blood type after pregnancy is terminated, the mother should receive the medication.


 CN: Pharmacological and parenteral therapies; CL: Apply

**96. 1.** After a cesarean delivery, most mothers have the greatest comfort when the neonate is positioned in the football hold with the mother in a semi-Fowler position, supporting the neonate's head in her hand and resting the neonate's body on pillows alongside her hip. This position prevents pressure on the uterine incision yet allows the neonate easy access to the mother's breast. The scissors hold, where the mother places her hand well back on the breast to prevent touching the areola and interfering with the neonate's mouth placement, is used by the mother to hold the breast and support it during breast-feeding. The cross-cradle hold is done when the mother holds the neonate's head in the hand opposite from the breast on which the neonate will feed and the mother's arm supports the neonate's body across her lap. This position can be uncomfortable because of the pressure placed on the client's incision line. For the cradle hold, the mother cradles the infant alongside the arm at the breast on which the neonate will feed. This position also can be uncomfortable because of the pressure placed on the incision line.

 CN: Basic care and comfort;  
CL: Synthesize

### The Postpartal Client with Complications

**97. 2.** The separation of the abdominal muscles is a frequent occurrence during pregnancy and postpartum, caused by the size of the fetus and influenced by maternal hormones. The nurse should discuss the separation with the client and assure her that there are no further actions indicated. Exercises involving the head and shoulders may be initiated after the 6-week checkup to improve the muscle tone of the abdomen but exercise will not repair the separation. A referral to a surgeon for surgical repair is a personal choice of the client but would not be medically indicated for the separation.


 CN: Physiological adaptation;  
CL: Synthesize

**98. 3.** A positive Homan's sign, discomfort behind the knee or in the upper calf area on dorsiflexion of the foot, may be indicative of

thrombophlebitis. Other signs include edema and redness at the site and may be more reliable as an indicator of thrombophlebitis. The nurse should notify the physician immediately and ask the client to remain in bed to minimize the risk for pulmonary embolus, a serious consequence of thrombophlebitis should a clot dislodge. The Homan sign is observed on the client's legs, so placing an ice pack on the perineal area is inappropriate. However, ice to the perineum would be useful for episiotomy pain and swelling. The client does not need to be positioned in a semi-Fowler's position but should remain on bed rest to prevent dislodgement of a potential clot.

 CN: Reduction of risk potential;  
CL: Synthesize

**99. 4.** Heparin therapy is ordered to prevent further clot formation by inhibiting further thrombus and clot formation. Heparin, an anticoagulant, does not make blood clots thinner. An adverse effect of heparin therapy during the puerperium is increased lochia flow, so the nurse must be observant for symptoms of hemorrhage, such as heavy lochial flow. Heparin does not increase diaphoresis, which is normal for the postpartum client.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**100. 2.** A major complication of deep vein thrombosis is pulmonary embolism. Signs and symptoms, which may occur suddenly and require immediate treatment, include dyspnea, severe chest pain, apprehension, cough (possibly accompanied by hemoptysis), tachycardia, fever, hypotension, diaphoresis, pallor, shortness of breath, and friction rub. Pain in the calf is common with a diagnosis of deep vein thrombosis. Hypotension, not hypertension, would suggest a possible pulmonary embolism. It also could suggest possible hemorrhage secondary to intravenous heparin therapy. Bradycardia for the first 7 days in the postpartum period is normal.

 CN: Reduction of risk potential;  
CL: Synthesize

**101. 3.** A slow pulse (bradycardia) is normal for the first 7 days postpartum as the body begins to adjust to the decrease in blood volume and return to the prepregnant state. Adverse effects of heparin therapy suggesting prolonged bleeding include hematuria, epistaxis, increased lochial flow, and bleeding gums. Typically, tachycardia, not bradycardia, would be associated with hemorrhage. Petechiae indicate bleeding under the skin or in subcutaneous tissue.

 CN: Reduction of risk potential;  
CL: Evaluate


**102. 3.** Successful teaching is demonstrated when the client says, “I should use a soft toothbrush to brush my teeth.” Heparin therapy can cause the gums to bleed, so a soft toothbrush should be used to minimize this adverse effect. Use of aspirin and other nonsteroidal anti-inflammatory medications should be avoided because of the increased risk for possible hemorrhage. Protamine sulfate is the antidote for heparin therapy. Vitamin K is the antidote for warfarin excess. Alcohol can inhibit the metabolism of oral anticoagulants and should be avoided.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**103. 4.** Frequent hand washing is the most important aspect of infection control. The nurse can emphasize, monitor, and ensure this strategy for all who come in contact with this client. The use of gowns and gloves are appropriate when there is blood and stool. Barrier isolation and individual client care equipment are not needed in this situation.

 CN: Reduction of risk potential; CL: Evaluate

**104. 1.** Before administering ampicillin sodium (Polycillin) intravenously, the nurse must ask the client if she has any drug allergies, especially to penicillin. Antibiotic therapy can cause adverse effects, such as rash or even anaphylaxis. If the client is allergic to penicillin, the physician should be notified and ampicillin should not be given. Checking the client’s pulse rate or placing her in a side-lying position and are not necessary. Assessing the amount of lochia by checking the perineal pad is important for all postpartum clients but is not necessary before antibiotic therapy.

 CN: Pharmacological and parenteral therapies; CL: Apply

**105. 3.** The nurse should encourage the client to maintain Fowler’s position, which promotes comfort and facilitates drainage. Endometritis can make the client feel extremely uncomfortable and fatigued, so ambulation during intravenous therapy is not as important at this time. The client does not need to discontinue breast-feeding, although she may become quite fatigued and need assistance in caring for the neonate. Typically, breast-feeding would be discontinued only if the mother lacks the necessary energy. The institution’s policy regarding visitors is to be followed. However, visitors do not need to be restricted to prevent contamination because the client is not considered to be contagious. The nurse should maintain the client’s need for privacy and rest and should respect the client’s wishes related to visitors.

 CN: Reduction of risk potential; CL: Synthesize


**106. 2.** The client diagnosed with cystitis needs to void every 2 to 4 hours while awake to keep her bladder empty. In addition, she should maintain adequate fluid intake; 3,000 mL per day is recommended. Intake of acidic fruit juices (e.g., cranberry, apricot) is recommended because of their association with reducing the risk for infection. The client should wear cotton underwear and avoid tight-fitting slacks. She does not need to wash with povidone iodine (Betadine) after voiding. Plain warm water is sufficient to keep the perineal area clean.

 CN: Basic care and comfort; CL: Create

**107. 1.** The client can continue to breast-feed as often as she desires. Continuation of breast-feeding is limited only by the client’s discomfort or malaise. Antibiotics for treatment are chosen carefully so that they avoid affecting the neonate through breast milk. Drugs such as sulfonamides, nitrofurantoin, and cephalosporins usually are not prescribed for breast-feeding mothers. Manual pumping of the breasts is not necessary.

 CN: Health promotion and maintenance; CL: Apply

**108. 1.** Methylergonovine maleate (Methergine) can cause hypertension, so the nurse should assess the client’s blood pressure before and after administration. This drug should not be administered to clients who are hypertensive. Assessing pulse, respiration, and temperature is important for all postpartum clients to provide evidence of possible complications, such as infection. Tachycardia and diminished breath sounds are associated with pulmonary embolism, but these signs are not specific to methylergonovine (Methergine) administration. Assessing breath sounds would be important for a client who has had pregnancy-induced hypertension and received magnesium sulfate before delivery. However, by the fourth postpartum day, the effects of magnesium sulfate should have disappeared. Bowel sounds should be assessed after an operative delivery to determine whether peristalsis has begun so that the client can begin to drink clear liquids or eat soft foods.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**109. 1.** The client is exhibiting signs of early postpartal hemorrhage, defined as blood loss greater than 500 mL in the first 24 hours postpartum. Rapid intravenous oxytocin infusion of 40 to 80 units in 1,000 mL of normal saline, oxygen therapy, and gentle fundal massage to contract the uterus are usually effective. If bleeding persists, the nurse should inspect the cervix and vagina for lacerations. Intramuscular or intravenous


methylergonovine may be administered, but this drug elevates the blood pressure. Other pharmacologic interventions include prostaglandin (Hemabate, Prostin,  $\text{PGF}_{2\alpha}$ ) I.M. and misoprostol (Cytotec) rectally or vaginally. Severe uncontrolled hemorrhage may require bimanual uterine compression, a dilation and curettage to remove any retained placental tissue, or a hysterectomy to prevent maternal death from hemorrhage. The client should be placed in the supine position to allow evaluation of the fundus. The side-lying position is not helpful in controlling postpartum hemorrhage. Vigorous fundal massage every 5 minutes is unnecessary. In addition, it can be very painful for the mother. Rather, gentle massage along with oxytocin administration is used to stimulate the uterus to contract. A hysteromyomectomy is used to remove fibroid tumors. With massive hemorrhage, a hysterectomy (removal of the uterus) may be necessary to control the bleeding.

 CN: Health promotion and maintenance;  
CL: Create


**110. 4.** The most likely cause of this client's uterine atony is overdistention of the uterus caused by the hydramnios. As a result, the stretched uterine musculature contracts less vigorously. Besides hydramnios, a large infant, bleeding from abruptio placentae or placenta previa, and rapid labor and delivery can also contribute to uterine atony during the postpartum period. Trauma during labor and delivery is not a likely cause. In addition, no evidence of excessive trauma was described in the scenario. Moderate fundal massage helps to contract the uterus, not contribute to uterine atony. Although a lengthy or prolonged labor can contribute to uterine atony, this client had a cesarean delivery for breech presentation. Therefore, it is unlikely that she had a long labor.

 CN: Physiological adaptation; CL: Apply


**111. 4.** Scant and odorless vaginal discharge is associated with endometritis due to b-hemolytic streptococcus. The client also will exhibit "saw-tooth" temperature spikes between  $101^{\circ}$  and  $104^{\circ}$  F ( $38.3^{\circ}$  to  $40^{\circ}$  C), tachycardia, and chills. The classic symptom of foul-smelling lochia is not associated with this type of endometritis. Profuse and foul-smelling lochia is associated with classic endometritis from pathogens such as chlamydia or staphylococcus, not group B hemolytic streptococcus. Abdominal distention is associated with parametritis as the pelvic cellulitis advances and spreads, causing severe pain and distention. Nausea and vomiting are associated with parametritis resulting from an abscess and advancing pelvic cellulitis.

 CN: Reduction of risk potential;  
CL: Analyze

**112. 4.** The most likely cause of delayed postpartum hemorrhage is retained placental fragments. The client may be scheduled for a dilatation and curettage to remove remaining placental fragments. Uterine atony, cervical lacerations, and vaginal lacerations are commonly associated with early, not late, postpartum hemorrhage.

 CN: Health promotion and maintenance;  
CL: Apply


**113. 1.** The client being treated for infectious mastitis should continue to breast-feed often, or at least every 2 to 3 hours. Treatment also includes bed rest, increased fluid intake, local heat application, analgesics, and antibiotic therapy. Continually emptying the breasts decreases the risk of engorgement or breast abscess. The client should not discontinue breast-feeding unless she chooses to do so. The client may continue breast-feeding while receiving antibiotic therapy. Generally, the breast milk is not contaminated by the offending organism and is safe for the neonate.

 CN: Physiological adaptation;  
CL: Synthesize


**114. 1.** Down syndrome is a genetic abnormality that is caused by an extra chromosome that results in mental retardation. The degree of mental retardation is difficult to predict in a neonate, although most children born with Down syndrome have some degree of mental retardation. Various methods can be used to determine whether a neonate has Down syndrome, which is commonly manifested by hypotonia, poor Moro reflex, flat facial profile, upslanting palpebral fissures, epicanthal folds, and hyperflexible joints. Genetic studies can be indicative of this disorder. Mothers older than 35 years of age are at a higher risk for having a child with Down syndrome. However, chromosomal abnormalities can occur regardless of the mother's age.

 CN: Reduction of risk potential;  
CL: Evaluate


**115. 1.** After birth, the client should make the decision about how much she would like to participate in the neonate's care. Seeing and caring for the neonate commonly facilitates the grief process. The nurse should be nonjudgmental and should allow the client any opportunity to see, hold, and care for the neonate. The physician does not need to be contacted about the client's desire to see the baby, which is a normal reaction. The social worker and the adoptive parents do not need to give the client permission to feed the baby.

 CN: Health promotion and maintenance;  
CL: Synthesize

**116. 4.** The client needs further instruction when she says that she should begin feeding on the right (painful) breast to decrease the pain. Starting the feeding on the unaffected (left) breast can stimulate the milk ejection reflex in the right breast and thereby decrease the pain. Frequent nursing or pumping is recommended to empty the breast. For some mothers, mastitis is so painful that they choose to discontinue breast-feeding, so these mothers need a great deal of support. Applying heat to the infected area before starting to feed is appropriate because heat stimulates circulation and promotes comfort. Increasing fluid intake is advised to ensure adequate hydration. Antibiotics need to be taken until all medication has been used, usually 7 to 10 days to ensure eradication of the infection.

 CN: Reduction of risk potential;  
CL: Evaluate

**117. 3.** The client is probably experiencing postpartum depression, and the doctor should be contacted. Postpartum depression is usually treated with psychotherapy, social support groups, and antidepressant medications. Contributing factors include hormonal fluctuations, a history of depression, and environmental factors (e.g., job loss). An estimated 50% to 70% of women experience some degree of postpartum “blues,” but these feelings of sadness disappear within 1 to 2 weeks after birth. However, the client is voicing more than just sadness. Telling her that she is overreacting is not helpful and may make her feel even less worthy. She is not exhibiting symptoms of a serious mental illness (loss of contact with reality) and does not need hospitalization.


 CN: Health promotion and maintenance;  
CL: Synthesize

### Managing Care Quality and Safety

**118. 4, 2, 3, 1, 5.** The nurse should immediately ask the client what her reaction is as a result of the exposure to Betadine. This gives the nurse an idea of whether there needs to be preparation for an event as severe as cardiac arrest or as simple as skin irritation. The nurse should then clean the Betadine from the client, notify the physician of the incident, and ask for an order for medication if needed to counteract the Betadine. The nurse will need to document the incident on the client’s chart as soon as the client has physically been taken care of. The nurse also will need to file an incident report.

 CN: Management of care; CL: Synthesize

**119. 4.** The process for infant abduction in a hospital system focuses on utilizing all health care workers to observe for anyone who may possibly be concealing an infant in a large bag or under an oversized coat and is attempting to leave the building. Moving to the entrances and exits and checking each individual would be a responsibility of the doorman or security staff within the hospital system. Going to the obstetrics unit to determine if they need help would not be advised as the doors to the unit will be locked and access will not be available. Calling the nursery to ask about a missing baby wastes time, and the nursery staff should not reveal such information.

 CN: Safety and infection control;  
CL: Synthesize

**120.**

5:00	3
5:30	1
6:00	4
6:30	2

Drawing the bilirubin levels at 6 a.m. must occur at a specific time. The admission assessment should be completed as soon after admission as possible; 5 a.m. is available to complete this task. The IV should be started at 6:30 and completed as close to change of shift as possible. The nurse should then draw the blood at 5:30 a.m., right after the newborn assessment.

 CN: Management of care; CL: Create

**121. 2.** The client who is a G4 P4 can be cared for by the CNA II. There are no indications that there are any problems with this couplet and the assessments have been completed by the RN. The client with gestational diabetes will need specific assessments, medications, and potentially other actions based on recent delivery. Her infant is within the first 24 hours of delivery when infants of gestational diabetics often drop their blood glucose levels and this will require frequent assessment and possible interventions. The client who is G3 P3 postpartum and receiving Magnesium Sulfate must be cared for by a registered nurse. The respiratory rate of this client’s infant is borderline low and often is related to the administration of Magnesium Sulfate and should receive a higher level of nursing care. The client who is a G2 P2, with an infant with documented low blood sugars, will require assessment and potential intervention if the blood sugar levels change; only registered nurses can safely manage this care.

 CN: Management of care; CL: Synthesize

# TEST 5

## The Neonatal Client

- Neonatal Care
- Physical Assessment of the Neonatal Client
- The Preterm Neonate
- The Post-term Neonate
- The Neonate with Risk Factors
- Managing Care Quality and Safety
- Correct Answers and Rationales

### Neonatal Care

**1.** A newborn who is 20 hours old has a respiratory rate of 66, is grunting when exhaling, and has occasional nasal flaring. The newborn's temperature is 98; he is breathing room air and is pink with acrocyanosis. The mother had membranes that were ruptured 26 hours before delivery. Based on these data, the nurse should include which of the following in the management of the infant's care?

- 1. Continue recording vital signs, voiding, stooling, and eating patterns every 4 hours for 24 hours, infant at bedside.
- 2. With a health care provider (HCP) order, draw blood cultures, monitor vital signs every 2 hours as well as feeding and elimination patterns every 4 hours, newborn at bedside.
- 3. Transfer the newborn to the neonatal intensive care unit with diagnosis of possible sepsis, parents at bedside.
- 4. Request CBC with differential from the health care provider, keep the newborn under the radiant warmer, and monitor vital signs every 4 hours, parents at bedside.

**2.** A neonate is delivered by primary cesarean section at 36 weeks' gestation. The temperature in the delivery room is 70° F. To prevent heat loss from convection, which action should the nurse take?

- 1. Dry the neonate quickly after delivery.
- 2. Keep the neonate away from air conditioning vents.
- 3. Place the neonate away from outside windows.
- 4. Prewarm the bed.

**3.** The physician orders ampicillin 100 mg/kg/dose for a newly admitted neonate. The neonate weighs 1,350 g. How many milligrams should the nurse administer?

\_\_\_\_\_ mg.

**4.** A neonate delivered at 30 weeks' gestation and weighing 2,000 g is admitted to the neonatal intensive care unit. What nursing measure will decrease insensible water loss in a neonate?

- 1. Bathing the baby as soon after birth as possible.
- 2. Use of eye patches with phototherapy.
- 3. Use of humidity in the incubator.
- 4. Use of a radiant warmer.

**5.** A neonate delivered at 37 weeks' gestation has been admitted to the neonatal intensive care unit for respiratory distress. The physician has ordered an I.V. for fluid support. To increase safety prior to hanging new I.V. fluids for a neonate, the nurse should:

- 1. Check the neonate's weight.
- 2. Determine if the neonate has adequate urine output.
- 3. Determine the neonate's glucose level.
- 4. Double-check the fluids and physician's order with another nurse.

**6.** A septic preterm neonate's I.V. was removed due to infiltration. While restarting the I.V., the nurse should carefully assess the neonate for:

- 1. Fever.
- 2. Hyperkalemia.
- 3. Hypoglycemia.
- 4. Tachycardia.

**7.** The nurse makes a home visit to a 3-day-old full-term neonate who weighed 3,912 g (8 lb, 10 oz) at birth. Today the neonate, who is being bottle-fed, weighs 3,572 g (7 lb, 14 oz). Which of the following instructions should the nurse give to the mother?

- 1. Continue feeding every 3 to 4 hours since the weight loss is normal.
- 2. Contact the physician if the weight loss continues over the next few days.
- 3. Switch to a soy-based formula because the current one seems inadequate.
- 4. Change to a higher-calorie formula to prevent further weight loss.

**8.** Commercial formulas contain 20 calories per ounce. A 1-day-old infant's weight in the morning was 8 lb and he was fed 45 mL at 2 a.m., 5:30 a.m., 8 a.m., 11 a.m., 2 p.m., 4:30 p.m., 8 p.m., and 10:30 p.m. What is the total amount of calories the infant received today?

\_\_\_\_\_ calories.

**9.** A viable female neonate was delivered 10 minutes ago and is in stable condition under a radiant warmer. To prevent infant heat loss by convection, the nurse should:

- 1. Move the infant away from cool window surfaces.
- 2. Make certain the infant has no contact with cool surfaces.
- 3. Dry the infant's skin with a towel.
- 4. Position the infant away from drafts and cooling ducts.

Use rationale in 9<sup>th</sup> Edition, page 132. (A)

**10.** After the nurse explains to the mother of a male neonate scheduled to receive an injection of vitamin K soon after birth about the rationale for the medication, which of the following statements by the mother indicates successful teaching?

- 1. "My baby doesn't have the normal bacteria in his intestines to produce this vitamin."
- 2. "My baby is at a high risk for a problem involving his blood's ability to clot."
- 3. "The red blood cells my baby formed during pregnancy are destroying the vitamin K."
- 4. "My baby's liver is not able to produce enough of this vitamin so soon after birth."

**11.** The nurse is teaching the mother of a newborn to develop her baby's sensory system. To further improve the infant's most developed sense, the nurse should instruct the mother to:

- 1. Speak in a high-pitched voice to get the newborn's attention.
- 2. Place the newborn about 12 inches from maternal face for best sight.
- 3. Stroke the newborn's cheek with her nipple to direct the baby's mouth to nipple.
- 4. Give infant formula with a sweetened taste to stimulate feeding.

**12.** While making a home visit to a primiparous client and her 3-day-old son, the nurse observes the mother changing the baby's disposable diaper. Before putting the clean diaper on the neonate, the mother begins to apply baby powder to the neonate's buttocks. Which of the following statements about baby powder should the nurse relate to the mother?

- 1. It may cause pneumonia to develop.
- 2. It helps prevent diaper rash.
- 3. It keeps the diaper from adhering to the skin.
- 4. It can result in allergies later in life.

**13.** After teaching a new mother about the care of her neonate after circumcision with a Gomco clamp, which of the following statements by the mother indicates to the nurse that the mother needs additional instructions?

- 1. "The petroleum gauze may fall off into the diaper."
- 2. "A few drops of blood oozing from the site is normal."
- 3. "I'll leave the gauze in place for 24 hours."
- 4. "I'll remove any yellowish crusting gently with water."

**14.** After completing discharge instructions for a primiparous client who is bottle-feeding her term neonate, the nurse determines that the mother understands the instructions when the mother says that she should contact the pediatrician if the neonate exhibits which of the following?

- 1. Ability to fall asleep easily after each feeding.
- 2. Spitting up of a tablespoon of formula after feeding.
- 3. Passage of a liquid stool with a watery ring.
- 4. Production of one to two light brown stools daily.

**15.** The nurse instructs a primiparous client about bottle-feeding her neonate. Which of the following demonstrates that the mother has understood the nurse's instructions?

- 1. Placing the neonate on his back after the feeding.
- 2. Bubbling the baby after 1 oz of formula.
- 3. Putting three-fourths of the bottle nipple into the baby's mouth.
- 4. Pointing the nipple toward the neonate's palate.

**16.** The nurse is to draw a blood sample for glucose testing from a term neonate during the first hour after birth. The nurse should obtain the blood sample from the neonate's foot near which of the following areas?

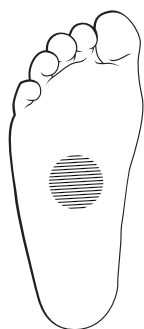
1.



2.



3.



4.



**17.** After circumcision with a Plastibell, the nurse should instruct the neonate's mother to cleanse the circumcision site with which of the following?

- 1. Antibacterial soap.
- 2. Warm water.
- 3. Povidone-iodine (Betadine) solution.
- 4. Diluted hydrogen peroxide.

**18.** Approximately 90 minutes after birth, the nurse should encourage the mother of a term neonate to do which of the following?

- 1. Feed the neonate.
- 2. Allow the neonate to sleep.
- 3. Get to know the neonate.
- 4. Change the neonate's diaper.

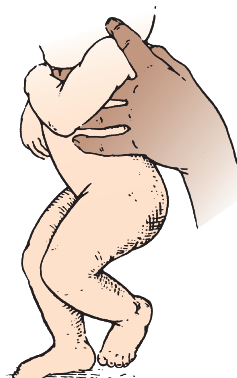
### Physical Assessment of the Neonatal Client

**19.** The nurse is to assess a newborn for incurving of the trunk. Which illustration indicates the position in which the nurse should place the newborn?

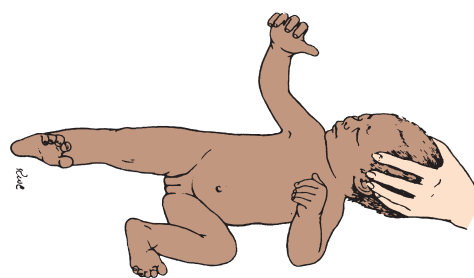
1.



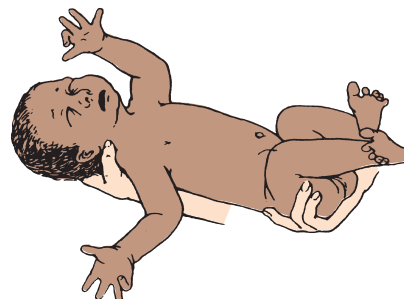
2.



3.



4.





**20.** A full-term neonate is admitted to the normal newborn nursery. The nurse notes a Moro reflex. What should the nurse do next?

- 1. Call a code.
- 2. Identify this reflex as a normal finding.
- 3. Place the neonate on seizure precautions.
- 4. Start supplemental oxygen.

**21.** After the delivery of a neonate, a quick assessment is completed. The neonate is found to be apneic. After quickly drying the neonate, what should the nurse do next?

- 1. Assign the first Apgar score.
- 2. Place the head in a “sniff” position.
- 3. Administer oxygen.
- 4. Start cardiac compressions.

**22.** A 6-lb, 8-oz neonate was delivered vaginally at 38 weeks’ gestation. At 5 minutes of life, the neonate has the following signs: heart rate 110, intermittent grunting with respiratory rate of 70, flaccid tone, no response to stimulus, overall pale white in color. The Apgar score is:

- 1. 2.
- 2. 3.
- 3. 4.
- 4. 6.

**23.** A neonate has a large amount of secretions. After vigorously suctioning the neonate, the nurse should assess for what possible result?

- 1. Bradycardia.
- 2. Rapid eye movement.
- 3. Seizures.
- 4. Tachycardia.

**24.** When reviewing the prenatal history for a newly delivered neonate, the nurse notes that the mother has neurofibromatosis. The nurse should further assess the neonate for:

- 1. Acrocyanosis.
- 2. Café au lait spots.
- 3. Port wine nevus.
- 4. Strawberry hemangiomas.

**25.** A 24-hour-old, full-term neonate is showing signs of possible sepsis. The nurse is assisting the physician with a lumbar puncture on this neonate. What should the nurse do to assist in this procedure? Select all that apply.

- 1. Administer the I.V. antibiotic.
- 2. Hold the neonate steady in the correct position.
- 3. Ensure a patent airway.
- 4. Maintain a sterile field.
- 5. Obtain a serum glucose level.

**26.** After a vaginal delivery of a term neonate, the nurse observes that the neonate has one artery and one vein in the umbilical cord. The nurse notifies the pediatrician based on the analysis that this may be indicative of ?

- 1. Respiratory anomalies.
- 2. Musculoskeletal anomalies.
- 3. Cardiovascular anomalies.
- 4. Facial anomalies.

**27.** Shortly after birth, the nurse measures the circumference of a term neonate’s head and chest. When the two measurements are compared, which of the following would the nurse expect to find about the head circumference?

- 1. Equal to the chest circumference.
- 2. Approximately 2 cm larger than the chest.
- 3. About 3 cm smaller than the chest.
- 4. Approximately 4 cm larger than the chest.

**28.** After explaining to a primiparous client about the causes of her neonate’s cranial molding, which of the following statements by the mother indicates the need for further instruction?

- 1. “The molding was caused by an overlapping of the baby’s cranial bones during my labor.”
- 2. “The amount of molding is related to the amount and length of pressure on the head.”
- 3. “The molding will usually disappear in a couple of days.”
- 4. “Brain damage may occur if the molding doesn’t resolve quickly.”

**29.** Initial assessment of a term female neonate about 4 hours old reveals a normal anterior fontanel. The nurse documents its shape as which of the following?

- 1. Oval.
- 2. Square.
- 3. Diamond shaped.
- 4. Triangular.

**30.** Which of the following observations is expected when the nurse is assessing the gestational age of a neonate delivered at term?

- 1. Ear lying flat against the head.
- 2. Absence of rugae in the scrotum.
- 3. Sole creases covering the entire foot.
- 4. Square window sign angle of 90 degrees.

**31.** While performing a complete assessment of a term neonate, which of the following findings would alert the nurse to notify the pediatrician?

- 1. Red reflex in the eyes.
- 2. Expiratory grunt.
- 3. Respiratory rate of 45 breaths/minute.
- 4. Prominent xiphoid process.

**32.** After instructing a mother about normal reflexes of term neonates, the nurse determines that the mother understands the instructions when she describes the tonic neck reflex as occurring when the neonate does which of the following?

- 1. Steps briskly when held upright near a firm, hard surface.
- 2. Pulls both arms and does not move the chin beyond the point of the elbows.
- 3. Turns head to the left, extends left extremities, and flexes right extremities.
- 4. Extends and abducts the arms and legs with the toes fanning open.

**33.** A primiparous client expresses concern, asking the nurse why her neonate's eyes are crossed. Which of the following would the nurse include when teaching the mother about neonatal strabismus?

- 1. The neonate's eyes are unable to focus on light at this time.
- 2. Neonates commonly lack eye muscle coordination.
- 3. Congenital cataracts may be present.
- 4. The neonate is able to fixate on distant objects immediately.

**34.** While performing a physical assessment on a term neonate shortly after birth, which of the following would cause the nurse to notify the pediatrician?

- 1. Deep creases across the soles of the feet.
- 2. Frequent sneezing during the assessment.
- 3. Single crease on each of the palms.
- 4. Absence of lanugo on the skin.

**35.** Metabolic screening of an infant revealed a high phenylketonuria (PKU) level. Which of the following statements by the infant's mother indicates understanding of the disease and its management? Select all that apply.

- 1. "My baby can't have milk-based formulas."
- 2. "My baby will grow out of this by the age of 2."
- 3. "This is a hereditary disease, so any future children will have it, too."
- 4. "My baby will eventually become retarded because of this disease."
- 5. "We have to follow a strict phenylalanine diet."
- 6. "A dietitian can help me plan a diet that keeps a safe phenylalanine level but lets my baby grow."

**36.** Assessment of a term neonate at 2 hours after birth reveals a heart rate of 110 bpm, periods of apnea approximately 25 to 30 seconds in length, and mild cyanosis around the mouth. The nurse notifies the pediatrician based on the interpretation that these findings may lead to which condition?

- 1. Respiratory arrest.
- 2. Bronchial pneumonia.
- 3. Intraventricular hemorrhage.
- 4. Epiglottitis.

**37.** A new mother asks, "When will the soft spot near the front of my baby's head close?" The nurse should tell the mother the soft spot will close in about?

- 1. 2 to 3 months.
- 2. 6 to 8 months.
- 3. 9 to 10 months.
- 4. 12 to 18 months.

**38.** Which of the following assessment findings in a term neonate would cause the nurse to notify the pediatrician?

- 1. Absence of tears.
- 2. Unequally sized corneas.
- 3. Pupillary constriction to bright light.
- 4. Red circle on pupils with ophthalmoscopic examination.

**39.** At 24 hours of age, assessment of the neonate reveals the following: eyes closed, skin pink, no sign of eye movements, heart rate of 120 bpm, and respiratory rate of 35 breaths/minute. The nurse interprets these findings as indicating that this neonate is most likely experiencing which of the following?

- 1. Drug withdrawal.
- 2. First period of reactivity.
- 3. A state of deep sleep.
- 4. Respiratory distress.

**40.** While assessing a male neonate whose mother desires him to be circumcised, the nurse observes that the neonate's urinary meatus appears to be located on the ventral surface of the penis. The physician is notified because the nurse suspects which of the following?

- 1. Phimosis.
- 2. Hydrocele.
- 3. Epispadias.
- 4. Hypospadias.

### The Preterm Neonate

**41.** The nurse is discussing kangaroo care with the parents of a premature neonate. The nurse should tell the parents that the advantages of kangaroo care include which of the following? Select all that apply.

- 1. Facilitate a positive bonding experience.
- 2. Increased IQ.
- 3. Physiologic stability.
- 4. Shorten length of stay in the neonatal intensive care unit.
- 5. Time to grow.

**42.** A neonate at 37 weeks' gestation is delivered by cesarean delivery because of placenta previa. Which of the following would the circulating nurse do **first** as soon as the neonate is delivered?

- 1. Stimulate the neonate to cry vigorously.
- 2. Aspirate mucus from the mouth with a bulb syringe.
- 3. Begin resuscitation procedures with a bag and mask.
- 4. Hold the neonate upright for the mother to view.

**43.** After a vaginal delivery, a preterm neonate is to receive oxygen via mask. While administering the oxygen, the nurse would place the neonate in which of the following positions?

- 1. Left side, with the neck slightly flexed.
- 2. Back, with the head turned to the left side.
- 3. Abdomen, with the head down.
- 4. Back, with the neck slightly extended.

**44.** Which of the following actions should the nurse take when performing external cardiac massage on a neonate born at 28 weeks' gestation?

- 1. Alternate cardiac massage with ventilation.
- 2. Compress the sternum with the palm of the hand.
- 3. Compress the chest 70 to 80 times per minute.
- 4. Displace the chest wall half the depth of the anterior-posterior diameter of the chest.

**45.** A preterm neonate who has been stabilized is placed in a radiant warmer and is receiving oxygen via an oxygen hood. While administering oxygen in this manner, the nurse should do which of the following?

- 1. Humidify the air being delivered.
- 2. Cover the neonate's scalp with a warm cap.
- 3. Record the neonate's temperature every 3 to 4 minutes.
- 4. Assess the neonate's blood glucose level.

**46.** Two hours ago, a neonate at 38 weeks' gestation and weighing 3,175 g (7 lb) was born to a primiparous client who tested positive for beta-hemolytic *Streptococcus*. Which of the following would alert the nurse to notify the pediatrician?

- 1. Alkalosis.
- 2. Increased muscle tone.
- 3. Temperature instability.
- 4. Positive Babinski's reflex.

**47.** Assessment of a 2-day-old neonate delivered at 34 weeks' gestation reveals absent apical pulse left of the midclavicular line, cyanosis, grunting, and diminished breath sounds. The nurse should **first**:

- 1. Consult with health care provider to obtain a chest x-ray.
- 2. Reposition the neonate and then assess if the grunting and cyanosis resolve.
- 3. Begin oxygen administration at 6-8 L via mask.
- 4. Obtain a complete blood count to determine infection.

**48.** Twenty-four hours after cesarean delivery, a neonate at 30 weeks' gestation is diagnosed with respiratory distress syndrome (RDS). When explaining to the parents about the cause of this syndrome, the nurse should include a discussion about an alteration in the body's secretion of which of the following?

- 1. Somatotropin.
- 2. Surfactant.
- 3. Testosterone.
- 4. Progesterone.

**49.** When caring for a neonate born at 30 weeks' gestation who is in an isolette and receiving continuous oxygen, which of the following would the nurse use as the **best** method to determine the effectiveness of this treatment?

- 1. Evidence of cyanosis on mouth, hands, and feet.
- 2. Continuous pulse rate monitoring.
- 3. Arterial blood gas levels.
- 4. Percentage of oxygen delivered.

**50.** A viable male neonate delivered to a 28-year-old multiparous client by cesarean delivery because of placenta previa is diagnosed with respiratory distress syndrome (RDS). Which of the following would the nurse explain as the factor placing the neonate at the greatest risk for this syndrome?

- 1. Mother's development of placenta previa.
- 2. Neonate delivered preterm.
- 3. Mother receiving analgesia 4 hours before delivery.
- 4. Neonate with sluggish respiratory efforts after delivery.

**51.** While the nurse is caring for a neonate at 32 weeks' gestation in an isolette with continuous oxygen administration, the neonate's mother asks why the neonate's oxygen is humidified. The nurse should tell the mother?

- 1. "The humidity promotes expansion of the neonate's immature lungs."
- 2. "The humidity helps to prevent viral or bacterial pneumonia."
- 3. "Oxygen is drying to the mucous membranes unless it is humidified."
- 4. "Circulation to the baby's heart is improved with humidified oxygen."

**52.** A preterm neonate admitted to the neonatal intensive care unit at about 30 weeks' gestation is placed in an oxygenated isolette. The neonate's mother tells the nurse that she was planning to breast-feed the neonate. Which of the following instructions about breast-feeding would be **most** appropriate?

- 1. Breast-feeding is not recommended because the neonate needs increased fat in the diet.
- 2. Once the neonate no longer needs oxygen and continuous monitoring, breast-feeding can be done.
- 3. Breast-feeding is contraindicated because the neonate needs a high-calorie formula every 2 hours.
- 4. Gavage feedings using breast milk can be given until the neonate can coordinate sucking and swallowing.

**53.** Which of the following best identifies the reason for assessing a neonate weighing 1,500 g at 32 weeks' gestation for retinopathy of prematurity (ROP)?

- 1. The neonate is at risk because of multiple factors.
- 2. Oxygen is being administered at a level of 21%.
- 3. The neonate was alkalotic immediately after birth.
- 4. Phototherapy is likely to be ordered by the pediatrician.

**54.** Which of the following would lead the nurse to suspect retinopathy of prematurity (ROP) when assessing a neonate at 32 weeks' gestation who weighs 2,000 g?

- 1. Sunken orbital sockets.
- 2. Strabismus.
- 3. Reaction to bright light.
- 4. Constricted retinal vessels.

**55.** Which of the following subjects should the nurse include when teaching the mother of a neonate diagnosed with retinopathy of prematurity (ROP) about possible treatment for complications?

- 1. Laser therapy.
- 2. Cromolyn sodium (Intal) eye drops.
- 3. Frequent testing for glaucoma.
- 4. Corneal transplants.

**56.** Three days after admission of a neonate delivered at 30 weeks' gestation, the neonatologist plans to assess the neonate for periventricular-intraventricular hemorrhage (PIVH). The nurse should plan to assist the neonatologist by preparing the neonate for which of the following?

- 1. Computed tomography scan.
- 2. Arterial blood specimen collection.
- 3. Radiographs of the skull.
- 4. Complete blood count specimen collection.

**57.** Which of the following would the nurse expect to assess in a neonate delivered at 28 weeks' gestation who is diagnosed with intraventricular hemorrhage (IVH)?

- 1. Increased muscle tone.
- 2. Hyperbilirubinemia.
- 3. Bulging fontanel.
- 4. Hyperactivity.

**58.** An infant born premature at 34 weeks is receiving gavage feedings. The client holding her infant asks why the nurse places a pacifier in the infant's mouth during these feedings. The nurse replies that the pacifier helps in what ways? Select all that apply.

- 1. Teaches the infant to suck and swallow.
- 2. Provides oral stimulation.
- 3. Keeps oral mucus membranes moist while the tube is in place.
- 4. Reminds the infant how to suck.
- 5. Stimulates secretions that help gastric emptying.

**59.** While caring for a neonate delivered at 32 weeks' gestation, the nurse assesses the neonate daily for symptoms of necrotizing enterocolitis (NEC). Which of the following would alert the nurse to notify the neonatologist?

- 1. The presence of 1 mL of gastric residual before a gavage feeding.
- 2. Jaundice appearing on the face and chest.
- 3. An increase in bowel peristalsis.
- 4. Abdominal distention.

**60.** Which of the following statements by the mother of a neonate diagnosed with bronchopulmonary dysplasia (BPD) indicates effective teaching?

- 1. "BPD is an acute disease that can be treated with antibiotics."
- 2. "My baby may require permanent assisted ventilation."
- 3. "Bronchodilators can cure my baby's condition."
- 4. "My baby may have seizures later on in life because of this condition."

**61.** A preterm infant delivered 2 hours ago at 34 weeks' gestation is experiencing rapid respirations, grunting, no breath sounds on one side, and a shift in location of heart sounds. The nurse should prepare to assist with which of the following?

- 1. Placement of the neonate on a ventilator.
- 2. Administration of bronchodilators through the nares.
- 3. Suctioning of the neonate's nares with wall suction.
- 4. Insertion of a chest tube into the neonate.

**62.** Which of the following would alert the nurse to suspect that a neonate delivered at 34 weeks' gestation who is currently in an isolette with humidified oxygen and receiving intravenous fluids has developed overhydration?

- 1. Hypernatremia.
- 2. Polycythemia.
- 3. Hypoproteinemia.
- 4. Increased urine specific gravity.

**63.** A newborn weighing 6½ lb is to be given naloxone hydrochloride (Narcan) due to respiratory depression as a result of a narcotic given to the mother shortly before delivery. The drug is to be given 0.01 mg/kg into the umbilical vein. The vial is marked 0.4 mg/mL. How many milligrams would the newborn receive? Round to two decimals.

\_\_\_\_\_ mg.

### The Post-Term Neonate

**64.** A neonate born by cesarean delivery at 42 weeks' gestation, weighing 4.1 kg (9 lb, 1 oz), with Apgar scores of 8 at 1 minute and 9 at 5 minutes after birth, develops an increased respiratory rate and tremors of the hands and feet 2 hours postpartum. Which of the following nursing diagnoses would be the priority?

- 1. *Ineffective airway clearance* related to post-term gestational age.
- 2. *Hyperthermia* related to large size and use of a radiant warmer.
- 3. *Decreased cardiac output* related to difficult delivery.
- 4. *Imbalanced nutrition: Less than body requirements* related to depleted glycogen stores.

**65.** At a home visit, the nurse assesses a neonate delivered vaginally at 41 weeks' gestation 5 days ago, noting the following findings: frequent hiccups; loose, watery stool in diaper; red rash on face; and dry, peeling skin. Which of these findings warrants further assessment?

- 1. Frequent hiccups.
- 2. Loose, watery stool in diaper.
- 3. Pink papular vesicles on the face.
- 4. Dry, peeling skin.

**66.** When performing an initial assessment of a post-term male neonate weighing 4,000 g (9 lb) who was admitted to the observation nursery after a vaginal delivery with low forceps, the nurse detects Ortolani's sign. Which of the following actions should the nurse do next?

- 1. Determine the length of the mother's labor.
- 2. Notify the pediatrician immediately.
- 3. Keep the neonate under the radiant warmer for 2 hours.
- 4. Obtain a blood sample to check for hypoglycemia.

**67.** A neonate is admitted to the neonatal intensive care unit for observation with a diagnosis of probable meconium aspiration syndrome (MAS). The neonate weighs 10 lb, 4 oz (4,650 g) and is at 41 weeks' gestation. Which of the following nursing diagnoses would be the priority for this neonate?

- 1. *Impaired skin integrity* related to post-term status.
- 2. *Imbalanced nutrition: More than body requirements* related to large size.
- 3. *Risk for impaired parent-infant-child attachment* related to transfer to the intensive care unit.
- 4. *Impaired gas exchange* related to the effects of respiratory distress.

**68.** When developing the initial plan of care for a neonate who was born at 41 weeks' gestation, was diagnosed with meconium aspiration syndrome (MAS), and requires mechanical ventilation, which of the following should the nurse include?

- 1. Care of an umbilical arterial line.
- 2. Frequent ultrasound scans.
- 3. Orogastic feedings as soon as possible.
- 4. Assessment for symptoms of hyperglycemia.

**69.** A post-term neonate diagnosed with persistent pulmonary hypertension is prescribed intravenous tolazoline (Priscoline). While administering this drug, the nurse should monitor the neonate for?

- 1. Feeding behaviors.
- 2. Temperature.
- 3. Skin color.
- 4. Blood pressure.

### The Neonate with Risk Factors

**70.** A nurse is attempting to resuscitate a neonate. After following the Neonatal Resuscitation Program guidelines, 30 seconds of chest compressions have been completed. The neonate's heart rate remains less than 60 bpm. Epinephrine is given. What is the expected outcome for a neonate who has received epinephrine during resuscitation?

- 1. Increased urine output.
- 2. A normal heart rate.
- 3. Pain relief.
- 4. Sedation.

**71.** A mother is visiting her neonate in the neonatal intensive care unit. Her baby is fussy and the mother wants to know what to do. In order to quiet a sick neonate, which of the following can the nurse teach the mother to do?

- 1. Bring in toys for distraction.
- 2. Place a musical mobile over the crib.
- 3. Stroke the neonate's back.
- 4. Use constant, gentle touch.

**72.** A neonate delivered at 40 weeks' gestation admitted to the nursery is found to be hypoglycemic. At 4 hours of age, the neonate appears pale and his pulse oximeter is reading 75%. The nurse should:

- 1. Increase the I.V. rate.
- 2. Provide supplemental oxygen.
- 3. Record the finding on the chart and repeat the reading in 30 minutes.
- 4. Wrap the neonate to increase body temperature.

**73.** A neonate born at 29 weeks' gestation received nasal continuous positive airway pressure. The neonate is receiving oxygen at 1 L/minute via nasal cannula at a fraction of inspired oxygen ( $F_{IO_2}$ ) of 0.23. The pulse oximetry reading is 70% saturation. In which order of priority from first to last should the nurse take these actions?

1. Increase the  $F_{IO_2}$ .

2. Make sure the pulse oximeter is correlating to the heart rate.

3. Assess the neonate for color.

4. Assess the neonate for respiratory effort.

**74.** A neonate with heart failure is being discharged home. In teaching the parents about the neonate's nutritional needs, the nurse should explain that:

- 1. Fluids should be restricted.
- 2. Decreased activity level should reduce the need for additional calories.
- 3. The formula should be low in sodium.
- 4. The neonate may need a formula with higher calories per fluid ounce.

**75.** During an assessment of a neonate born at 33 weeks' gestation, a nurse finds and reports a heart murmur. An echocardiogram reveals patent ductus arteriosus, for which the neonate received indomethacin. An expected outcome after the administration of indomethacin to a neonate with patent ductus arteriosus is:

- 1. Closure of a patent ductus arteriosus.
- 2. Decreased bleeding time.
- 3. Increased gastrointestinal function.
- 4. Increased renal output.

**76.** A preterm neonate is unable to breast- or bottle-feed. The physician writes an order to feed the neonate via nasogastric (NG) tube. When choosing an NG feeding tube for a neonate, the nurse should base the tube size on the neonate's:

- 1. Disease process.
- 2. Gestational age.
- 3. Length.
- 4. Weight.

**77.** A nurse is reviewing a client's maternal prenatal record and notes that the mother used narcotics during her pregnancy. A primary nursing intervention when caring for a drug-exposed neonate is to:

- 1. Assess vital signs including blood pressure every hour.
- 2. Minimize environmental stimuli.
- 3. Place the infant in a well-lighted area for observation.
- 4. Provide stimulation to increase adaptation to the environment.

**78.** The nurse is receiving over the telephone a laboratory results report of a neonate's blood glucose level. The nurse should:

- 1. Write down the results, read back the results to the caller from the laboratory, and receive confirmation from the caller that the nurse understands the results.
- 2. Repeat the results to the caller from the laboratory, write the results on scrap paper first, and then transfer the results to the chart.
- 3. Indicate to the caller that the nurse cannot receive verbal results from laboratory tests for neonates, and ask the laboratory to bring the written results to the nursery.
- 4. Request that the laboratory send the results by e-mail to transfer to the client's electronic record.

**79.** A multiparous client who has a neonate diagnosed with hemolytic disease of the newborn asks the nurse why the neonate has developed this problem. Which of the following responses by the nurse would be **most** appropriate?

- 1. "You are Rh-positive and the neonate's father is Rh-negative."
- 2. "You and the neonate's father are both Rh-negative."
- 3. "You are Rh-negative and the neonate's father is Rh-positive."
- 4. "The fetus is Rh-negative and you are Rh-positive."

**80.** After teaching the multiparous mother about hemolytic disease of the newborn and Rh sensitization, the nurse determines that the client understands why she was not sensitized during her other pregnancy when she says which of the following?

- 1. "My other baby had a different father."
- 2. "Like most women, I have immunity against the Rh factor."
- 3. "Antibodies are not usually formed until after exposure to an antigen."
- 4. "My blood couldn't neutralize antibodies formed from my first pregnancy."

**81.** After teaching a multiparous client about the effects of hemolysis due to Rh sensitization on the neonate at delivery, the nurse determines that the client needs further instruction when the mother reports that the neonate may have which of the following?

- 1. Cardiac decompensation.
- 2. Polycythemia.
- 3. Anemia.
- 4. Splenic enlargement.

**82.** After delivery, a direct Coombs test is performed on the umbilical cord blood of a neonate with Rh-positive blood born to a mother with Rh-negative blood. The nurse explains to the client that this test is done to detect which of the following?

- 1. Degree of anemia in the neonate.
- 2. Electrolyte imbalances in the neonate.
- 3. Antibodies coating the neonate's red blood cells.
- 4. Antigens coating the neonate's red blood cells.

**83.** After teaching the mother of a neonate with erythroblastosis fetalis who is to receive an exchange transfusion, which of the following, if stated by the mother as the purpose of the transfusion, indicates effective teaching?

- 1. To replenish the neonate's leukocytes.
- 2. To restore the fluid and electrolyte balance.
- 3. To correct the neonate's anemia.
- 4. To replace Rh-negative blood with Rh-positive blood.

**84.** The nurse explains to the mother of a neonate diagnosed with erythroblastosis fetalis that the exchange transfusion is necessary to prevent damage primarily to which of the following organs in the neonate?

- 1. Kidneys.
- 2. Brain.
- 3. Lungs.
- 4. Liver.

**85.** The nurse determines that a newborn is hypoglycemic based on which of the following findings? Select all that apply.

- 1. Glucometer reading of 40 mg/dL.
- 2. Family history of insulin-dependent diabetes.
- 3. Internal fetal monitor tracing.
- 4. Irregular respirations, tremors, and hypothermia.
- 5. Large for gestational age.

**86.** The nurse is caring for an infant of an insulin-dependent diabetic primiparous client. When the mother visits the neonate at 1 hour after birth, the nurse explains to the mother that the neonate is being closely monitored for symptoms of hypoglycemia because of which of the following?

- 1. Increased use of glucose stores during a difficult labor and delivery process.
- 2. Interrupted supply of maternal glucose and continued high neonatal insulin production.
- 3. A normal response that occurs during transition from intrauterine to extrauterine life.
- 4. Increased pancreatic enzyme production caused by decreased glucose stores.

**87.** When caring for the neonate of a diabetic mother weighing 4,564 g (10 lb, 1 oz) who was delivered vaginally, the nurse should assess the neonate for fracture of the:

- 1. Clavicle.
- 2. Skull.
- 3. Wrist.
- 4. Rib cage.

**88.** While caring for a neonate of a diabetic mother soon after delivery, the nurse has fed the newborn formula to prevent hypoglycemia. The nurse checks the neonate's blood glucose level and it is 60 mg/dL, but the neonate continues to exhibit jitteriness and tremors. The nurse should **first**:

- 1. Inform the physician of the neonate's glucose levels and tremors and request an order for blood calcium levels.
- 2. Administer glucose intravenously based on infant glucose level.
- 3. Take the neonate's temperature and place him in the radiant warmer.
- 4. Refeed the infant to continue to increase the blood glucose level.

**89.** The nurse is caring for a neonate weighing 4,536 g (10 lb) who was born via cesarean delivery 1 hour ago. The mother is a class B insulin-dependent diabetic primipara. She asks the nurse, "Why is my baby in the neonatal intensive care unit?" The nurse bases a response on the understanding that neonates of class B diabetic mothers commonly develop which of the following conditions?

- 1. Anemia.
- 2. Persistent pulmonary hypertension.
- 3. Hemolytic disease.
- 4. Hypoglycemia.

**90.** While assessing a neonate weighing 3,175 g (7 lb) who was born at 39 weeks' gestation to a primiparous client who admits to cocaine use during pregnancy, which of the following would alert the nurse to possible cocaine withdrawal?

- 1. Bradycardia.
- 2. High-pitched cry.
- 3. Sluggishness.
- 4. Hypocalcemia.

**91.** After teaching a primiparous client who used cocaine during pregnancy about possible gastrointestinal signs and symptoms in her neonate, which of the following, if stated by the mother as common, indicates effective teaching?

- 1. Hypotonia.
- 2. Constipation.
- 3. Vomiting.
- 4. Abdominal distention.

**92.** When teaching a primiparous client who used cocaine during pregnancy how to comfort her fussy neonate, the nurse can advise the mother to:

- 1. Tightly swaddle the neonate.
- 2. Feed the neonate extra, high-calorie formula.
- 3. Keep the neonate in a brightly lit environment.
- 4. Touch the baby only when he is crying.

**93.** A neonate born at 38 weeks' gestation is admitted to the neonatal nursery for observation. The neonate's mother, who is positive for human immunodeficiency virus (HIV) infection, has received no prenatal care. The mother asks the nurse if her neonate is positive for HIV. The nurse can tell the mother which of the following?

- 1. "More than 50% of neonates born to mothers who are positive for HIV will be positive at 18 months of age."
- 2. "An enlarged liver at birth generally means the neonate is HIV positive."
- 3. "A complete blood count analysis is the primary method for determining whether the neonate is HIV positive."
- 4. "Most neonates are asymptomatic at birth and usually test positive for the HIV antibody at this time."

**94.** When caring for a multiparous client who is human immunodeficiency virus (HIV)-positive and asking to breast-feed her neonate as soon as possible, which of the following instructions about breast milk should the nurse include in the teaching plan?

- 1. It may help prevent the spread of the HIV virus.
- 2. It contains antibodies that can protect the neonate from HIV.
- 3. It can be beneficial for the bonding process.
- 4. It has been found to contain the retrovirus HIV.

**95.** While caring for the neonate of a human immunodeficiency virus-positive mother, the nurse prepares to administer an ordered hepatitis B intramuscular injection at 4 hours after birth. Which of the following actions should the nurse do **first**?

- 1. Bathe the neonate with an antibacterial soap.
- 2. Place the neonate under a radiant warmer.
- 3. Wash the injection site with povidone-iodine (Betadine) solution.
- 4. Apply clean gloves before administering the medication.

**96.** A male neonate born at 38 weeks' gestation by cesarean delivery after prolonged rupture of the membranes and a maternal oral temperature of 102° F (38.8° C) is being observed for signs and symptoms of infection. Which of the following would alert the nurse to notify the physician?

- 1. Leukocytosis.
- 2. Apical heart rate of 132 bpm.
- 3. Behavioral changes.
- 4. Warm, moist skin.

**97.** The nurse is caring for a neonate shortly after birth when the neonate is diagnosed with sepsis and is to be treated with intravenous antibiotics. Which of the following will the nurse need to instruct the parents to do because of the neonate's infection?

- 1. Use caution near the isolation incubator and equipment.
- 2. Visit but do not touch the neonate.
- 3. Wash their hands thoroughly before touching the neonate.
- 4. Wear a mask when holding the neonate.

**98.** A female neonate delivered vaginally at term with a cleft lip and cleft palate is admitted to the regular nursery. Which of the following actions should the nurse do the first time that the parents visit the neonate in the nursery?

- 1. Explain the surgical interventions that will be performed.
- 2. Stress that this defect is not life-threatening.
- 3. Emphasize the neonate's normal characteristics.
- 4. Reassure the parents about the success rate of the surgery.

**99.** After teaching the parents of a neonate born with a cleft lip and cleft palate about appropriate feeding techniques, the nurse determines that the mother needs further instruction when the mother says which of the following?

- 1. "I should clean her mouth with soapy water after feeding."
- 2. "I should feed her in an upright position."
- 3. "I need to remember to burp her often."
- 4. "I may need to use a special nipple for feeding."



**100.** A newborn with a cleft palate at 1 hour of life has a nursing diagnosis of Risk for Infection related to potential aspiration during feedings. Which of the following nursing actions would support the best feeding practice for this infant?

- 1. Use an appropriate nipple and bottle set.
- 2. Encourage the mother to breast-feed.
- 3. Assess daily weights and wet diapers to monitor intake.
- 4. Allow unlimited length of time for each feeding.

**101.** A male neonate born at 36 weeks' gestation is admitted to the neonatal intensive care nursery with a diagnosis of probable fetal alcohol syndrome (FAS). The mother visits the nursery soon after the neonate is admitted. Which of the following instructions should the nurse expect to include when developing the teaching plan for the mother about FAS?

- 1. Withdrawal symptoms usually do not occur until 7 days postpartum.
- 2. Large-for-gestational-age size is common with this condition.
- 3. Facial deformities associated with FAS can be corrected by plastic surgery.
- 4. Symptoms of withdrawal include tremors, sleeplessness, and seizures.

**102.** Which of the following characteristics should the nurse teach the mother about her neonate diagnosed with fetal alcohol syndrome (FAS)?

- 1. Neonates are commonly listless and lethargic.
- 2. The IQ scores are usually average.
- 3. Hyperactivity and speech disorders are common.
- 4. The mortality rate is 70% unless treated.

**103.** A newborn is diagnosed with fetal alcohol syndrome. The nurse is teaching this mother what to expect when she goes home with her baby. The nurse determines the mother needs further instruction when she says which of the following?

- 1. "The way my baby's face looks now will stay that way."
- 2. "My baby may be irritable as a newborn."
- 3. "I may need some help coping with my newborn."
- 4. "My baby will be fine soon after we are home."

**104.** When caring for a neonate diagnosed with gastroschisis, which of the following actions should the nurse expect to do **first**?

- 1. Weigh the neonate.
- 2. Insert an orogastric tube.
- 3. Prepare for immediate blood transfusion.
- 4. Cover the abdomen with a moistened sterile gauze.

**105.** The father of a neonate diagnosed with gastroschisis tells the nurse that his wife had planned on breast-feeding the neonate. Which of the following should the nurse include in the preoperative teaching plan about feeding the neonate?

- 1. The neonate will remain on nothing-by-mouth (NPO) status until after surgery.
- 2. An iron-fortified formula will be given before surgery.
- 3. The neonate will need total parenteral nutrition for nourishment.
- 4. The mother may breast-feed the neonate before surgery.

**106.** The nurse is developing a plan of care for a neonate who is to undergo gastroschisis surgery. What should be included? Select all that apply.

- 1. Prevention of hypothermia.
- 2. Maintenance of fluid and electrolyte balance.
- 3. Provision of time for parental bonding.
- 4. Prevention of infection.
- 5. Providing developmental care.

**107.** While caring for a male neonate diagnosed with gastroschisis, the nurse observes that the parents seem hesitant to touch the neonate because of his appearance. The nurse determines that the parents are most likely experiencing which of the following stages of grief?

- 1. Denial.
- 2. Shock.
- 3. Bargaining.
- 4. Anger.

**108.** Which of the following instructions should the nurse give to the parents of a neonate diagnosed with hyperbilirubinemia who is receiving phototherapy?

- 1. Keep the neonate's eyes completely covered.
- 2. Use a regular diaper on the neonate.
- 3. Offer feedings every 4 hours.
- 4. Check the oral temperature every 8 hours.

**109.** While caring for a term neonate who has been receiving phototherapy for 8 hours, the nurse should notify the health care provider if which of the following is noted?

- 1. Bronze-colored skin.
- 2. Maculopapular chest rash.
- 3. Urine specific gravity of 1.018.
- 4. Absent Moro reflex.

**110.** The nurse is caring for a neonate at 38 weeks' gestation when the nurse observes marked peristaltic waves on the neonate's abdomen. After this observation, the neonate exhibits projectile vomiting. The nurse notifies the pediatrician because these signs are indicative of which of the following?

- 1. Esophageal atresia.
- 2. Pyloric stenosis.
- 3. Diaphragmatic hernia.
- 4. Hiatal hernia.

**111.** The nurse is caring for a term neonate who is diagnosed with patent ductus arteriosus. While performing a physical assessment of the neonate, the nurse anticipates that the neonate will exhibit which of the following?

- 1. Decreased cardiac output with faint peripheral pulses.
- 2. Profound cyanosis over most of the body.
- 3. Loud cardiac murmurs through systole and diastole.
- 4. Harsh systolic murmurs with a palpable thrill.

**112.** Assessment of a term neonate at 8 hours after birth reveals tachypnea, dyspnea, sternal retractions, diminished femoral pulses, poor lower body perfusion, and cyanosis of the lower body and extremities, with a pink upper body. The nurse notifies the pediatrician based on the interpretation that these symptoms are associated with which of the following?

- 1. Coarctation of the aorta.
- 2. Atrioventricular septal defect.
- 3. Pulmonary atresia.
- 4. Transposition of the great arteries.

**113.** The nurse is caring for a 2-day-old neonate in the recovery room 30 minutes after surgical correction for the cardiac defect, transposition of the great vessels. Which of the following would alert the nurse to notify the physician?

- 1. Oxygen saturation of 90%.
- 2. Pale pink extremities.
- 3. Warm, dry skin.
- 4. Femoral pulse of 90 bpm.

**114.** After the physician explains the prognosis and medical management for atrial septal defect to a primiparous client whose 2-day-old female neonate was diagnosed with this condition, the nurse determines that the mother needs further instructions when she says which of the following?

- 1. "As my child grows, she may have increased fatigue and difficulty breathing."
- 2. "My child may need to have antibiotics if she develops an infection."
- 3. "This condition occurs more commonly in females than in males."
- 4. "About half of the children born with this defect heal spontaneously."

## Managing Care Quality and Safety

**115.** The nurse is making clinical rounds on a group of clients in a newborn nursery. Which infant is at greatest risk of developing respiratory distress syndrome (RDS)?

- 1. A neonate born at 36 weeks' gestation.
- 2. A neonate born by Cesarean section.
- 3. A neonate experiencing apneic episodes.
- 4. A neonate who is 42 weeks' gestation

**116.** The nurse has received shift report on a group of newborns. The nurse should make rounds on which of the following clients **first**?

- 1. A newborn who is large for gestational age (LGA) who needs a repeat blood glucose prior to the next feeding in 15 minutes.
- 2. A newborn delivered at 36-weeks' gestation weighing 5 lb who is due to breast-feed for the first time in 15 minutes.
- 3. A newborn who was delivered 24 hours ago by Cesarean section and had a respiratory rate of 62 30 minutes ago.
- 4. A newborn who had a borderline low temperature and was double-wrapped with a hat on ½ hour ago to bring up the temperature.

**117.** The nurse managing the admission nursery is beginning the shift. There are 2 infants under the care of a primary staff nurse and are remaining in the nursery while their mothers sleep. One newborn is waiting to be transferred to the special care nursery (SCN) with a diagnosis of possible sepsis. The SCN cannot accept a transfer for 30 minutes. The nurse has been notified that another infant has been born and is breathing at a rate of 80 bpm and needs to be admitted to the nursery. There are also two infants who are waiting for social services to determine follow-up. There can be no other additions to the nursery until at least one newborn leaves the area. How should the nurse manage this situation?

- 1. Ask the nurses in SCN if they can take the newborn with possible sepsis now.
- 2. Ask the primary staff nurses to take their babies back to the sleeping mothers' rooms.
- 3. Call social services to determine if either of the babies who are waiting to be discharged are ready to leave.
- 4. Ask the nurse with the infant who is breathing at 80 bpm to wait ½ hour.

**118.** The nurse in a postpartum couplet room is making rounds prior to ending the shift. Which of the following indicate that the safety needs of the clients have been met?

- 1. Infant lying on abdomen.
- 2. Security tags in place.
- 3. Identification system on mother and infant.
- 4. Bulb syringe within sight.
- 5. Someone in room able to care for infant.
- 6. Infant in the mother's bed, side rails up.
- 7. Infant in the mother's arms, both asleep.

**119.** The nurse in the newborn nursery has just received shift report about a group of newborns and is to receive another admission in 30 minutes. In order to provide the safest care and plan for the new admission, the nurse should do which of the following in order of first to last?

1. Move quickly from room to room and assess all clients.

2. Check the room to which the new client will be admitted to be sure all supplies and equipment are available.

3. Log on to the clinical information system and determine if there are new orders.

4. Review notes from shift report and prioritize all clients; make rounds on the most critical first.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Neonatal Client

**1. 2.** The concern with this infant is sepsis based on prolonged rupture of membranes before delivery. Blood cultures would provide an accurate diagnosis of sepsis, but will take 48 hours from the time drawn. Frequent monitoring of infant vital signs, looking for changes, and maintaining contact with the parents is also part of care management while awaiting culture results. Continuing with vital signs, voiding, stooling, and eating every 4 hours is the standard of care for a normal newborn, but a respiratory rate > 60, grunting, and occasional flaring are not normal. Although not normal, the need for the intensive care unit is not warranted as newborns with sepsis can be treated with antibiotics at the maternal bedside. The CBC does not establish the diagnosis of sepsis but the changes in the WBC levels can identify an infant at risk. The use of the radiant warmer is not warranted for that length of time.

🔑 CN: Reduction of risk potential;  
CL: Synthesize

**2. 2.** The neonate should be kept away from drafts, such as from air conditioning vents, which may cause heat loss by convection. Evaporation is one of the most common mechanisms by which the neonate will lose heat, such as when the moisture on the newly delivered neonate's body is converted to vapor. Radiation is heat loss between solid objects that are not in contact with one another such as walls and windows. Conduction is when heat is transferred between solid objects in contact with one another, such as when a neonate comes in contact with a cold mattress or scale.

🔑 CN: Reduction of risk potential;  
CL: Synthesize


**3. 135 mg**

The recommended dose of ampicillin for a neonate is 100 mg/kg/dose. First, determine the neonate's weight in kilograms, and then multiply the kilograms by 100 mg. The nurse should use this formula:


$$\begin{aligned} 1,000 \text{ g} &= 1 \text{ kg} \\ 1,350 \text{ g} &= 1.35 \text{ kg} \\ 100 \text{ mg} \times 1.35 \text{ kg} &= 135 \text{ mg/kg} \end{aligned}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**4. 3.** Adding humidity to the incubator adds moisture to the ambient air, which helps to decrease the insensible water loss. Bathing and the use of eye patches has no impact on insensible water loss. The use of a radiant warmer will increase the insensible water loss by drawing moisture out of the skin.

 CN: Reduction of risk potential; CL: Synthesize

**5. 4.** Safe practice and error reduction can be increased by double-checking orders and medications before administration. Knowing the neonate's weight, urinary output, and glucose level is an important part of understanding the potential needs of the neonate; however, double-checking orders and interventions is the most important step to increase safety.

 CN: Safety and infection control; CL: Synthesize

**6. 3.** Neonates that are septic use glucose at an increased rate. During the time the I.V. is not infusing, the neonate is using the limited glucose stores available to a preterm neonate and may deplete them. Hypoglycemia is too little glucose in the blood; without the constant infusion of I.V. glucose, hypoglycemia will result. Fevers and hyperkalemia are not related to glucose levels. Tachycardia is the result of untreated hypoglycemia.

 CN: Reduction of risk potential; CL: Analyze

**7. 1.** This 3-day-old neonate's weight loss falls within a normal range, and therefore no action is needed at this time. Full-term neonates tend to lose 5% to 10% of their birth weight during the first few days after birth, most likely because of minimal nutritional intake. With bottle-feeding, the neonate's intake varies from one feeding to another. Additionally, the neonate experiences a loss of extracellular fluid. Typically, neonates regain any weight loss by 7 to 10 days of life. If the weight loss continues after that time, the physician should be called.

 CN: Health promotion and maintenance; CL: Synthesize

**8. 240 calories**


$$\begin{aligned} 45 \text{ mL} &= 1\frac{1}{2} \text{ oz} \\ 1\frac{1}{2} \text{ oz} \times 8 \text{ feedings} &= 12 \\ 12 \times 20 \text{ calories/oz} &= 240 \text{ calories} \end{aligned}$$

 CN: Physiological adaptation; CL: Apply

**9. 2.** Keeping the neonate away from drafts and cooling ducts prevents heat loss by convection (flow of heat from the body surface to the cooler surrounding air). The neonate also loses heat through evaporation (conversion of a liquid to a vapor, as when a wet surface, such as the neonate's skin, is exposed to air); conduction (transfer of body heat to a cooler solid object in contact with the baby, as when the neonate comes in direct contact with a cold surface such as a scale or a cold stethoscope); and radiation (transfer of heat to cooler solid objects that are not in direct contact with the baby, as when the neonate is placed near a cold window surface or air conditioner).

 CN: Health promotion and maintenance; CL: Apply

**10. 1.** To begin vitamin K synthesis, which occurs in the intestines, food and normal intestinal flora are needed. However, at birth, the neonate's intestines are sterile. Therefore, vitamin K is administered via injection to prevent a vitamin K deficiency that may result in a bleeding tendency. When administered, vitamin K promotes formation in the liver of clotting factors II, VII, IX, and X. Neonates are not normally susceptible to clotting disorders, unless they are diagnosed with hemophilia or demonstrate a deficiency of or a problem with clotting factors. Hemolysis of fetal red blood cells does not destroy vitamin K. Hemolysis may be caused by Rh or ABO incompatibility, which leads to anemia and necessitates an exchange transfusion. Vitamin K synthesis occurs in the intestines, not the liver.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**11. 3.** Currently, the sense of touch is believed to be the most highly developed sense at birth. It is probably for this reason that neonates respond well to touch. Auditory sense typically is relatively immature in the neonate, as evidenced by the neonate's selective response to the human voice. By 4 months, the neonate should turn his eyes and head toward a sound coming from behind. Visual sense tends to be relatively immature. At birth, visual acuity is estimated at approximately 20/100 to 20/150, but it improves rapidly during infancy and toddlerhood. Taste is well developed, with a preference toward glucose; however, touch is more developed at birth.

 CN: Health promotion and maintenance; CL: Synthesize

**12. 1.** The nurse should inform the mother that baby powder can enter the neonate's lungs and result in pneumonia secondary to aspiration of the particles. The best prevention for diaper rash is frequent diaper changing and keeping the neonate's skin dry. The new disposable diapers have moisture-collecting materials and generally do not adhere to the skin unless the diaper becomes saturated. Typically, allergies are not associated with the use of baby powder in neonates.

 CN: Reduction of risk potential;  
CL: Synthesize

**13. 4.** The mother needs further instruction when she says that a yellowish crust should be removed with water. The yellowish crust is normal and indicates scar formation at the site. It should not be removed, because to do so might cause increased bleeding. The petroleum gauze prevents the diaper from sticking to the circumcision site, and it may fall off in the diaper. If this occurs, the mother should not attempt to replace it but should simply apply plain petroleum jelly to the site. The gauze should be left in place for 24 hours, and the mother should continue to apply petroleum jelly with each diaper change for 48 hours after the procedure. A few drops of oozing blood is normal, but if the amount is greater than a few drops the mother should apply pressure and contact the physician. Any bleeding after the first day should be reported.

 CN: Reduction of risk potential;  
CL: Evaluate

**14. 3.** The mother demonstrates understanding of the discharge instructions when she says that she should contact the pediatrician if the baby has a liquid stool with a watery ring, because this indicates diarrhea. Infants can become dehydrated very quickly, and frequent diarrhea can result in dehydration. Normally, babies fall asleep easily after a feeding because they are satisfied and content. Spitting up a tablespoon of formula is normal. However, projectile or forceful vomiting in larger amounts should be reported. Bottle-fed infants typically pass one to two light brown stools each day.

 CN: Reduction of risk potential;  
CL: Evaluate

**15. 1.** Placing the neonate on his back after the feeding is recommended to minimize the risk for sudden infant death syndrome (SIDS). Placing the neonate on the abdomen after feeding has been associated with SIDS. The mother should burp or bubble the baby after ½ oz of formula has been taken and then again when the baby is finished. Waiting until the baby has eaten 1 oz of formula can lead to regurgitation. The entire nipple should be placed on top of the baby's tongue and into the mouth to prevent

excessive air from being swallowed. The nipple is pointed directly into the mouth, not toward the neonate's palate, to provide adequate sucking.

 CN: Reduction of risk potential;  
CL: Evaluate

**16. 1.** In a neonate, the lateral aspect of the heel is the most appropriate site for obtaining a blood specimen. Using this area prevents damage to the calcaneus bone, which is located in the middle of the heel. The middle of the heel is to be avoided because of the increased risk for damaging the calcaneus bone located there. The middle of the foot contains the medial plantar nerve and the medial plantar artery, which could be injured if this site is selected. Using the base of the big toe as the site for specimen collection would cause a great deal of discomfort for the neonate; therefore, it is not the preferred site.

 CN: Reduction of risk potential;  
CL: Apply



**17. 2.** After circumcision with a Plastibell, the most commonly recommended procedure is to clean the circumcision site with warm water with each diaper change. Other treatments are necessary only if complications, such as an infection, develop. Antibacterial soap or diluted hydrogen peroxide may cause pain and is not recommended. Povidone-iodine solution may cause stinging and burning, and therefore its use is not recommended.

 CN: Health promotion and maintenance;  
CL: Apply

**18. 2.** As part of the neonate's physiologic adaptation to birth, at 90 minutes after birth the neonate typically is in the rest or sleep phase. During this time, the heart and respiratory rates slow and the neonate sleeps, unresponsive to stimuli. At this time, the mother should rest and allow the neonate to sleep. Feedings should be given during the first period of reactivity, considered the first 30 minutes after birth. During this period, the neonate's respirations and heart rate are elevated. Getting to know the neonate typically occurs within the first hour after birth and then when the neonate is awake and

during feedings. Changing the neonate's diaper can occur at any time, but at 90 minutes after birth the neonate is usually in a deep sleep, unresponsive, and probably hasn't passed any meconium.

 CN: Health promotion and maintenance;  
CL: Apply


### Physical Assessment of the Neonatal Client

**19. 1.** When assessing the incurving of the trunk tests for automatic reflexes in the newborn, the nurse places the infant horizontally and in a prone position with one hand, and strokes the side of the newborn's trunk from the shoulder to the buttocks using the other hand. If the reflex is present, the newborn's trunk curves toward the stimulated side. Answer 2 shows a figure for testing for a stepping response. Answer 3 shows a figure for testing for a tonic neck reflex. Answer 4 shows a figure for testing for the Moro (startle) reflex.


 CN: Physiological adaptation; CL: Apply



**20. 2.** The Moro reflex is a normal reflex of a neonate and requires no intervention. Calling a code, placing the neonate on seizure precautions, and starting supplemental oxygen are not necessary for a normally occurring reflex.

 CN: Basic care and comfort;  
CL: Synthesize

**21. 2.** When resuscitating the neonate, the principle of airway-breathing-circulation (ABCs) must be followed. Positioning the neonate on the back with the neck slightly extended in the "sniffing" position will open the airway, allowing oxygen to get to the neonate's lungs. Apgar scores are an evaluation of the neonate's status at 1 and 5 minutes of life. Waiting to open the airway until after assigning an Apgar score would be a waste of valuable time. If the airway is not patent, oxygen cannot be delivered. Cardiac compression must be accompanied by adequate oxygenation.

 CN: Physiological adaptation;  
CL: Synthesize


**22. 3.** The neonate has a heart rate greater than 100, which earns him 2 points. His respiratory rate of 70 is equivalent to a 2 on the scale. His flaccid muscle tone is equal to 0 on the scale. The lack of response to stimulus also equals 0, as does his overall pale white color. Thus, the total score equals 4.

 CN: Basic care and comfort; CL: Apply

**23. 1.** As a result of vigorous suctioning the nurse must watch for bradycardia due to potential vagus nerve stimulation. Rapid eye movement is not associated with vagus nerve stimulation. Vagal stimulation will not cause seizures or tachycardia.

 CN: Reduction of risk potential;  
CL: Analyze

**24. 2.** There is a correlation between café au lait spots and the development of neurofibromatosis. Acrocyanosis is a normal finding of bluish hands and feet as a result of poor capillary perfusion. Port wine nevus and strawberry hemangiomas are a collection of dilated capillaries and are not associated with any other disease process.

 CN: Reduction of risk potential;  
CL: Analyze

**25. 2, 3, 4.** Holding the neonate steady and in the proper position will help ensure a safe and accurate lumbar puncture. The neonate is usually held in a "C" position to open the spaces between the vertebral column. This position puts the neonate at risk for airway obstruction. Thus, ensuring the patency of the airway is the first priority, and the nurse should observe the neonate for adequate ventilation. Maintaining a sterile field is important to avoid infection in the neonate. It is not necessary to administer antibiotics or obtain a serum glucose level during the procedure.

 CN: Safety and infection control;  
CL: Synthesize


**26. 3.** Normally, the umbilical cord has two umbilical arteries and one vein. When a neonate is born with only one artery and one vein, the nurse should notify the pediatrician for further evaluation of cardiac anomalies. Other common congenital problems associated with a missing artery include renal anomalies, central nervous system lesions, tracheoesophageal fistulas, trisomy 13, and trisomy 18. Respiratory anomalies are associated with dyspnea and respiratory distress; musculoskeletal anomalies include fractures or dislocated hip; and facial anomalies are associated with fetal alcohol syndrome or Down syndrome, not a missing umbilical artery.

 CN: Reduction of risk potential;  
CL: Analyze


**27. 2.** Normally at birth, the neonate's head circumference is approximately 2 cm larger than the chest circumference. The average normal head circumference is 13 to 14 inches (33 to 35 cm); average normal chest circumference is 12.5 to 14 inches (31 to 35 cm). A head circumference that is equal to or smaller than the chest circumference may indicate microcephaly; a head that is larger than normal may indicate hydrocephalus. The presence of any of these conditions warrants further evaluation.

 CN: Health promotion and maintenance;  
CL: Analyze


**28. 4.** The mother needs further instruction if she says the molding can result in brain damage. Brain damage is highly unlikely. Molding occurs during vaginal delivery when the cranial bones tend to override or overlap as the head accommodates to the size of the mother's birth canal. The amount and duration of pressure on the head influence the degree of molding. Molding usually disappears in a few days without any special attention.

 CN: Health promotion and maintenance;  
CL: Evaluate

**29. 3.** The anterior fontanel is normally diamond-shaped, approximately 2 to 3 cm wide and 3 to 4 cm long. This allows for brain growth during the early months of life. The posterior fontanel is small and triangular.

 CN: Health promotion and maintenance;  
CL: Analyze

**30. 3.** Sole creases covering the entire foot are indicative of a term neonate. If the neonate's ear is lying flat against the head, the neonate is most likely preterm. An absence of rugae in the scrotum typically suggests a preterm neonate. A square window sign angle of 0 degrees occurs in neonates of 40 to 42 weeks' gestation. A 90-degree square window angle suggests an immature neonate of approximately 28 to 30 weeks' gestation.

 CN: Health promotion and maintenance;  
CL: Apply

**31. 2.** An expiratory grunt is significant and should be reported promptly, because it may indicate respiratory distress and the need for further intervention such as oxygen or resuscitation efforts. The presence of a red reflex in the eyes is normal. An absent red reflex may indicate congenital cataracts. A respiratory rate of 45 breaths/minute and a prominent xiphoid process are normal findings in a term neonate.

 CN: Reduction of risk potential;  
CL: Synthesize

**32. 3.** The tonic neck reflex, also called the fencing position, is present when the neonate turns the head to the left side, extends the left extremities, and flexes the right extremities. This reflex disappears in a matter of months as the neonatal nervous system matures. The stepping reflex is demonstrated when the infant is held upright near a hard, firm surface. The prone crawl reflex is demonstrated when the infant pulls both arms but does not move the chin beyond the elbows. When the infant extends and abducts the arms and legs with the toes fanning open, this is a normal Babinski reflex.

 CN: Health promotion and maintenance;  
CL: Apply

**33. 2.** Convergent strabismus is common during infancy until about age 6 months because of poor oculomotor coordination. The neonate has peripheral vision and can fixate on close objects for short periods. The neonate can also perceive colors, shapes, and faces. Neonates can focus on light and should blink or close their eyes in response to light. However, this is not associated with strabismus. An absent red reflex or white areas over the pupils, not strabismus, may indicate congenital cataracts. Most neonates cannot focus well or accommodate for distance immediately after birth.

 CN: Health promotion and maintenance;  
CL: Apply


**34. 3.** A single crease across the palm (simian crease) is most commonly associated with chromosomal abnormalities, notably Down syndrome. Deep creases across the soles of the feet is a normal finding in a term neonate. Frequent sneezing in a term neonate is normal. This occurs because the neonate is a nose breather and sneezing helps to clear the nares. An absence of lanugo on the skin of a term neonate is a normal finding.

 CN: Reduction of risk potential;  
CL: Synthesize


**35. 1, 5, 6.** Phenylketonuria, an inherited autosomal recessive disorder, involves the body's inability to metabolize the amino acid phenylalanine. A diet low in phenylalanine must be followed. Such foods as meats, eggs, and milk are high in phenylalanine. Assistance from a dietitian is commonly necessary to keep phenylalanine levels low and to provide the essential amino acids necessary for cell function and tissue growth. With autosomal recessive disorders, future children will have a 25% chance of having the disease, a 50% chance of carrying the disease, and a 35% chance of being free of the disease. If a diet low in phenylalanine is followed until brain growth is complete (sometime in adolescence), the child should achieve normal intelligence.

 CN: Health promotion and maintenance;  
CL: Evaluate


**36. 1.** Periods of apnea lasting longer than 20 seconds, mild cyanosis, and a heart rate of 110 bpm (bradycardia) are associated with a potentially life-threatening event and subsequent respiratory arrest. The neonate needs further evaluation by the pediatrician. Pneumonia is associated with tachycardia, anorexia, malaise, cyanosis, diminished breath sounds, and crackles. Intraventricular hemorrhage is associated with prematurity. Assessment findings include bulging fontanels and seizures. Epiglottitis is a bacterial form of croup. Assessment findings include inspiratory stridor, cough, and irritability. It occurs most commonly in children age 3 to 7 years.

 CN: Reduction of risk potential;  
CL: Analyze

**37. 4.** Normally, the anterior fontanel closes between ages 12 and 18 months. Premature closure (craniosynostosis or premature synostosis) prevents proper growth and expansion of the brain, resulting in mental retardation. The posterior fontanel typically closes by ages 2 to 3 months.

 CN: Health promotion and maintenance;  
CL: Apply

**38. 2.** Corneas of unequal size should be reported because this may indicate congenital glaucoma. An absence of tears is common because the neonate's lacrimal glands are not yet functioning. The neonate's pupils normally constrict when a bright light is focused on them. The finding implies that light perception and visual acuity are present, as they should be after birth. A red circle on the pupils is seen when an ophthalmoscope's light shines onto the retina and is a normal finding. Called the red reflex, this indicates that the light is shining onto the retina.

 CN: Reduction of risk potential;  
CL: Synthesize

**39. 3.** At 24 hours of age, the neonate is probably in a state of deep sleep, as evidenced by the closed eyes, lack of eye movements, normal skin color, and normal heart rate and respiratory rate. Jitteriness, a high-pitched cry, and tremors are associated with drug withdrawal. The first period of reactivity occurs in the first 30 minutes after birth, evidenced by alertness, sucking sounds, and rapid heart rate and respiratory rate. There is no evidence to suggest respiratory distress because the neonate's respiratory rate of 35 breaths/minute is normal.

 CN: Health promotion and maintenance;  
CL: Analyze

**40. 4.** The condition in which the urinary meatus is located on the ventral surface of the penis, termed hypospadias, occurs in 1 of every 500 male infants. Circumcision is delayed until the condition is corrected surgically, usually between 6 and 12 months

of age. Phimosis is an inability to retract the prepuce at an age when it should be retractable or by age 3 years. Phimosis may necessitate circumcision or surgical intervention. Hydrocele is a painless swelling of the scrotum that is common in neonates. It is not a contraindication for circumcision. Epispadias occurs when the urinary meatus is located on the dorsal surface of the penis. It is extremely rare and is commonly associated with bladder extrophy.

 CN: Reduction of risk potential;  
CL: Analyze

## The Preterm Neonate

**41. 1, 3, 4.** Kangaroo care is skin-to-skin holding of a neonate by one of the parents. Research has shown increased bonding, physiologic stability, and decreased length of stay for neonates who experience this method of holding. Research has not shown an increase in IQ as a developmental outcome. Kangaroo care has not been shown to cause the neonate to gain weight quickly. The experience is usually limited to 1 to 2 hours, 2 to 3 times per day.

 CN: Health promotion and maintenance;  
CL: Apply


**42. 2.** The first step after cesarean delivery is to aspirate mucus from the neonate's mouth. If this is not done, the neonate will aspirate mucus when beginning to breathe. A patent airway is most important. Once mucus has been aspirated, the neonate may be stimulated to cry if necessary. If, once the airway has been established, the neonate does not begin breathing efforts on his or her own, then resuscitation may be necessary. Although the mother will want to see the neonate, holding the neonate upright is inappropriate because the neonate's head should be kept lower than the rest of the body to aid in the expulsion of mucus or other fluids.

 CN: Health promotion and maintenance;  
CL: Synthesize

**43. 4.** When receiving oxygen by mask, the neonate is placed on the back with the neck slightly extended, in the "sniffing" or neutral position. This position optimizes lung expansion and places the upper respiratory tract in the best position for receiving oxygen. Placing a small rolled towel under the neonate's shoulders helps to extend the neck properly without overextending it. Once stabilized and transferred to an isolette in the intensive care unit, the neonate can be positioned in the prone position, which allows for lung expansion in the oxygenated environment. Placing the neonate on the left side does not allow for maximum lung




expansion. Also, slightly flexing the neck interferes with opening the airway. Placing the neonate on the back with the head turned to the left side does not allow for lung expansion. Placing the neonate on the abdomen interferes with proper positioning of the oxygen mask.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**44. 1.** Cardiac massage should be alternated with ventilation to ensure breathing and circulation. Two fingers, not the palm of the hand, are used to compress a neonate's sternum. The chest is compressed 100 to 120 times per minute. The proper technique recommended by the American Heart Association and the American Academy of Pediatrics is to use enough pressure to depress the sternum to a depth of approximately one-third of the anterior-posterior diameter of the chest.

 CN: Physiological adaptation; CL: Apply

**45. 1.** Whenever oxygen is administered, it should be humidified to prevent drying of the nasal passages and mucous membranes. Because the neonate is under a radiant warmer, a stocking cap is not necessary. Temperature, continuously monitored by a skin probe attached to the radiant warmer, is recorded every 30 to 60 minutes initially. Although the oxygen concentration in the hood requires close monitoring and measurement of blood gases, checking the blood glucose level is not necessary.


 CN: Pharmacological and parenteral therapies; CL: Apply

**46. 3.** The neonate is at high risk for sepsis due to exposure to the mother's infection. Temperature instability in a neonate at 38 weeks' gestation is an early sign of sepsis. Other signs include tachycardia, decreased muscle tone, acidosis, apnea, respiratory distress, hypotension, poor feeding behaviors, vomiting, and diarrhea. Late signs of infection include jaundice, seizures, enlarged liver and spleen, respiratory failure, and shock. Alkalosis is not typically seen in neonates who develop sepsis. Acidosis and respiratory distress may develop unless treatment such as antibiotics is started. A positive Babinski's reflex is a normal finding and does not need to be reported.

 CN: Reduction of risk potential; CL: Analyze

**47. 1.** With an absent apical pulse left of the mid-clavicular line accompanied by cyanosis, grunting, and diminished breath sounds, the neonate is most likely experiencing pneumothorax. Pneumothorax occurs when alveoli are over-distended and subsequently the lung collapses, compressing the heart and lung and compromising the venous return to the right side of the heart. This condition can be

confirmed by X-ray or ultrasound studies. Repositioning the infant may open the airway, administering oxygen will improve oxygen saturation levels, and obtaining blood studies for infection will rule that out, but until pneumothorax is resolved, the other symptoms will continue.

 CN: Physiological adaptation; CL: Synthesize

**48. 2.** RDS, previously called hyaline membrane disease, is a developmental condition involving a decrease in lung surfactant leading to improper expansion of the lung alveoli. Surfactant contains a group of surface-active phospholipids, of which one component—lecithin—is the most critical for alveolar stability. Surfactant production peaks at about 35 weeks' gestation. This syndrome primarily attacks preterm neonates, although it can also affect term and post-term neonates. Altered somatotropin secretion is associated with growth disorders such as gigantism or dwarfism. Altered testosterone secretion is associated with masculinization. Altered progesterone secretion is associated with spontaneous abortion during pregnancy.

 CN: Physiological adaptation; CL: Apply


**49. 3.** The best way to determine the adequacy of oxygen therapy is to monitor the neonate's arterial blood gas values. These results quantitatively measure oxygen and carbon dioxide tensions. Cyanosis, a late sign, can validate laboratory findings, but without laboratory results it is not a reliable indicator of the effectiveness of oxygen therapy. Likewise, pulse rate does not serve as a good index because there is poor correlation between it and extreme hyperoxia. The percentage of oxygen received is not a good indicator of the arterial blood gas level of oxygen. Even with high levels of oxygen, the preterm neonate may continue to have poor perfusion because of immature development of the heart and lungs. The percentage delivered is based on the analysis of the neonate's arterial blood gases.

 CN: Reduction of risk potential; CL: Evaluate


**50. 2.** RDS is a developmental condition that primarily affects preterm infants before 35 weeks' gestation because of inadequate lung development from deficient surfactant production. The development of placenta previa has little correlation with the development of RDS. Although excessive analgesia can depress the neonate's respiratory condition if it is given shortly before birth, the scenario presents no information that this has occurred. The neonate's sluggish respiratory activity postpartum is not the likely cause of RDS but may be a sign that the neonate has the condition.

 CN: Reduction of risk potential; CL: Synthesize


**51. 3.** Oxygen should be humidified before administration to help prevent drying of the mucous membranes in the respiratory tract. Drying impedes the normal functioning of cilia in the respiratory tract and predisposes to mucous membrane irritation. Humidification of oxygen does not promote expansion of the immature lungs. Expansion is promoted by placing the infant in a prone position or providing the preterm infant with surfactant medication. Humidified oxygen does not prevent viral or bacterial pneumonia. In fact, in some nurseries, *Staphylococcus aureus* has been detected in moist environments and on the hands and nails of staff members, predisposing the neonate to pneumonia. Humidified oxygen does not improve blood circulation in the cardiac system.

 CN: Pharmacological and parenteral therapies; CL: Apply


**52. 4.** Many intensive care units that care for high-risk neonates recommend that the mother pump her breasts, store the milk, and bring it to the unit so the neonate can be fed with it, even if the neonate is being fed by gavage. As soon as the neonate has developed a coordinated suck-and-swallow reflex, breast-feeding can begin. Secretory immunoglobulin A, found in breast milk, is an important immunoglobulin that can provide immunity to the mucosal surfaces of the gastrointestinal tract. It can protect the neonate from enteric infections, such as those caused by *Escherichia coli* and *Shigella* species. Some studies have also shown that breast-fed preterm neonates maintain transcutaneous oxygen pressure and body temperature better than bottle-fed neonates. There is some evidence that breast milk can decrease the incidence of necrotizing enterocolitis. The preterm neonate does not need additional fat in the diet. However, some neonates may need an increased caloric intake. In such cases, breast milk can be fortified with an additive to provide additional calories. Neonates who are receiving oxygen can breast-feed. During feedings, supplemental oxygen can be delivered by nasal cannula.

 CN: Health promotion and maintenance; CL: Apply

**53. 1.** ROP, previously called retrolental fibroplasia, is associated with multiple risk factors, including high arterial blood oxygen levels, prematurity, and very low birth weight (less than 1,500 g). In the early acute stages of ROP, the neonate's immature retinal vessels constrict. If vasoconstriction is sustained, vascular closure follows, and irreversible capillary endothelial damage occurs. Normal room air is at 21%. Acidosis, not alkalosis, is commonly seen in preterm neonates, but this is not related to the development of ROP. Phototherapy is not related to the development of ROP. However, during phototherapy, the neonate's eyes should be constantly covered to prevent damage from the lights.

 CN: Reduction of risk potential; CL: Apply

**54. 4.** Constricted retinal vessels may indicate the degree of ROP. In ROP, immature blood vessels in the retina constrict and become permanently occluded. New vessels proliferate to reestablish circulation. If the new vessels extend into the vitreous humor of the eye, hemorrhage can occur, resulting in scarring and retinal detachment. Sunken orbital sockets would be suggestive of dehydration, not ROP. Strabismus ("crossed eyes") is common in all neonates because of poor oculomotor coordination. A reaction to bright light is a normal finding.

 CN: Reduction of risk potential; CL: Analyze


**55. 1.** Because the retina may become detached with ROP, laser therapy has been used successfully in some medical centers to treat ROP. Cromolyn sodium (Intal) is used to treat seasonal allergies. ROP is not associated with glaucoma, so frequent testing is not necessary. Because the vessels of the eye are affected, not the corneas, corneal transplantation is not used.

 CN: Physiological adaptation; CL: Apply

**56. 1.** Neonates who weigh less than 1,500 g or are born at less than 34 weeks' gestation are susceptible to PIVH. Computed tomography scanning or ultrasound scanning can confirm the diagnosis. The spinal fluid will show an increased number of red blood cells. Arterial blood gas specimen collection is done to evaluate the neonate's oxygen saturation level. Skull radiographs are not commonly used because of the danger of radiation. Additionally, computed tomography scans have replaced the use of skull X-ray films because they can provide more definitive results. Complete blood count specimen collection is usually performed to determine the hemoglobin, hematocrit, and white blood cell count. The results are not specific for PIVH.

 CN: Reduction of risk potential; CL: Apply


**57. 3.** A common finding of IVH is a bulging fontanel. The most common site of hemorrhage is the periventricular subependymal germinal matrix, where there is a rich blood supply and where the capillary walls are thin and fragile. Rapid volume expansion, hypercarbia, and hypoglycemia contribute to the development of IVH. Other common manifestations include neurologic signs such as hypotonia, lethargy, temperature instability, nystagmus, apnea, bradycardia, decreased hematocrit, and increasing hypoxia. Seizures also may occur. Hyperbilirubinemia refers to an increase in bilirubin in the blood and is not associated with IVH.

 CN: Physiological adaptation; CL: Analyze


**58. 2, 4, 5.** Nonnutritive sucking has been seen in infants as early as 28 weeks and ultrasound examinations have shown thumb sucking in utero even earlier. Nonnutritive sucking provides oral stimulation and allows the baby to maintain the sucking reflex needed for breast- or bottle-feedings later. It does not teach the infant how to suck and swallow. Sucking is thought to help with gastric emptying by stimulating secretions of GI peptides. Moisture of the mucus membranes is an indication of adequate hydration, and nonnutritive sucking will not have an effect.

 CN: Basic care and comfort; CL: Apply


**59. 4.** Indications of NEC include abdominal distention with gastric retention and vomiting. Other signs may include lethargy, irritability, positive blood culture in stool, absent or diminished bowel sounds, apnea, diarrhea, metabolic acidosis, and unstable temperature. A gastric residual of 1 mL is not significant. Jaundice of the face and chest is associated with the neonate's immature liver function and increased bilirubin, not NEC. Typically with NEC, the neonate would exhibit absent or diminished bowel sounds, not increased peristalsis.

 CN: Physiological adaptation;  
CL: Analyze

**60. 2.** BPD is a chronic illness that may require prolonged hospitalization and permanent assisted ventilation. The disease typically occurs in compromised very-low-birth-weight neonates who require oxygen therapy and assisted ventilation for treatment of respiratory distress syndrome. The cause is multifactorial, and the disease has four stages. The neonate's activities may be limited by the disease. Antibiotics may be ordered, and bronchodilators may be used, but these medications will not cure the chronic disease state. Seizure activity is associated with periventricular-intraventricular hemorrhage, not BPD.

 CN: Physiological adaptation;  
CL: Evaluate

**61. 4.** The client data supports the diagnosis of pneumothorax which would be confirmed with a chest X-Ray. Pneumothorax is an accumulation of air in the thoracic cavity between the parietal and visceral pleurae and requires immediate removal of the accumulated air. Resolution is initiated with insertion of a chest tube connected to continuous negative pressure. The neonate does not need to be placed on a ventilator unless there is evidence of severe respiratory distress. The goal of treatment is to re-inflate the collapsed lung. Administering bronchodilators through the nares or suctioning the neonates' nares would do nothing to aid in lung re-inflation.

 CN: Physiological adaptation;  
CL: Synthesize


**62. 3.** Decreased protein or hypoproteinemia is a sign of overhydration, which can lead to patent ductus arteriosus or congestive heart failure. Bulging fontanel, decreased serum sodium, decreased urine specific gravity, and decreased hematocrit are other signs of overhydration. Hyponatremia (increased serum sodium concentration) or increased urine specific gravity would suggest dehydration, not overhydration. Polycythemia evidenced by an elevated hematocrit would suggest hypoxia or congenital heart disorder.

 CN: Reduction of risk potential;  
CL: Analyze

**63. 0.03 mg**

$$6\frac{1}{2} \text{ lb} \div 2.2 = 2.95 \text{ kg}$$

$$2.95 \text{ kg} \times 0.01 \text{ mg} = 0.029 \text{ mg, rounded to } 0.03 \text{ mg}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

## The Post-Term Neonate

**64. 4.** Increased respiratory rate and tremors are indicative of hypoglycemia, which commonly affects the post-term neonate because of depleted glycogen stores. Therefore, *Imbalanced nutrition: Less than body* requirements is the priority nursing diagnosis. There is no indication that the neonate has ineffective airway clearance, which would be evidenced by excessive amounts of mucus or visualization of meconium on the vocal cords. Lethargy, not tremors, would suggest infection or hyperthermia. Furthermore, the post-term neonate typically has difficulty maintaining temperature, resulting in hypothermia, not hyperthermia. Decreased cardiac output is not indicated, particularly because the neonate was delivered by cesarean delivery, which is not considered a difficult delivery.

 CN: Health promotion and maintenance;  
CL: Analyze


**65. 2.** A loose, watery stool in the diaper is indicative of diarrhea and needs immediate attention. The infant may become severely dehydrated quickly because of the higher percentage of water content per body weight in the neonate, compared with the adult. Frequent hiccups are considered normal in a neonate and do not warrant additional investigation. Pink papular vesicles (*erythema toxicum*) on the face are considered normal in a neonate and disappear without treatment. Dry, peeling skin is normal in a post-term neonate.

 CN: Health promotion and maintenance;  
CL: Analyze


**66. 2.** Ortolani's maneuver involves flexing the neonate's knees and hips at right angles and bringing the sides of the knees down to the surface of the examining table. A characteristic click or "clunk," felt or heard, represents a positive Ortolani's sign, suggesting a possible hip dislocation. The nurse should notify the physician promptly because treatment is needed, while maintaining the dislocated hip in a position of flexion and abduction. Determining the length of the mother's labor provides no useful information related to the nurse's finding. Keeping the infant under the radiant warmer is necessary only if the neonate's temperature is low or unstable. Checking for hypoglycemia is not indicated at this time, unless the neonate is exhibiting jitteriness.

 CN: Reduction of risk potential;  
CL: Synthesize

**67. 4.** The priority nursing diagnosis for the neonate with probable MAS is *Impaired gas exchange* related to the effects of respiratory distress. Obstruction of the airways may be complete or partial. Meconium aspiration may lead to pneumonia or pneumothorax. Establishing adequate respirations is the primary goal. *Impaired skin integrity* related to post-term status is a concern, but establishing and maintaining an airway and gas exchange is always the priority. Although nutrition may be altered, oxygenation takes priority over nutrition. If the parents do not express interest or concern for the neonate, then *Risk for impaired parent-infant-child attachment* may be appropriate once the airway is established.


 CN: Physiological adaptation;  
CL: Analyze

**68. 1.** Care of an umbilical arterial line would be included in the neonate's plan of care because an umbilical arterial line is commonly inserted to monitor arterial blood pressures, blood pH, blood gases, and infusion of intravenous fluids, blood, or medications. Frequent ultrasound scans are not indicated at this time. However, chest radiographs may be used to detect lung densities, because pneumonia is a major complication of this disorder. Orogastric feeding may not be feasible while the health care team focuses on interventions to establish adequate oxygenation. The neonate with MAS commonly experiences hypoglycemia, not hyperglycemia. Hypoglycemia occurs because of depletion of glucose stores related to hypothermia.

 CN: Physiological adaptation;  
CL: Synthesize


**69. 4.** Tolazoline (Priscoline) can cause profound hypotension. Therefore, the nurse should monitor the neonate's blood pressure when giving this drug. Adverse effects of the medication include petechiae,

dark stools, bleeding, and diarrhea. Plasma expanders are commonly used with tolazoline to prevent dramatic changes in blood pressure. Feeding behaviors, temperature, and skin color are routine assessments for all neonates, unrelated to the use of tolazoline.


 CN: Pharmacological and parenteral therapies;  
CL: Analyze

## The Neonate with Risk Factors

**70. 2.** Epinephrine is given for severe bradycardia and hypotension. An expected outcome would be an increased heart rate to a normal range. Epinephrine decreases renal blood flow, so a decrease in urine output would be expected. Epinephrine also stimulates alpha- and beta-adrenergic receptors, which do not offer pain relief or sedation.

 CN: Pharmacological and parenteral therapies;  
CL: Evaluate

**71. 4.** Neonates that are sick do not have the physical resources or energy to respond to all elements of the environment. The use of a constant touch provides comfort and only requires one response to a stimulus. To comfort a sick neonate, the care provider applies gentle, constant physical support or touch. Toys for distraction are not developmentally appropriate for a neonate. Sick neonates react to any stimulus; in responding, the sick neonate may have increased energy demands and increased oxygen requirements. A musical mobile may be too much audio stimulation and thus increases energy and oxygen demands. Repetitive touching with a hand going off and on the neonate, as with stroking or patting, requires the neonate to respond to every touch, thus increasing energy and oxygen demands.

 CN: Basic care and comfort;  
CL: Synthesize

**72. 2.** Recommended pulse oximetry reading in a full-term neonate is 95% to 100%. The saturation reading of only 75% is an indication that the neonate is not adequately oxygenating in room air. Providing supplemental oxygen will increase the neonate's oxygen saturation. Increasing the I.V. rate will not improve the oxygen saturation. Documenting the finding and taking no action is not appropriate with a saturation of 75%. Wrapping and increasing the body temperature of the neonate may increase the saturation reading only if it is inaccurate due to cold extremities. Caution must be used because overheating a neonate can be harmful.

 CN: Reduction of risk potential;  
CL: Synthesize

**73.**

4. Assess the neonate for respiratory effort.

3. Assess the neonate for color.

2. Make sure the pulse oximeter is correlating to the heart rate.

1. Increase the  $F_{IO_2}$ .


Assessment of the neonate is the most important priority and should be completed first. Respiratory effort must be assessed first to determine if the neonate is breathing. Once breathing is established, assessment of color is next. Then verification of proper equipment function is necessary. The last measure is to increase the  $F_{IO_2}$  due to the potential harmful effects of oxygen. Oxygen should be viewed as a drug and its use evaluated carefully. Increasing the  $F_{IO_2}$  should be done only when indicated; possible causes of low saturation readings must be evaluated first.

 CN: Reduction of risk potential;  
CL: Synthesize

**74. 4.** Neonates with heart failure may need calorie-dense formula to provide extra calories for growth. Fluids should not be restricted because the nutritional requirements are based on calories per ounce of formula. Decreasing fluid intake will decrease calories needed for growth. These neonates may have limited energy due to their heart condition but have a high caloric need to stimulate proper growth and development. The sodium level should be at a normal level to ensure adequate fluid and electrolyte balance unless prescribed by the physician.


 CN: Health promotion and maintenance;  
CL: Create

**75. 1.** The indication for the use of indomethacin is to close a patent ductus arteriosus. Adverse effects include decreased renal blood flow, platelet dysfunction with coagulation defects, decreased GI motility, and an increase in necrotizing enterocolitis. Thus, increased bleeding time, decreased gastrointestinal function, and decreased renal output would be expected outcomes after the administration of indomethacin.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**76. 4.** The size of the nasogastric (NG) feeding tube is based on the neonate's weight. A larger feeding tube can be inserted into a heavier neonate. The disease process plays no role in the size of the


feeding tube used. The neonate's weight and size can vary widely; thus, there is no standard tube size for any gestational age. Length will determine the depth at which the NG tube is placed in the stomach, not the size of the tube.

 CN: Basic care and comfort;  
CL: Synthesize

**77. 2.** A quiet environment with decreased stimulation is the best treatment for a drug-exposed neonate. The drug-exposed neonate has limited ability to deal with stress and cope with stimuli. Assessing vital signs with blood pressure every hour will disturb the neonate's rest periods and cause increased physical and psychological demands. Placement in a well-lighted or stimulating environment is overwhelming for the neonate and will increase the neonate's stress level.

 CN: Physiological adaptation; CL: Apply

**78. 1.** To ensure client safety, the nurse should first write the results on the chart, then read them back to the caller and wait for the caller to confirm that the nurse has understood the results. Using a scrap paper increases the risk of losing the results as well as transcription errors. The nurse may receive results by telephone, and while electronic transfer to the client's electronic record is appropriate, the nurse can also accept the telephone results if the laboratory has called the results to the nursery. Sending client information via e-mail is unacceptable due to potential security and privacy issues.


 CN: Safety and infection control;  
CL: Apply

**79. 3.** Hemolytic disease of the newborn is associated with Rh problems. Hemolytic disease of the newborn occurs most commonly when the mother is Rh-negative and the father is Rh-positive. About 13% of white Americans, 7% to 8% of African Americans, and 1% of Asian Americans are Rh-negative. Rh-positive cells enter the mother's Rh-negative bloodstream, and antibodies to the Rh-positive cells are produced. In a subsequent pregnancy, the antibodies cross the placenta to the Rh-positive fetus and begin the destruction of Rh-positive cells through hemolysis. This results in severe fetal anemia.


 CN: Physiological adaptation; CL: Apply

**80. 3.** The problem of Rh sensitivity arises when the mother's blood develops antibodies after fetal red blood cells enter the maternal circulation. In cases of Rh sensitivity, this usually does not occur until after the first pregnancy. Hence, hemolytic disease of the newborn is rare in a primiparous client. A mismatched blood transfusion in the past or an unrecognized spontaneous abortion could also result in hemolytic disease because the transfusion

or abortion would have the same effects on the client. The statement about the other baby having a different father may be true. However, if both fathers were Rh-positive, then sensitization could occur. Most women do not have immunity against the antibodies formed when Rh-positive cells enter the mother's bloodstream. Antibodies are not neutralized by the mother's system.

 CN: Reduction of risk potential;  
CL: Evaluate


**81. 2.** The Rh-sensitized neonate generally does not have problems related to polycythemia. Therefore, the client needs additional teaching. In general, moderate to severe Rh sensitization can cause anemia, enlarged spleen, and cardiac decompensation. Cardiac decompensation (as in heart failure) occurs because of severe anemia. Anemia is caused by the destruction of red blood cells by antibodies as the severity of hemolytic disease of the neonate increases. Splenic enlargement is caused by the excessive destruction of fetal red blood cells.

 CN: Physiological adaptation;  
CL: Evaluate

**82. 3.** A direct Coombs test is done on umbilical cord blood to detect antibodies coating the neonate's red blood cells. Hematocrit is used to detect anemia. Sodium, potassium, and chloride are used to detect electrolyte imbalances. Antigens on the neonate's red blood cells are proteins that help determine the neonate's blood type.

 CN: Reduction of risk potential;  
CL: Apply

**83. 3.** An exchange transfusion is done to reduce the blood concentration of bilirubin and correct the anemia. The exchange transfusion does not replenish the white blood cells or restore the fluid and electrolyte balance. The neonate's Rh-positive blood is replaced by Rh-negative blood.

 CN: Reduction of risk potential;  
CL: Apply

**84. 2.** The organ most susceptible to damage from uncontrolled hemolytic disease is the brain. Bilirubin levels increase as the red blood cells are destroyed. Bilirubin crosses the blood-brain barrier and damages the cells of the central nervous system. This condition, called kernicterus, is potentially fatal. Although the kidneys, lungs, and liver may be affected by increased bilirubin levels, the brain will sustain the most life-threatening injury.

 CN: Reduction of risk potential;  
CL: Apply

**85. 1, 4.** A glucometer reading of 40 mg/dL (or less) and irregular respirations, tremors, and hypothermia are indicative of hypoglycemia. Internal

fetal monitors detect the strength of contractions and the fetal heart rate. An infant of an insulin-dependent mother and a large-for-gestational-age infant are at greater risk of developing hypoglycemia and need to be observed carefully but these findings are not definitive for the diagnosis of hypoglycemia.

 CN: Physiological adaptation;  
CL: Analyze

**86. 2.** Glucose crosses the placenta, but insulin does not. Hence, a high maternal blood glucose level causes a high fetal blood glucose level. This causes the fetal pancreas to secrete more insulin. At birth, the neonate loses the maternal glucose source but continues to produce much insulin, which commonly causes a drop in blood glucose levels (hypoglycemia), usually at 30 to 60 minutes postpartum. Most neonates do not develop hypoglycemia if their mothers are not insulin dependent unless they are preterm. Therefore, hypoglycemia is not a normal response as the neonate transitions to extrauterine life.

 CN: Reduction of risk potential;  
CL: Analyze

**87. 1.** Infants born to diabetic mothers tend to be larger than average, and this neonate weighs 10 lb, 1 oz (4,564 g). The most common fractures are those of the clavicle and long bones, such as the femur. In a neonate, the skull bones are not fused and move to allow for vaginal delivery, so skull fracture is rarely seen. Wrist and rib cages are rarely fractured.

 CN: Reduction of risk potential;  
CL: Apply

**88. 1.** This neonate has a diabetic mother who tends to have higher calcium levels, which can cause secondary hypoparathyroidism in their neonates. This lack of calcium may be the cause of the tremors and jitteriness of this neonate and a serum calcium level should be obtained. Other factors contributing to hypocalcemia in neonates include hypophosphatemia from tissue metabolism, vitamin D antagonism from increased cortisol levels and decreased serum magnesium levels. Beginning a glucose IV based on a normal infant glucose level would have no benefit. Rechecking the neonate's temperature is a precaution that can be taken to assure that it is within normal limits but is not the action to take first. Refeeding the infant who has a normal newborn blood glucose level is not appropriate.

 CN: Management of care; CL: Synthesize

**89. 4.** Hypoglycemia is caused by the rapid depletion of glucose stores. In addition, neonates born to class B diabetic women are about seven times more likely to suffer from respiratory distress syndrome than neonates born to nondiabetic women. This neonate should be closely monitored

for symptoms of hypoglycemia and respiratory distress. Neonates of diabetic mothers commonly have polycythemia, not anemia. Anemia and hemolytic disease are associated with erythroblastosis fetalis. Persistent pulmonary hypertension is associated with meconium aspiration syndrome.

 CN: Reduction of risk potential;  
CL: Apply

**90. 2.** Manifestations of cocaine withdrawal in the neonate include a shrill, high-pitched cry; tachycardia; muscle rigidity; irritability; restlessness; fist-sucking; and an exaggerated startle reflex. These signs usually appear within 72 hours and persist for several days. These neonates are difficult to console, have poor feeding behaviors, and have diarrhea. Bradycardia is associated with preterm neonates. Sluggishness and lethargy are associated with neonates whose mothers received analgesia shortly before delivery. Hypocalcemia occurs most commonly in infants of diabetic mothers, premature infants, and low-birth-weight infants.

 CN: Reduction of risk potential;  
CL: Analyze

**91. 3.** Neonates experiencing cocaine withdrawal have gastrointestinal problems similar to those of adults withdrawing from cocaine. The neonates exhibit poor sucking, vomiting, drooling, diarrhea, regurgitation, and anorexia. In addition, they are difficult to console and difficult to feed. Because of these problems, the neonate withdrawing from cocaine needs to be monitored carefully to prevent dehydration. Neonates with cocaine exposure experience hypertonia, not hypotonia, due to increased central nervous system irritability. Diarrhea, not constipation, is seen in these neonates. Abdominal distention is associated with necrotizing enterocolitis, not cocaine withdrawal.

 CN: Reduction of risk potential;  
CL: Evaluate

**92. 1.** A neonate undergoing cocaine withdrawal is irritable, often restless, difficult to console, and often in need of increased activity. It is commonly helpful to swaddle the neonate tightly with a blanket, offer a pacifier, and cuddle and rock the neonate. Offering extra nourishment is not advised because overfeeding tends to increase gastrointestinal problems such as vomiting, regurgitation, and diarrhea. Environmental stimuli such as bright lights and loud noises should be kept to a minimum to decrease agitation. Minimizing touching of the neonate to only when he or she is crying will not aid the bonding process between mother and neonate. Frequent holding and touching are permissible.

 CN: Reduction of risk potential;  
CL: Synthesize


**93. 4.** Although most neonates are asymptomatic, they do test positive for HIV at birth because of the mother's antibodies. It may take several months before an accurate diagnosis can be made. It is estimated that 20% to 40% of all HIV-positive mothers deliver HIV-positive infants. With appropriate drug intervention to the mother during pregnancy, 95% of these neonates can be born unaffected. An enlarged liver at birth is associated with erythroblastosis fetalis, not HIV infection. Virologic testing, such as deoxyribonucleic acid polymerase chain reaction, viral culture, or ribonucleic acid plasma assay, can diagnose HIV infection by 6 months of age and commonly in the first month.

 CN: Reduction of risk potential;  
CL: Apply

**94. 4.** Breast milk has been found to contain the retrovirus HIV. In general, mothers are discouraged from breast-feeding if they are HIV positive because of the risk of possible transmission of the virus if the neonate is HIV negative. Breast milk does contain some immunoglobulins, but it does not protect the neonate from HIV infection.

 CN: Health promotion and maintenance;  
CL: Create


**95. 4.** As part of standard precautions, the nurse should don a pair of clean gloves. Additionally, the site is cleaned thoroughly with an alcohol swab before the skin is injected. Sterile gloves are not necessary. Bathing the neonate is not necessary before giving the injection. Some research suggests that bathing removes the neonate's protective skin oils. Placing the neonate under the radiant warmer is not necessary unless the neonate's temperature is subnormal. The neonate's temperature has usually stabilized by 4 hours of age. Washing the injection site with povidone-iodine before giving the injection is not necessary because of the risk for possible allergy to iodine preparations.

 CN: Safety and infection control;  
CL: Synthesize


**96. 3.** Symptoms of infection in a neonate include subtle behavioral changes, such as lethargy and irritability, and color changes such as pallor or cyanosis. Other symptoms include temperature instability, poor feeding, gastrointestinal disorders, hyperbilirubinemia, and apnea. Leukocytosis, an elevated white blood cell count possibly as high as 30,000 cells/mm<sup>3</sup> or more, may be normal during the first 24 hours. An apical heart rate of 132 bpm is normal. Warm, moist skin is not a typical sign of infection in neonates. Typically, temperature instability is common. The neonate's temperature is low and the skin is cool and dry.

 CN: Health promotion and maintenance;  
CL: Analyze

**97. 3.** The parents of a neonate with an infection should be allowed to participate in daily care as long as they use good handwashing technique. This includes touching and holding the neonate. The parents must be careful around medical equipment to ensure proper function and around the intravenous site so that it is not dislodged, but being careful with the equipment is not sufficient to prevent transmission of microbes to the neonate. Restricting parental visits has not been shown to have any effect on the infection rate and may have detrimental effects on the neonate's psychological development. Normally, the neonate does not need to be isolated. It is not necessary for the parents to wear a mask while holding the neonate. The neonate is not contagious and is receiving treatment for the infection.

 CN: Safety and infection control;  
CL: Apply

**98. 3.** On the initial visit, the parents may be shocked, fearful, and anxious. Nursing care should include spending time with the parents to allow them to express their emotions. The nurse should initially emphasize the neonate's normal characteristics. After the parents have had sufficient time to adjust to the neonate's special needs, surgical interventions can be discussed. Telling the parents that this is not a life-threatening defect or that everything will be all right after the surgery is not helpful. Doing so discounts their feelings. Reassuring the parents about the success rate of the surgery can be done once the parents have had time to adjust to the neonate and express their emotions.

 CN: Psychosocial adaptation;  
CL: Synthesize

**99. 1.** After feeding, the mouth should be cleaned with sterile water, not soapy water, to reduce the risk for aspiration. The cleft lip should be cleaned with sterile water to prevent crusting before surgical repair. The neonate needs to be fed in an upright position to prevent aspiration. The neonate with a cleft lip and palate commonly swallows large amounts of air during feeding. Therefore, the neonate needs to be burped frequently to help eliminate the air and decrease the risk for regurgitation. The neonate with a cleft lip and palate should be fed with a special soft nipple that fills the cleft and facilitates sucking.


 CN: Reduction of risk potential;  
CL: Evaluate

**100. 2.** Breast-feeding is the method of choice for all neonates. Infant feeding is more difficult for infants with cleft palates because of the inability to create a seal around the nipple. Maternal nipples most readily conform to the palate and create an adequate seal. Secondarily utilizing a nipple especially made for the particular cleft facilitates the seal and encourages an easier suck and swallow.

Assessing the infant's weight and wet diapers on a daily basis monitors the hydration and nutritional status. An unlimited length of time for each feeding can cause fatigue and poor weight gain.

 CN: Health promotion and maintenance;  
CL: Apply

**101. 4.** The long-term prognosis for neonates with FAS is poor. Symptoms of withdrawal include tremors, sleeplessness, seizures, abdominal distention, hyperactivity, and inconsolable crying. Symptoms of withdrawal commonly occur within 6 to 12 hours or, at the latest, within the first 3 days of life. The neonate with FAS is usually growth deficient at birth. Most neonates with FAS are mildly to severely mentally retarded. The facial deformities, such as short palpebral fissures, epicanthal folds, broad nasal bridge, flattened midfacies, and short, upturned nose are not easily corrected with plastic surgery.

 CN: Reduction of risk potential;  
CL: Create

**102. 3.** Central nervous system disorders are common in neonates with FAS. Speech and language disorders and hyperactivity are common manifestations of central nervous system dysfunction. Mild to severe mental retardation and feeding problems also are common. Delayed growth and development is expected. These neonates feed poorly and commonly have persistent vomiting until age 6 to 7 months. These neonates do not have a 70% mortality rate, and there is no treatment for FAS.

 CN: Reduction of risk potential;  
CL: Apply

**103. 4.** Changes seen in the facial features of newborns with fetal alcohol syndrome remain that way. These include epicanthal folds, whorls, irregular hair, cleft lip or palate, small teeth, and lack of filtrum. Newborns with fetal alcohol syndrome are usually difficult to calm and frequently cry for long periods of time. Parents do need assistance with caring for themselves and their infants, particularly with continued alcohol use. A supportive family or support systems are essential. The problems seen with this newborn do not go away and remain with the infant throughout life and are compounded when the child begins to develop mentally.

 CN: Health promotion and maintenance;  
CL: Evaluate

**104. 4.** Gastroschisis is a rare anomaly characterized by the evisceration of abdominal contents through a full-thickness defect in the abdominal wall. The nurse should first protect the abdominal contents with sterile gauze moistened with sterile saline. Immediate surgery is required. Weighing the neonate is not a priority at this time, but it may need to be done before surgery to determine the



appropriate amount of anesthesia. An orogastric tube is not necessary because the infant will not be fed before surgery. An immediate blood transfusion is not needed at this time.

 CN: Reduction of risk potential;  
CL: Synthesize


**105. 1.** The parents need to know that the neonate will be kept on NPO status and will receive intravenous therapy before surgery. After surgery, feeding will depend on the neonate's condition. Total parenteral nutrition may be ordered after surgery, but not before. Breast-feeding may be started after surgery if the neonate's condition is stable. The mother can pump the breasts until that time.

 CN: Reduction of risk potential;  
CL: Apply

**106. 1, 2, 4.** The major goals for the neonate include preventing hypothermia, maintaining fluid and electrolyte balance, and preventing infection. The neonate needs immediate surgery, so bonding is not a priority at this time. Developmental care is important and should be addressed after the closure of the abdominal wall defect.

 CN: Reduction of risk potential;  
CL: Create

**107. 2.** The physical appearance of the anomaly and the life-threatening nature of the disorder may result in shock to the parents. The parents may hesitate to form a bond with the neonate because of the guarded prognosis. Denial would be evidenced if the parents acted as if nothing were wrong. Bargaining would be evidenced by parental statements involving "if-then" phrasing, such as, "If the surgery is successful, I will go to church every Sunday." Anger would be evidenced if the parents attempted to blame someone, such as health care personnel, for the neonate's condition.

 CN: Psychosocial adaptation;  
CL: Analyze

**108. 1.** To prevent eye damage from phototherapy, the eyes must remain covered at all times while under the lights. The eye patches can be removed when the neonate is held out of the lights by the parents for feeding. Instead of a regular diaper, a "string" diaper or disposable face mask may be used to help contain loose stools, while allowing maximum skin exposure. Feeding formula or breast milk every 2 to 3 hours is recommended to prevent hypoglycemia and to encourage gastrointestinal motility. Because the phototherapy lights can overheat the neonate, the temperature should be checked by the axillary route every 2 to 4 hours.

 CN: Reduction of risk potential;  
CL: Apply

**109. 4.** An absent Moro reflex, lethargy, opisthotonos, and seizures are symptoms of bilirubin encephalopathy, which, although rare, can be life-threatening. Bronze discoloration of the skin and maculopapular chest rash are normal and are caused by the phototherapy. They will disappear once the phototherapy is discontinued. A urine specific gravity of 1.001 to 1.020 is normal in term neonates.

 CN: Reduction of risk potential;  
CL: Analyze


**110. 2.** Marked visible peristaltic waves in the abdomen and projectile vomiting are signs of pyloric stenosis. If the condition progresses without surgical intervention, the neonate will become dehydrated and develop metabolic alkalosis. Signs of esophageal atresia include coughing and regurgitation with feedings. Diaphragmatic hernia, a life-threatening event in which the abdominal contents herniate into the thoracic cavity, may be evidenced by breath sounds being heard over the abdomen and significant respiratory distress with cyanosis. Signs of hiatal hernia include vomiting, failure to thrive, and short periods of apnea.

 CN: Reduction of risk potential;  
CL: Analyze

**111. 3.** With a patent ductus arteriosus, a cardiac defect marked by a failure of the patent ductus arteriosus to close completely at birth, blood from the aorta flows into the pulmonary arteries to be reoxygenated in the lungs and returned to the left atrium and ventricle. The effect of this altered circulation includes increased workload on the left side of the heart and increased pulmonary vascular congestion. Term infants are commonly asymptomatic, but a loud, machinery-like murmur may be heard throughout systole and diastole. This murmur may be accompanied by a suprasternal thrill, and the heart may be enlarged. Decreased cardiac output with faint peripheral pulses, poor peripheral perfusion, feeding difficulties, and severe congestive heart failure are symptoms associated with severe aortic stenosis. With this defect, the aortic valve is thickened and rigid, leading to decreased cardiac output and reduced myocardial blood flow. Profound cyanosis over most of the body, fatigue on exertion, feeding difficulties, and chronic hypoxemia are associated with tetralogy of Fallot. With this defect, malalignment of the ventricular system results in nonrestricted ventral septal defects, pulmonic stenosis, overriding of the aorta, and hypertrophy of the left ventricle. The heart appears boot shaped. A harsh systolic murmur with a palpable thrill is associated with truncus arteriosus. It is marked by incomplete division of the great vessel. This is caused by a ventral septal defect. Bounding pulses and a widening pulse pressure may also be present.

 CN: Reduction of risk potential;  
CL: Analyze

**112. 1.** Coarctation of the aorta accounts for 5% to 7% of congenital heart disease. There is localized constriction of the aorta, at or near the insertion site of the ductus arteriosus, that increases afterload and decreases cardiac output. The infant with coarctation of the aorta presents with symptoms of poor lower body perfusion, metabolic acidosis, and congestive heart failure. Cyanosis is present in the lower part of the body because of decreased cardiac output. The child with a partial atrioventricular septal defect may be asymptomatic at birth. The symptoms in a child with a complete defect depend on the pulmonary artery pressure. If the pressure is high, the child will experience cyanosis on exertion; if it is low, congestive heart failure, manifested by tachypnea, dyspnea, and sternal retractions, may be present. The child with pulmonary atresia has profound (complete) cyanosis. On auscultation, the second heart sound is heard as a single sound. This is caused by failure of the pulmonary valve to develop and is accompanied by hypoplastic development of the pulmonary artery and right ventricle. Transposition of the great arteries is associated with complete cyanosis during the first few hours of life. These infants demonstrate hypoxemia with a minimal response to oxygen. In this defect, the pulmonary and systemic systems exist in parallel. Systemic blood (unoxygenated) travels to the right atrium and right ventricle, then into the aorta. Pulmonary venous blood (oxygenated) recirculates through the left side of the heart and through the lungs.

 CN: Reduction of risk potential;  
CL: Analyze

**113. 4.** The normal pulse rate in a neonate is 120 to 160 beats per minute. Therefore, a femoral pulse rate of 90 bpm is too low. Diminished peripheral pulses, coolness and mottling of the extremities, delayed capillary refill, hypotension, and decreased urine output are indicative of low cardiac output and poor perfusion. The neonate may be experiencing a complication of the surgery, such as blood loss or leaking of fluid into the interstitial space. The surgeon should be notified immediately to correct the diminished pulse, through either medications or transfusions. An oxygen saturation between 85% and 100% is considered normal. The surgeon does not need to be notified unless the oxygen saturation falls below 85%. Pale pink extremities are considered a normal finding. If mottling or cyanosis develops, the surgeon should be notified immediately. Warm, dry skin is also a normal finding. If the skin becomes cool or appears cyanotic, the surgeon should be notified.

 CN: Reduction of risk potential;  
CL: Synthesize

**114. 4.** A child with atrial septal defect will be monitored by a cardiologist. Nonsurgical closure may be attempted via cardiac catheterization. Surgical closure, using either a prosthetic patch or sutures, is performed on an elective basis early in childhood. Children diagnosed with this disorder do not have spontaneous healing or closure. About 20% to 60% of children born with a ventricular septal defect, an abnormal opening between the right and left ventricles, have spontaneous closure. Atrial septal defect accounts for approximately 10% of all congenital heart disease and is seen in more female than male neonates. This lesion consists of an abnormal opening between the atria. Ostium secundum, a defect located in the middle of the atrial septum, is the most common type seen. As the child grows, she may experience fatigue and dyspnea on exertion. A large defect may result in congestive heart failure if the lesion is unrepaired. Bacterial endocarditis prophylaxis with antibiotics may be ordered if the child develops an infection.

 CN: Reduction of risk potential;  
CL: Evaluate

### Managing Care Quality and Safety

**115. 1.** The preterm infant is at greatest risk for developing RDS as the lungs are immature and unable to produce adequate surfactant to reduce the surface tension in the lungs and promote the stability of the alveoli. The neonate born at 42 weeks' gestation is at greater risk of having meconium stained amniotic fluid and developing meconium aspiration syndrome. The neonate born by Cesarean section is at greater risk of fluid retention in the lungs as the lungs were not compressed during the delivery process as they are in a vaginal delivery. Generally, these infants are able to overcome this situation with adequate crying. The infant experiencing apneic episodes may be related to several conditions including hypothermia, sepsis, hypoglycemia and as a result of a rapid increase in the infant's temperature.

 CN: Management of care; CL: Analyze

**116. 3.** The nurse should make rounds and first assess the neonate with the respiratory rate of 62. The respiratory rate is out of the normal range and needs reevaluation. The newborn who is LGA still has 15 minutes before being due for the feeding and much can be accomplished by the nurse in that time. A 36-week newborn weighing 5 lb will need to be fed on time to maintain the blood glucose level. The nurse should next assess the infant with a borderline low temperature to determine if his body temperature is increasing.

 CN: Management of care; CL: Synthesize

**117. 2.** The nurse should manage this situation by asking the staff nurses to take at least one baby back to a room with a sleeping mother. This would allow the babies who are in need of care in the nursery to remain there. To maintain safety, the SCN cannot admit a client until they are prepared and have the staffing for this infant to be transferred. Social services can be called to determine if either of the newborns who have been referred to them can be discharged, but releasing these infants from the nursery will take several hours. It is unsafe to keep the infant with a respiratory rate of 80s waiting for a bed.

 CN: Management of care; CL: Create

**118. 2,3,4, 5.** A hospital-specific security system is the standard of care to prevent neonatal abduction. The bulb syringe should be visible and easily accessible to both the mother and the nurse in case of choking. Someone should remain in the room who is able to safely care for the infant. This may be the mother or a family member if the mother is physically not able to care for the infant. The infant should be lying on the back or side, rather than the abdomen to prevent sudden infant death syndrome (“back to sleep”). The infant should be in the mother’s arms or in the crib rather than lying on a bed even with the side rails up as side rails do not prevent an infant from slipping through the rails. A sleeping mother in not aware of the status of the infant who can easily fall out of the mother’s arms; the infant can be in the mother’s arms only if she is awake.

 CN: Safety and infection control;  
CL: Evaluate

## 119.

4. Review notes from shift report and prioritize all clients; make rounds on the most critical first.

1. Move quickly from room to room and assess all clients.

3. Log on to the clinical information system and determine if there are new orders.

2. Check the room to which the new client will be admitted to be sure all supplies and equipment are available.

Based on the report given by the preceding nurse, the nurse should plan to prioritize all clients and first make rounds on the client needing the highest level of nursing care. The nurse can then make rounds on all clients. The nurse can then check for new orders and, finally, inspect the room in which the next client will be admitted to be sure all of the equipment is available.

 CN: Management of care; CL: Synthesize

# 2

## The Nursing Care of Children

### TEST

### 1

## Health Promotion

- Health Promotion of the Infant and Family
- Health Promotion of the Toddler and Family
- Health Promotion of the Preschooler and Family
- Health Promotion of the School-Age Child and Family
- Health Promotion of the Adolescent and Family
- Common Childhood and Adolescent Health Problems
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### Health Promotion of the Infant and Family

**1.** After reading the vaccine information sheets, the parent of a 2-month-old infant is hesitant to consent to the recommended vaccinations. The nurse should **first** ask the parent:

- 1. “Did you know that vaccinations are required by law for school entry?”
- 2. “What personal beliefs or safety concerns do you have about vaccinations?”
- 3. “Would you prefer that fewer vaccines are given at a time?”
- 4. “Can you please sign this vaccine waiver form?”

**2.** Which of the following is appropriate language development for an 8-month-old? The child should be:

- 1. Saying “dada” and “mama” specifically (“dada” to father and “mama” to mother).
- 2. Saying three other words besides “mama” and “dada.”
- 3. Saying “dada” and “mama” nonspecifically.
- 4. Saying “ball” when parents point to a ball.

**3.** The nurse should refer the parents of an 8-month-old child to a health care provider if the child is unable to:

- 1. Stand momentarily without holding onto furniture.
- 2. Stand alone well for long periods of time.
- 3. Stoop to recover an object.
- 4. Sit without support for long periods of time.

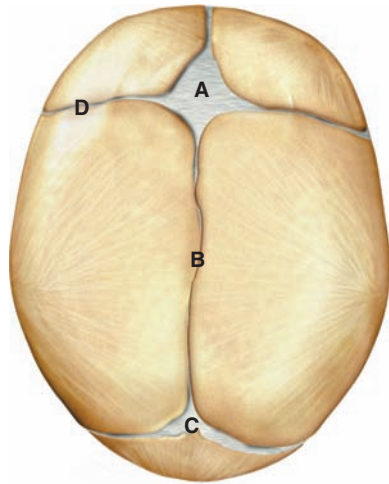
**4.** The nurse is teaching the parents of an 8-month-old about what the child should eat. The nurse should include which of the following points in the teaching plan?

- 1. Items from all four food groups should be introduced to the infant by the time the child is 10 months old.
- 2. Solid foods should not be introduced until the infant is 10 months old.
- 3. Iron deficiency rarely develops before 12 months of age, so iron-fortified cereals should not be introduced until the infant is 12 months old.
- 4. The infant’s diet can be changed from formula to whole milk when the infant is 12 months old.

**5.** A 10-month-old looks for objects that have been removed from his view. The nurse should instruct the parents that:

- 1. Neuromuscular development enables the child to reach out and grasp objects.
- 2. The child's curiosity has increased.
- 3. The child understands the permanence of objects even though the child cannot see them.
- 4. The child is now able to transfer objects from hand to hand.

**6.** Which of the following structures should be closed by the time the child is 2 months old?



- 1. A.
- 2. B.
- 3. C.
- 4. D.

**7.** The nurse is discharging an 8-month-old who weighs 15 lb from the hospital. The parents have put the child in the back seat of the car with the car seat facing the front. The nurse should:

- 1. Ask the parents to wait while obtaining the correct car seat.
- 2. Complete the discharge with the child sitting facing the front seat.
- 3. Give the parents a manual on proper car seat placement.
- 4. Explain the need for the rear-facing position and request assistance from a car seat technician.

**8.** A parent brings a 4-month-old to the clinic for a regular well visit and expresses concern that the infant is not developing appropriately. Which findings in the infant would indicate the need for further developmental screening?

- 1. Has no interest in peek-a-boo games.
- 2. Does not turn front to back.
- 3. Does not babble.
- 4. Continues to have head lag.

**9.** The nurse assesses a 6-month-old for vaccination readiness. Which finding would most likely indicate the need to delay administering the diphtheria, tetanus, and acellular pertussis (DTaP) vaccine?

- 1. A family history of sudden infant death syndrome (SIDS).
- 2. A fever of 38.5 °C following the 4-month vaccinations.
- 3. An acute bilateral ear infection.
- 4. Living with a family member who is immunosuppressed.

**10.** The parents of a 9-month-old bring the infant to the clinic for a regular checkup. The infant has received no immunizations. Which of the following would be appropriate for the nurse to administer at this visit?

- 1. Diphtheria, tetanus, and acellular pertussis (DTaP); *Haemophilus influenzae* type B (Hib); inactivated poliomyelitis vaccine (IPV); and purified protein derivative (PPD).
- 2. DTaP; Hib; oral polio vaccine (OPV); and measles, mumps, and rubella (MMR).
- 3. PPD, MMR, hepatitis B (hepB), and OPV.
- 4. HepB, IPV, Hib, and varicella.

**11.** To assess the development of a 1-month-old, the nurse asks the parent if the infant is able to:

- 1. Smile and laugh out loud.
- 2. Roll from back to side.
- 3. Hold a rattle briefly.
- 4. Turn the head from side to side.

**12.** The mother of a 6-month-old states that she started her infant on 2% milk. The nurse should **first** ask the mother:

- 1. "Do you think your baby will be fine with this milk?"
- 2. "Is it possible for you to switch your baby to whole milk?"
- 3. "Can you tell me more about the reason you switched your baby to 2% milk?"
- 4. "You cannot switch to 2% milk right now. Did your pediatrician tell you to do this?"

**13.** The nurse notes that an infant stares at an object placed in her hand and takes it to her mouth, coos and gurgles when talked to, and sustains part of her own weight when held in a standing position. The nurse correctly interprets these findings as characteristic of an infant at which of the following ages?

- 1. 2 months.
- 2. 4 months.
- 3. 7 months.
- 4. 9 months.

**14.** An 8-month-old infant is seen in the well-child clinic for a routine checkup. The nurse should expect the infant to be able to do which of the following? Select all that apply.

- 1. Say “mama” and “dada” with specific meaning.
- 2. Feed self with a spoon.
- 3. Play peek-a-boo.
- 4. Walk independently.
- 5. Stack two blocks.
- 6. Transfer object from hand to hand.

**15.** The parent of a 9-month-old infant is concerned that the infant’s front soft spot is still open. The nurse should tell the parent:

- 1. “I will measure your baby’s head to see if it is a normal size.”
- 2. “Your infant will need to be referred for more testing.”
- 3. “You should contact your physician immediately.”
- 4. “This is normal because this soft spot usually closes between 12 and 18 months.”

**16.** A mother states that she thinks her 9-month-old “is developing slowly.” When assessing the infant’s development, the nurse is also concerned because the infant should be demonstrating which of the following characteristics?

- 1. Vocalizing single syllables.
- 2. Standing alone.
- 3. Building a tower of two cubes.
- 4. Drinking from a cup with little spilling.

### Health Promotion of the Toddler and Family

**17.** A 2-year-old tells his mother he is afraid to go to sleep because “the monsters will get him.” The nurse should tell his mother to:

- 1. Allow him to sleep with his parents in their bed whenever he is afraid.
- 2. Increase his activity before he goes to bed, so he eventually falls asleep from being tired.
- 3. Read a story to him before bedtime and allow him to have a cuddly animal or a blanket.
- 4. Allow him to stay up an hour later with the family until he falls asleep.

**18.** A 2-year-old always puts his teddy bear at the head of his bed before he goes to sleep. The parents ask the nurse if this behavior is normal. The nurse should explain to the parents that toddlers use ritualistic patterns to:

- 1. Establish a sense of identity.
- 2. Establish control over adults in their environment.
- 3. Establish sequenced patterns of learning behavior.
- 4. Establish a sense of security.

**19.** Which development is necessary for toilet training readiness for a 2-year-old? Select all that apply.

- 1. Adequate neuromuscular development for sphincter control.
- 2. Appropriate chronological age.
- 3. Ability to communicate the need to use the toilet.
- 4. Desire to please the parents.
- 5. Ability to play with other 2-year-olds.

**20.** A mother of a toilet-trained 3-year-old expresses concern over her child’s bedwetting while hospitalized. The nurse should tell the mother:

- 1. “He was too immature to be toilet trained. In a few months he should be old enough.”
- 2. “Children are afraid in the hospital and frequently wet their bed.”
- 3. “It’s very common for children to regress when they’re in the hospital.”
- 4. “This is normal. He probably received too much fluid the night before.”

**21.** A nurse working in the nursery identifies a goal for a mother of a newborn to demonstrate positive attachment behaviors upon discharge. Which intervention would be **least** effective in accomplishing this goal?

- 1. Provide opportunities for the mother to hold and examine the newborn.
- 2. Engage the mother in the newborn’s care.
- 3. Create an environment that fosters privacy for the mother and newborn.
- 4. Identify strategies to prevent difficulties in parenting.

**22.** A mother brings her 18-month-old to the clinic because the child “eats ashes, crayons, and paper.” Which of the following information about the toddler should the nurse assess **first**?

- 1. Evidence of eruption of large teeth.
- 2. Amount of attention from the mother.
- 3. Any changes in the home environment.
- 4. Intake of a soft, low-roughage diet.

**23.** When assessing a 2-year-old child brought by his mother to the clinic for a routine checkup, which of the following should the nurse expect the child to be able to do?

- 1. Ride a tricycle.
- 2. Tie his shoelaces.
- 3. Kick a ball forward.
- 4. Use blunt scissors.

**24.** A 2-year-old child brought to the clinic by her parents is uncooperative when the nurse tries to look in her ears. Which of the following should the nurse try **first**?

- 1. Ask another nurse to assist.
- 2. Allow a parent to assist.
- 3. Wait until the child calms down.
- 4. Restrain the child’s arms.

**25.** When observing the parent instilling prescribed ear drops ordered twice a day for a toddler, the nurse decides that the teaching about positioning of the pinna for instillation of the drops is effective when the parent pulls the toddler's pinna in which of the following directions?

- 1. Up and forward.
- 2. Up and backward.
- 3. Down and forward.
- 4. Down and backward.

**26.** The mother asks the nurse for advice about discipline for her 18-month-old. Which of the following should the nurse suggest that the mother use?

- 1. Structured interactions.
- 2. Spanking.
- 3. Reasoning.
- 4. Time out.

**27.** When assessing for pain in a toddler, which of the following methods should be the **most** appropriate?

- 1. Ask the child about the pain.
- 2. Observe the child for restlessness.
- 3. Use a numeric pain scale.
- 4. Assess for changes in vital signs.

**28.** When planning a 15-month-old toddler's daily diet with the parents, which of the following amounts of milk should the nurse include?

- 1. ½ to 1 cup.
- 2. 2 to 3 cups.
- 3. 3 to 4 cups.
- 4. 4 to 5 cups.

### Health Promotion of the Preschooler and Family

**29.** To encourage autonomy in a 4-year-old, the nurse should instruct the mother to:

- 1. Discourage the child's choice of clothing.
- 2. Button the child's coat and blouse.
- 3. Praise the child's attempts to dress herself.
- 4. Tell the child when the combination of clothes is not appropriate.

**30.** The mother of a 4-year-old expresses concern that her child may be hyperactive. She describes the child as always in motion, constantly dropping and spilling things. Which of the following actions would be appropriate at this time?

- 1. Determine whether there have been any changes at home.
- 2. Explain that this is not unusual behavior.
- 3. Explore the possibility that the child is being abused.
- 4. Suggest that the child be seen by a pediatric neurologist.

**31.** The mother of a preschooler reports that her child creates a scene every night at bedtime. The nurse and the mother decide that the best course of action would be to do which of the following?

- 1. Allow the child to stay up later one or two nights a week.
- 2. Establish a set bedtime and follow a routine.
- 3. Encourage active play before bedtime.
- 4. Give the child a cookie if bedtime is pleasant.

**32.** The parents of a preschooler ask the nurse how to handle their child's temper tantrums. Which of the following should the nurse include in the teaching plan? Select all that apply.

- 1. Putting the child in "time-out."
- 2. Telling the child to go to his bedroom.
- 3. Ignoring the child.
- 4. Putting the child to bed.
- 5. Spanking the child.
- 6. Trying to reason with the child.

**33.** After teaching a group of parents of preschoolers attending a well-child clinic about oral hygiene and tooth brushing, the nurse determines that the teaching has been successful when the parents state that children can begin to brush their teeth without help at which of the following ages?

- 1. 3 years.
- 2. 5 years.
- 3. 7 years.
- 4. 9 years.

**34.** After having a blood sample drawn, a 5-year-old child insists that the site be covered with a bandage. When the parent tries to remove the bandage before leaving the office, the child screams that all the blood will come out. The nurse encourages the parent to leave the bandage in place and tells the parent that the child:

- 1. Fears another procedure.
- 2. Does not understand body integrity.
- 3. Is expressing pain.
- 4. Is attempting to regain control.

**35.** The family of a 5-year-old, only child has just moved to a rural setting where the father has started a dental practice. At the well-child visit, the father expresses concern that his child seems prone to minor accidents such as, skinning his elbow and knees or falling off his scooter. The nurse tells the father:

- 1. "Only children use accidents as a way to seek parental attention."
- 2. "Children who live in the suburbs typically have more accidents."
- 3. "Children frequently have more accidents when families experience change."
- 4. "We see a relationship between accidents and parental education."

**36.** When developing the teaching plan about illness for the mother of a preschooler, which of the following should the nurse include about how a preschooler perceives illness?

- 1. A necessary part of life.
- 2. A test of self-worth.
- 3. A punishment for wrongdoing.
- 4. The will of God.

### Health Promotion of the School-Age Child and Family

**37.** To determine if a blood pressure reading is normal, the nurse must know which information about the child? Select all that apply.

- 1. Age.
- 2. Body mass index (BMI).
- 3. Gender.
- 4. Height.
- 5. Occipital frontal circumference (OFC).
- 6. Weight.

**38.** A nurse is assessing the growth and development of a 10-year-old. What is the expected behavior of this child?

- 1. Enjoys physical demonstrations of affection.
- 2. Is selfish and insensitive to the welfare of others.
- 3. Is uncooperative in play and school.
- 4. Has a strong sense of justice and fair play.

**39.** To assess a 9-year-old's social development, the nurse asks the parent if the child:

- 1. Thinks independently.
- 2. Is able to organize and plan.
- 3. Has a best friend.
- 4. Enjoys active play.

**40.** A 10-year-old child proudly tells the nurse that brushing and flossing her teeth is her responsibility. The nurse interprets this statement as indicating which of the following about the child?

- 1. She is too young to be given this responsibility.
- 2. She is most likely capable of this responsibility.
- 3. She should have assumed this responsibility much sooner.
- 4. She is probably just exaggerating the responsibility.

**41.** The mother tells the nurse that her 8-year-old child is continually telling jokes and riddles to the point of driving the other family members crazy. The nurse should explain this behavior is a sign of?

- 1. Inadequate parental attention.
- 2. Mastery of language ambiguities.
- 3. Inappropriate peer influence.
- 4. Excessive television watching.

**42.** The mother asks the nurse about her 9-year-old child's apparent need for between-meal snacks, especially after school. When developing a sound nutritional plan for the child with the mother, the nurse should advise the mother:

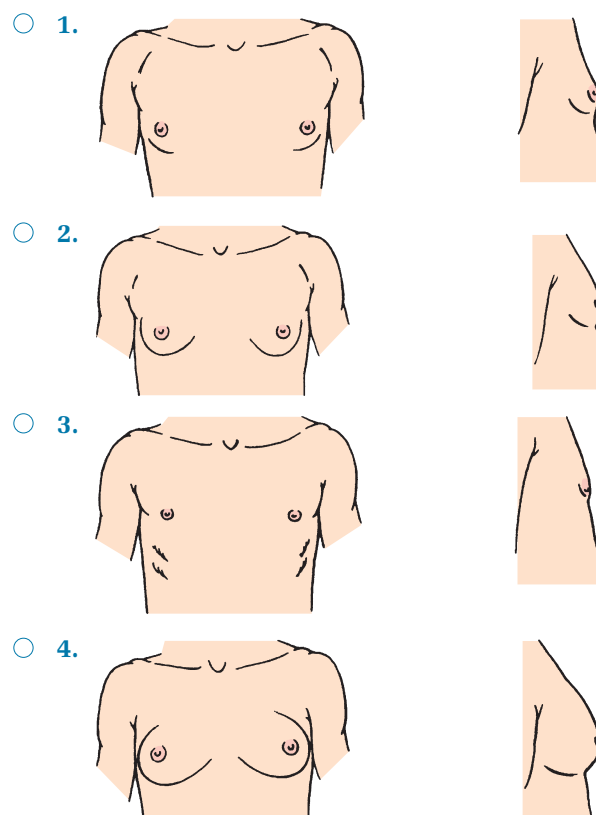
- 1. The child does not need to eat between-meal snacks.
- 2. The child should eat the snacks the mother thinks are appropriate.
- 3. The child should help with preparing his or her own snacks.
- 4. The child will instinctively select nutritional snacks.

**43.** A nurse compares a child's height and weight with standard growth charts and finds the child to be in the 50th percentile for height and in the 45th percentile for weight. The nurse interprets these findings as indicating that the child is:

- 1. Average height and weight.
- 2. Overweight for height.
- 3. Underweight for height.
- 4. Abnormal in height.

### Health Promotion of the Adolescent and Family

**44.** The nurse is assessing an 11-year-old female, using the Tanner Staging of Puberty. Which of the following indicates preadolescent development of the breasts?





**45.** The parents of a 12-year-old girl ask why their non-sexually active daughter should receive the human papillomavirus (HPV) vaccine. The nurse should tell the parents:

- 1. "The vaccine is most effective against cervical cancer if given before becoming sexually active."
- 2. "Parents are never sure when their child might become sexually active."
- 3. "HPV is most common in teens and women in their late twenties."
- 4. "If your daughter is sexually assaulted, she may be exposed to HPV."

**46.** The nurse is teaching an adolescent with asthma how to use an inhaler. In which order should the nurse instruct the client to follow the steps from first to last?

1. Inhale through an open mouth.

2. Breathe out through the mouth.

3. Hold the breath for 5 to 10 seconds.

4. Press the canister to release the medication.

**47.** Initiation of which of the following immunizations is recommended prior to the adolescent entering college?

- 1. Diphtheria, tetanus, and acellular pertussis (DTaP).
- 2. Varicella.
- 3. Meningococcal.
- 4. Pneumococcal conjugate vaccine (PCV).

**48.** The school nurse develops a plan with an adolescent to provide relief of dysmenorrhea to aid in her development of which of the following?

- 1. Positive peer relations.
- 2. Positive self-identity.
- 3. A sense of autonomy.
- 4. A sense of independence.

**49.** An adolescent tells the school nurse that she would like to use tampons during her period. The nurse should **first**:

- 1. Assess her usual menstrual flow pattern.
- 2. Determine whether she is sexually active.
- 3. Provide information about preventing toxic shock syndrome.
- 4. Refer her to a specialist in adolescent gynecology.

**50.** Several high-school seniors are referred to the school nurse because of suspected alcohol misuse. When the nurse assesses the situation, what would be **most** important to determine?

- 1. What they know about the legal implications of drinking.
- 2. The type of alcohol they usually drink.
- 3. The reasons they choose to use alcohol.
- 4. When and with whom they use alcohol.

### Common Childhood and Adolescent Health Problems

**51.** Which of the following actions initiated by the parents of an 8-month-old indicates they need further teaching about preventing childhood accidents?

- 1. Placing a fire screen in front of the fireplace.
- 2. Placing a car seat in a front-seat, front-facing position.
- 3. Inspecting toys for loose parts.
- 4. Placing toxic substances out of reach or in a locked cabinet.

**52.** The mother of a 2-year-old is concerned because the child's right eye seems to turn toward his nose when he is tired. The nurse should:

- 1. Assure the mother that this is a normal event when the child is tired.
- 2. Advise the mother to continue to watch his eyes closely and if the problem persists to call the clinic.
- 3. Test the child with the cover-uncover test and refer the mother and child to an ophthalmologist if the test is abnormal.
- 4. Explain to the mother that the child will probably outgrow the weakness and she need not be concerned.

**53.** A nurse is assessing the growth and development of a 14-year-old boy. He reports that his 13-year-old sister is 2 inches taller than he is. The nurse should advise the boy that the growth spurt in adolescent boys, compared with the growth spurt of adolescent girls:

- 1. Occurs at the same time.
- 2. Occurs 2 years earlier.
- 3. Occurs 2 years later.
- 4. Occurs 1 year earlier.

**54.** Parents of a 15-year-old state that he is moody and rude. The nurse should advise his parents to:

- 1. Restrict his activities.
- 2. Discuss their feelings with their child.
- 3. Obtain family counseling.
- 4. Talk to other parents of adolescents.

**55.** A parent asks the nurse about head lice (pediculosis capitis) infestation during a visit to the clinic. Which of the following symptoms should the nurse tell the parent is most common in a child infected with head lice?

- 1. Itching of the scalp.
- 2. Scaling of the scalp.
- 3. Serous weeping on the scalp surface.
- 4. Pinpoint hemorrhagic spots on the scalp surface.

**56.** A parent asks, "Can I get head lice too?" The nurse indicates that adults can also be infested with head lice but that pediculosis is more common among school children, primarily for which of the following reasons?

- 1. An immunity to pediculosis usually is established by adulthood.
- 2. School-age children tend to be more neglectful of frequent handwashing.
- 3. Pediculosis usually is spread by close contact with infested children.
- 4. The skin of adults is more capable of resisting the invasion of lice.

**57.** After teaching the parents about the cause of ringworm of the scalp (tinea capitis), which of the following, if stated by the father, indicates successful teaching?

- 1. "It results from overexposure to the sun."
- 2. "It's caused by infestation with a mite."
- 3. "It's a fungal infection of the scalp."
- 4. "It's an allergic reaction."

**58.** Griseofulvin (Grisactin) was ordered to treat a child's ringworm of the scalp. The nurse instructs the parents to use the medication for several weeks for which of the following reasons?

- 1. A sensitivity to the drug is less likely if it is used over a period of time.
- 2. Fewer side effects occur as the body slowly adjusts to a new substance over time.
- 3. Fewer allergic reactions occur if the drug is maintained at the same level long-term.
- 4. The growth of the causative organism into new cells is prevented with long-term use.

**59.** A mother asks the nurse, "How did my children get pinworms?" The nurse explains that pinworms are most commonly spread by which of the following when contaminated?

- 1. Food.
- 2. Hands.
- 3. Animals.
- 4. Toilet seats.

**60.** A mother tells the nurse that one of her children has chickenpox and asks what she should do to care for that child. When teaching the mother, the nurse should instruct the mother to help her child prevent:

- 1. Acid-base imbalance.
- 2. Malnutrition.
- 3. Skin infection.
- 4. Respiratory infection.

**61.** A mother calls the clinic to talk to the nurse. The mother states that a physician described her daughter as having 20/60 vision and she asks the nurse what this means. The nurse responds based on the interpretation that the child is experiencing which of the following?

- 1. A loss of approximately one-third of her visual acuity.
- 2. Ability to see at 60 feet what she should see at 20 feet.
- 3. Ability to see at 20 feet what she should see at 60 feet.
- 4. Visual acuity three times better than average.

**62.** After teaching a group of parents about temper tantrums, the nurse knows the teaching has been effective when one of the parents states which of the following?

- 1. "I will ignore the temper tantrum."
- 2. "I should pick up the child during the tantrum."
- 3. "I'll talk to my daughter during the tantrum."
- 4. "I should put my child in time out."

**63.** The nurse discusses the eating habits of school-age children with their parents, explaining that these habits are most influenced by:

- 1. Food preferences of their peers.
- 2. Smell and appearance of foods offered.
- 3. Examples provided by parents at mealtimes.
- 4. Parental encouragement to eat nutritious foods.

**64.** When discussing the onset of adolescence with parents, the nurse explains that it occurs at which of the following times?

- 1. Same age for both boys and girls.
- 2. 1 to 2 years earlier in boys than in girls.
- 3. 1 to 2 years earlier in girls than in boys.
- 4. 3 to 4 years later in boys than in girls.

**65.** A mother has heard that several children have been diagnosed with mononucleosis. She asks the nurse what precautions should be taken to prevent this from occurring in her child. The nurse should instruct the mother to:

- 1. Take no particular precautionary measures.
- 2. Sterilize the child's eating utensils before they are reused.
- 3. Wash the child's linens separately in hot, soapy water.
- 4. Wear masks when providing direct personal care.

**66.** A father asks the nurse how he would know if his child had developed mononucleosis. The nurse explains that in addition to fatigue, which of the following would be most common?

- 1. Liver tenderness.
- 2. Enlarged lymph glands.
- 3. Persistent nonproductive cough.
- 4. A blush-like generalized skin rash.

**67.** A parent asks why it is recommended that the second dose of the measles, mumps, and rubella (MMR) vaccine be given at 4 to 6 years of age? The nurse should explain to the parent that the second dose is given at this age for what reason?

- 1. If the child reaches puberty and becomes pregnant when receiving the vaccine, the risks to the fetus are high.
- 2. The chance of contracting the disease is much lower at this age.
- 3. The dangers associated with a strong reaction to the vaccine are increased at this age.
- 4. A serious complication from the vaccine is swelling of the joints.

### Managing Care Quality and Safety

**68.** An 18-year-old high school senior wishes to obtain birth control through her parents' insurance but does not want the information disclosed. The nurse tells the client that under the Health Information Portability and Accountability Act (HIPAA) parents:

- 1. Have the right to review a minor's medical records until high school graduation.
- 2. Have the right to review a minor's medical record if they are responsible for the payment.
- 3. May not view the medical record, but may learn of the visit through the insurance bill.
- 4. May not view the minor's medical record or the insurance bill.

**69.** A parent brings a 5-year-old child to a vaccination clinic to prepare for school entry. The nurse notes that the child has not had any vaccinations since 4 months of age. To determine the current evidence for best practices for scheduling missed vaccinations the nurse should:

- 1. Ask the primary care provider.
- 2. Check the website at the Center for Disease Control and Prevention (CDC).
- 3. Read the vaccine manufacturer's insert.
- 4. Contact the pharmacist.

**70.** A 13-month-old has a febrile seizure one month after the administration of the chicken pox vaccine. The nurse should:

- 1. Recognize that the events are unrelated.
- 2. Report the event through the Vaccine Adverse Event Reporting System.
- 3. Explain to the parents that this is a rare but acceptable risk.
- 4. Report the incident through the vaccine manufacturer's hotline.

**71.** The school nurse is invited to attend a meeting with several parents who express frustration with the amount of time their adolescents spend in front of the mirror and the length of time it takes them to get dressed. The nurse explains that this behavior indicates:

- 1. An abnormal narcissism.
- 2. A method of procrastination.
- 3. A way of testing the parents' limit-setting.
- 4. A result of developing self-concept.

## Answers, Rationales, and Test Taking Strategies

*The answers and rationales for each question follow below, along with keys (CN, CL) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.*

### Health Promotion of the Infant and Family

**1. 2.** By trying to determine the source of parents' concerns, the nurse is able to acknowledge their feelings and provide the most appropriate information. This approach increases the likelihood parents will listen to the health care provider's views. Exemptions for vaccines vary by state and many parents feel legal requirements for


vaccinations take away parental rights. The number of vaccinations given at one time may not be the issue. Waivers are used only if clients refuse vaccination after a discussion of risks and benefits.

 CN: Health promotion and maintenance;  
CL: Synthesize

**2. 3.** It is important for the nurse to assist parents in assessing speech development in their child so that developmental delays can be identified early. According to the Denver Developmental Screening Examination, at 8 months of age, the child should say “mama” and “dada” nonspecifically and imitate speech sounds. A child cannot say “dada” or “mama” specifically or use more than three words until they are about 12 months of age. A child cannot respond to specific commands or point to objects when requested until about 17 months of age.

 CN: Health promotion and maintenance;  
CL: Apply

**3. 4.** According to the Denver Developmental Screening Examination, a child of 8 months should sit without support for long periods of time. An 8-month-old child does not have the ability to stand without hanging on to a stationary object for support. His muscles are not developed enough to support all his weight without assistance. His balance has not developed to the point that he can stand and stoop over to reach an object.

 CN: Health promotion and maintenance;  
CL: Synthesize

**4. 4.** Infants should be kept on formula or breast milk until 1 year of age. The protein in cow’s milk is harder to digest than that found in formula. The infant cannot digest fats well, so some foods from the four food groups are not necessary in his diet during infancy. Solids are introduced into the infant’s diet around 4 to 6 months, after the extrusion reflex has diminished and when the child will accept new textures. Iron deficiency develops in term infants between 4 to 6 months when the prenatal iron stores are depleted. Fortified cereals can be added to the infant’s diet at 4 to 6 months to prevent iron deficiency anemia.

 CN: Health promotion and maintenance;  
CL: Create

**5. 3.** Understanding object permanence means that the child is aware of the existence of objects that are covered or displaced. Neuromuscular development, curiosity, and the ability to transfer objects are not associated with the principle of object permanence. Although, at 10 months, neuromuscular development is sufficient to grasp objects and a child’s curiosity has increased, neither are related to the thought process involved in object permanence.

 CN: Health promotion and maintenance;  
CL: Apply

**6. 3.** The posterior fontanel should be closed by age 2 months. The anterior fontanel and sagittal and frontal sutures should be closed by age 18 months.

 CN: Health promotion and maintenance;  
CL: Apply


**7. 4.** Proper car seat placement for a child younger than 1 year or weighing less than 20 lb is facing the rear of the car. Without specialized training, nurses may not understand how to correctly use all brands of car seats. Families who need help installing car seats should be referred to persons who have had specialized training. The car seat is not in question and does not need to be replaced. Keeping the infant in an incorrect position while completing the discharge reinforces the incorrect placement. The parents are unlikely to read a manual, especially since the child is 8 months old and it is very likely that they have been using this position since birth. Additionally, the manual may not be specific for their brand of car seat.

 CN: Safety and infection control;  
CL: Synthesize

**8. 3.** By the end of 3 months infants should babble. Lack of babbling suggests a language delay and warrants further investigation. Infants typically would begin playing peek-a-boo around 7 months. The ability to roll front to back typically occurs at 5 months. Head lag is expected to resolve by 5 months.

 CN: Health promotion and maintenance;  
CL: Analyze

**9. 3.** Vaccination in the presence of a moderate to severe infection, with or without fever, increases the risk of injury and decreases the chance of mounting good immunity. There is currently no evidence to suggest vaccines raise the risk of SIDS. A mild temperature may be expected with the DTaP. A fever of greater than 40.5° within 48 hours of vaccination would warrant caution. The DTaP is not a live vaccine. No special precautions are needed regarding immunosuppressed family members.

 CN: Reduction of risk potential;  
CL: Synthesize

**10. 1.** The American Academy of Pediatrics recommends that infants who are delayed in receiving their immunizations or have not started their series by 9 months of age begin with DTaP, Hib, IPV, and PPD. OPV is not used because cases of polio have been reported with use of the vaccine. MMR and varicella vaccines are not administered until 12 months of age.

 CN: Health promotion and maintenance;  
CL: Synthesize

**11. 4.** A 1-month-old infant is usually able to lift the head and turn it from side-to-side from a prone position. The full-term infant with no complications has probably been able to do this since birth. Smiling and laughing is expected behavior at 2 to 3 months. Rolling from back to side and holding a rattle are characteristics of a 4-month-old.

 CN: Health promotion and maintenance;  
CL: Analyze

**12. 3.** The American Academy of Pediatrics recommends that infants remain on iron fortified formula or breast milk until 1 year of age. The nurse needs to first assess if the mother switched the baby prematurely to due to lack of information or lack of resources. Then appropriate teaching or referrals may be determined. At 1 year of age the infant may be switched to whole milk, which has a higher fat content than 2%. The higher fat content is needed for brain growth. Demanding clients change behaviors without addressing the cause is unlikely to produce desired results.

 CN: Health promotion and maintenance;  
CL: Analyze

**13. 2.** Holding the head erect when sitting, staring at an object placed in the hand, taking the object to the mouth, cooing and gurgling, and sustaining part of her body weight when in a standing position are behaviors characteristic of a 4-month old infant. A 2-month-old typically vocalizes, follows objects to the midline, and smiles. A 7-month-old typically is able to sit without support, turns toward the voice, and transfers object from hand to hand. Usually, a 9-month-old can crawl, stand while holding on, and initiate speech sounds.

 CN: Health promotion and maintenance;  
CL: Analyze

**14. 3, 6.** Typical abilities demonstrated by 8-month-old infants include playing peek-a-boo and transferring objects from one hand to another. The ability to say “dada” and “mama” is more typical of 10-month-old infants. Infants usually are at least 12 months old when they achieve the ability to walk independently. Infants who are 15 months old commonly can feed themselves with a spoon and stack two blocks.

 CN: Health promotion and maintenance;  
CL: Analyze

**15. 4.** The anterior fontanel, commonly known as the soft spot, closes between 12 to 18 months in most infants. The nurse normally measures an infant’s occipital frontal circumference at each well-child visit. This action alone does not relieve the parent’s concerns. Referrals would be indicated for premature or delayed closures of the fontanel

especially if there were other abnormal findings. Closure of the anterior fontanel by 12 months can only be expected to occur in approximately a third of all infants.


 CN: Health promotion and maintenance;  
CL: Synthesize

**16. 1.** Normally, a 9-month-old infant should have been voicing single syllables since 6 months of age. Absence of this finding would be a cause for concern. An infant usually is able to stand alone at about 10 months of age. An infant usually is able to build a tower of two cubes at about 15 months of age. An infant usually is able to drink from a cup with little spilling at about 15 months of age.

 CN: Health promotion and maintenance;  
CL: Analyze

## Health Promotion of the Toddler and Family

**17. 3.** Behavior problems related to sleep and rest are common in young children. Consistent rituals around bedtime help to create an easier transition from waking to sleep. Allowing a child to sleep with his parents commonly creates more problems for the family and child and does not alleviate the problem or foster autonomy. Increasing activity before bedtime does not alleviate the separation anxiety in the toddler and causes further anxiety. Allowing him to stay up later than his normal time for bed will increase his anxiety, make it more difficult for him to fall asleep, and do nothing to lessen his fear.

 CN: Psychosocial adaptation;  
CL: Synthesize

**18. 4.** Toddlers establish ritualistic patterns to feel secure, despite inconsistencies in their environment. Establishing a sense of identity is the developmental task of the adolescent. The toddler’s developmental task is to use rituals and routines to help in making autonomy easier to accomplish. Ritualistic patterns do involve patterns of behavior but they are not utilized to develop learning behaviors.


 CN: Psychosocial adaptation; CL: Apply

**19. 1, 3, 4.** Readiness for toilet training is based on neurological, psychological, and physical developmental readiness. The nurse can introduce concepts of readiness for toilet training and encourage parents to look for adaptive and psychomotor signs such as the ability to walk well, balance, climb, sit in a chair, dress oneself, please the parent, and communicate awareness of the need to urinate or defecate. Chronological age is not an indicator


for toilet training. Two-year-olds engage in parallel play, which is not an indicator of readiness for toilet training.

 CN: Health promotion and maintenance;  
CL: Apply


**20. 3.** A child will regress to a behavior used in an earlier stage of development in order to cope with a perceived threatening situation. Readiness for toilet training should be based on neurological, physical, and psychological development, not the age of the child. Children are afraid of hospitalization but the bedwetting is a compensatory mechanism done to regress to a previous stage of development that is more comfortable and secure for the child. Telling the mother that bedwetting is related to fluid intake does not provide an adequate explanation for the underlying regression to an earlier stage of development.

 CN: Psychosocial adaptation;  
CL: Synthesize

**21. 4.** Identifying ways to prevent difficulties in parenting would be helpful in reducing the incidence of child abuse and reducing the stress of child rearing. However, it would not help to develop positive attachment behaviors. Providing opportunities for the mother to hold and examine the newborn and help with care helps establish a positive emotional bond between the mother and newborn. Providing time for the mother to be alone with the infant further allows the mother and newborn to bond.

 CN: Psychosocial adaptation;  
CL: Synthesize

**22. 3.** A craving to eat nonfood substances is known as pica. Toddlers use oral gratification as a means to cope with anxiety. Therefore, the nurse should first assess whether the child is experiencing any change in the home environment that could cause anxiety. Teething or the eruption of large teeth and the amount of attention from the mother are unlikely causes of pica. Nutritional deficiencies, especially iron deficiency, were once thought to cause pica, but research has not substantiated this theory. A soft, low-roughage diet is an unlikely cause.

 CN: Physiological adaptation;  
CL: Analyze


**23. 3.** A 2-year-old child usually can kick a ball forward. Riding a tricycle is characteristic of a 3-year-old child. Tying shoelaces is a behavior to be expected of a 5-year-old child. Using blunt scissors is characteristic of a 3-year-old child.

 CN: Health promotion and maintenance;  
CL: Analyze


**24. 2.** Parents can be asked to assist when their child becomes uncooperative during a procedure. Most commonly, the child's difficulty in cooperating is caused by fear. In most situations, the child will feel more secure with a parent present. Other methods, such as asking another nurse to assist or waiting until the child calms down, may be necessary, but obtaining a parent's assistance is the recommended first action. Restraints should be used only as a last resort, after all other attempts have been made to encourage cooperation.

 CN: Health promotion and maintenance;  
CL: Synthesize


**25. 4.** In a child younger than 3 years of age, the pinna is pulled back and down, because the auditory canals are almost straight in children. In an adult, the pinna is pulled up and backward because the auditory canals are directed inward, forward, and down.

 CN: Pharmacological and parenteral therapies;  
CL: Evaluate

**26. 4.** Time out is the most appropriate discipline for toddlers. It helps to remove them from the situation and allows them to regain control. Structuring interactions with 3-year-olds helps minimize unacceptable behavior. This approach involves setting clear and reasonable rules and calling attention to unacceptable behavior as soon as it occurs. Physical punishment, such as spanking, does cause a dramatic decrease in a behavior but has serious negative effects. However, slapping a child's hand is effective when the child refuses to listen to verbal commands. Reasoning is more appropriate for older children, such as preschoolers and those older, especially when moral issues are involved. Unfortunately, reasoning combined with scolding often takes the form of shame or criticism and children take such remarks seriously, believing that they are "bad."

 CN: Health promotion and maintenance;  
CL: Synthesize

**27. 2.** Toddlers usually express pain through such behaviors as restlessness, facial grimaces, irritability, and crying. It is not particularly helpful to ask toddlers about pain. In most instances, they would be unable to understand or describe the nature and location of their pain because of their lack of verbal and cognitive skills. However, preschool and older children have the verbal and cognitive skills to be able to respond appropriately. Numeric pain scales are more appropriate for children who are of school age or older. Changes in vital signs do occur as a result of pain, but behavioral changes usually are noticed first.

 CN: Physiological adaptation;  
CL: Analyze

**28. 2.** Toddlers around the age of 15 months need 2 to 3 cups of milk per day to supply necessary nutrients such as calcium. A daily intake of more than 3 cups of milk may interfere with the ingestion of other necessary nutrients.

 CN: Health promotion and maintenance;  
CL: Apply

## Health Promotion of the Preschooler and Family


**29. 3.** At age 4, the child should be learning to dress without supervision. A child will feel more autonomous if allowed to try to take on tasks herself. Such attempts should be encouraged to increase self-esteem. Allowing choices encourages the child's capacity to control her behavior. Continued dependency may cause the child to doubt her own abilities. Telling the child that a combination of clothes is not appropriate may cause the child to doubt her abilities. Feelings of guilt can develop from not being able to accomplish what the child feels the adult expects of her.

 CN: Health promotion and maintenance;  
CL: Synthesize

**30. 2.** Preschool-age children have been described as powerhouses of gross motor activity who seem to have endless energy. A limitation of their motor ability is that in moving as quickly as they do, they are not always able to judge distances, nor are they able to estimate the amount of strength and balance needed for activities. As a result, they have frequent mishaps. This level of activity typically is not associated with changes at home. However, if the behavior intensifies, a referral to a pediatric neurologist would be appropriate. Children who have been abused usually demonstrate withdrawn behaviors, not endless energy.

 CN: Health promotion and maintenance;  
CL: Synthesize

**31. 2.** Bedtime is often a problem with preschoolers. Recommendations for reducing conflicts at bedtime include establishing a set bedtime; having a dependable routine, such as story reading; and conveying the expectation that the child will comply. Allowing the child to stay up late one or two nights interferes with establishing the needed bedtime rituals. Excitement, such as active play, just before bedtime should be avoided because it stimulates the child, making it difficult for the child to calm down and prepare for sleep. Using food such as a cookie as a reward if bedtime is pleasant should be avoided because it places too much importance on food. Other rewards, such as stickers, could be used as an alternative.

 CN: Health promotion and maintenance;  
CL: Synthesize


**32. 1, 3.** Some parents find that putting the child in time-out until control is regained is very effective. Others find that ignoring the behaviors works just as well with their child. Both suggestions are appropriate to include in the teaching plan. Sending the child to his bedroom means the child is being punished for having a tantrum. Spanking the child is never an option. Attempting to reason with a child having a temper tantrum does not work because the child is out of control. A more appropriate time to discuss it with the child is when the child regains control.

 CN: Health promotion and maintenance;  
CL: Create


**33. 3.** Children younger than 7 years of age do not have the manual dexterity needed for tooth brushing. Therefore, parents need to help with this task until that time.

 CN: Health promotion and maintenance;  
CL: Evaluate

**34. 2.** The preschool-age child does not have an accurate concept of skin integrity and can view medical and surgical treatments as hostile invasions that can destroy or damage the body. The child does not understand that exsanguinations will not occur from the injection site. Here, the child is verbalizing a fear consistent with the developmental age. The child would most likely verbalize concerns of not wanting another procedure or exhibit other symptoms associated with pain if those were the underlying issues. If control was the main issue, the child would try to control more than just the bandage removal.

 CN: Psychosocial adaptation;  
CL: Analyze

**35. 3.** Family changes and stresses (e.g., moving, having company, taking a vacation, adding a new member) can distract parents and contribute to accidents. Only children typically receive more attention than those with siblings. Thus, the risk would be less. Families who live in the suburbs frequently are more affluent and, therefore, better able to maintain a home less conducive to accidents. A parent's formal education is unrelated to accidents.

 CN: Health promotion and maintenance;  
CL: Synthesize

**36. 3.** Preschool-age children may view illness as punishment for their fantasies. At this age children do not have the cognitive ability to separate fantasies from reality and may expect to be punished for their "evil thoughts." Viewing illness as a necessary part of life requires a higher level of cognition than preschoolers possess. This view is seen in children of middle school age and older. Perceiving illness as a test of self-worth or as the will of God is more characteristic of adults.

 CN: Health promotion and maintenance;  
CL: Apply

## Health Promotion of the School-Age Child and Family

**37. 1, 3, 4.** Blood pressures percentiles for children are referenced by the age, sex, and height. Measurements at or above the 95<sup>th</sup> percentile are considered indicative of hypertension. Weight and elevated BMI contributes to hypertension but are not used to define it. The OFC is not routinely measured in children over 2 years of age.

 CN: Health promotion and maintenance;  
CL: Analyze

**38. 4.** School-age children are concerned about justice and fair play. They become upset when they think someone is not playing fair. Physical affection makes them embarrassed and uncomfortable. They are concerned about others and are cooperative in play and school.

 CN: Health promotion and maintenance;  
CL: Analyze

**39. 3.** During the school-age years children learn to socialize with children of the same age. The “best friend” stage, which occurs around age 9 or 10 years of age, is important in providing a foundation for self-esteem and later relationships. Thinking independently, organizing, and planning are cognitive skills. Active play relates to motor skills.

 CN: Health promotion and maintenance;  
CL: Analyze

**40. 2.** Children are capable of mastering the skills required for flossing when they reach 9 years of age. At this age, many children are able to assume responsibility for personal hygiene. She is not too young to assume this responsibility and she should not have been expected to assume this responsibility much earlier. It is not likely that she is exaggerating; this is an expected behavior at this age.

 CN: Health promotion and maintenance;  
CL: Analyze


**41. 2.** School-age children delight in riddles and jokes. Mastery of the ambiguities of language and of sentence structure allows the school-age child to manipulate words, and telling riddles and jokes is a way of practicing this skill. Children who suffer from inadequate attention from parents tend to demonstrate abnormal behavior. Peer influence is less important to school-age children, and while the child may learn the joke from a friend, he is telling the joke to master language. Watching television does not influence the extent of joke telling.

 CN: Health promotion and maintenance;  
CL: Analyze

**42. 3.** Snacks are necessary for school-age children because of their high energy level. School-age children are in a stage of cognitive development in which they can learn to categorize or classify and can also learn cause and effect. By preparing their own snacks, children can learn the basics of nutrition (such as what carbohydrates are and what happens when they are eaten). The mother and child should make the decision about appropriate foods together. School-age children learn to make decisions based on information, not instinct. Some knowledge of nutrition is needed to make appropriate choices.

 CN: Health promotion and maintenance;  
CL: Synthesize

**43. 1.** The values of height and weight percentiles are usually similar for an individual child. Measurements between the 5th and 95th percentiles are considered normal. Marked discrepancies identify overweight or underweight children.

 CN: Health promotion and maintenance;  
CL: Analyze

## Health Promotion of the Adolescent and Family

**44. 3.** This figure indicates elevation of the papilla, without breast buds, considered Stage 1 and typical of a preadolescent. Figure 1 shows stage 2, breast bud enlargement; there is elevation of the breast and the diameter of the areola has increased. Figure 2 shows stage 3, enlargement of the breast and areola. Figure 4 shows stage 4, in which there is projection of areola and papilla to form a secondary mound above the level of the breast.

 CN: Physiological adaptation;  
CL: Analyze

**45. 1.** Vaccines are preventative in nature and ideally given before exposure. Focusing on the benefits of cancer prevention is most appropriate, as opposed to discussing with parents the potential that their child may become sexually active without their knowledge. It is true HPV is most common in adolescents and women in their late twenties, but parents still may not perceive that their child is at risk. Discussing the possibility of exposure through assault raises fears and does not focus on prevention.

 CN: Health promotion and maintenance;  
CL: Apply



**46.**


2. Breathe out through the mouth.

1. Inhale through an open mouth.


4. Press the canister to release the medication.

3. Hold the breath for 5 to 10 seconds.

When dispensing medication from an inhaler, the client should first breathe out through the mouth. Next the client inhales through an open mouth and then presses the canister to dispense the medication while continuing to inhale and holds the breath for 5 to 10 seconds. The client can then exhale and breathe normally.

 CN: Pharmacological and parenteral therapies; CL: Apply

**47. 3.** Meningococcal vaccine should be administered before the adolescent enters college because outbreaks of this type of meningitis are likely when people live in close association, such as in college dorms. DTaP, varicella, and PCV are given as boosters or initial doses before the child enters preschool or kindergarten.

 CN: Health promotion and maintenance; CL: Apply

**48. 2.** Relieving dysmenorrhea in adolescence is crucial for the female's development of positive self-identity, of which positive body image and sexual identity are important components. Menstruation should not be viewed as painful and debilitating. Positive peer relations and a sense of independence would develop with a positive self-identity. Sense of autonomy, according to Erikson, is the developmental task of toddlers that, if successfully mastered, leads to a sense of self-control.

 CN: Physiological adaptation; CL: Apply

**49. 3.** The nurse should provide the adolescent with information about toxic shock syndrome because of the identified relationship between tampon use and the syndrome's development. Additionally, about 95% of cases of toxic shock syndrome occur during menses. Most adolescent females can use tampons safely if they change them frequently. Using tampons is not related to menstrual flow or sexual activity. There is no need to refer the girl to a gynecologist; a nurse can provide health teaching about tampon use.


 CN: Reduction of risk potential; CL: Synthesize

**50. 3.** Information about why adolescents choose to use alcohol or other drugs can be used to determine whether they are becoming responsible users or problem users. The senior students likely know the legal implications of drinking, and the nurse will establish a more effective relationship with the students by understanding motivations for use. The type of alcohol and when and with whom they are using it are not the first data to obtain when assessing the situation.

 CN: Health promotion and maintenance; CL: Analyze

### Common Childhood and Adolescent Health Problems

**51. 2.** The recommended safety-seat arrangement for infants up to 20 lb and less than 1 year old is rear-facing with shoulder restraints. The middle of the back seat is considered the safest area of the car. Burns are a major cause of childhood accidents, and using fire screens in front of fireplaces can help prevent children from getting too close to a fire in a fireplace. Toys that contain loose parts or plastic eyes that can be swallowed or aspirated by small children should be avoided. Parents should inspect all toys for these parts before giving one to a child. Poisonings are most commonly caused by improper storage of a toxic substance. Keeping toxic substances in a child-proof container in a locked cabinet and continually observing the child's activities can prevent most poisonings.

 CN: Safety and infection control; CL: Evaluate

**52. 3.** Strabismus is diagnosed through observation and use of the corneal light reflex test. The cover-uncover test will reveal movement of the affected eye when the unaffected eye is covered, indicating abnormal fixation of the affected eye. The child should be referred to an ophthalmologist as soon as possible so that the correct vision in the affected eye can be restored. It is never normal for one eye to turn inward or outward even if the child is tired. If this condition is not corrected early, blindness can result in the unaffected eye due to the brain suppressing the double vision. Thus, telling the mother to watch the child and call later with concerns is not an appropriate response. The child will not grow out of this type of condition and may need surgery, an eye patch, daily exercises, or a combination of these interventions.

 CN: Health promotion and maintenance; CL: Synthesize


**53. 3.** Adolescent boys lag about 2 years behind adolescent girls in growth. Most girls are 1 to 2 inches taller than boys at the beginning of adolescence but tend to stop growing approximately 2 to 3 years after menarche with the closure of the epiphyseal lines of the long bones.

 CN: Health promotion and maintenance;  
CL: Apply

**54. 2.** Parents need to discuss with their adolescent how they perceive his behavior and how they feel about it. Moodiness is characteristic of adolescents. The adolescent may have a reason for or not be aware of his behavior. Restricting the adolescent's activities will not change his mood or the way he responds to others. It may increase his unacceptable responses. Counseling may not be needed at this time if the parents are open to communicating and listening to the adolescent. Talking to other parents may be of some help, but what is helpful to others may not be helpful to their child.

 CN: Health promotion and maintenance;  
CL: Synthesize


**55. 1.** The most common characteristic of head lice infestation (pediculosis capitis) is severe itching. The head is the most common site of lice infestation. If the child scratches, scaling may occur. Itching also occurs when lice infest other parts of the body. Scratch marks are almost always found when lice are present. Weeping on the scalp surface may be an indication of an infection or other dermatologic condition. Hemorrhagic spots are not a symptom of head lice, but may be caused by scratch marks.

 CN: Physiological adaptation;  
CL: Analyze


**56. 3.** Lice are spread by close personal contact and by contact with infested clothing, bed and bathroom linens, and combs and brushes. Lice are more common in school-age children than in adults because of the close contact in school and the common practice of sharing possessions. Lice are not commonly spread by hand contact. There is no immunity conferred by having head lice. Adults can have head lice, particularly if they come in close contact with their children's infested clothing or linens.

 CN: Physiological adaptation; CL: Apply

**57. 3.** Ringworm of the scalp is caused by a fungus of the dermatophyte group of the species. Overexposure to the sun would result in sunburn. Mites, such as chiggers or ticks, produce bites on the skin, resulting in inflammation. An allergic reaction commonly is manifested by hives, rash, or anaphylaxis.

 CN: Physiological adaptation;  
CL: Evaluate


**58. 4.** Griseofulvin is an antifungal agent that acts by binding to the keratin that is deposited in the skin, hair, and nails as they grow. This keratin is then resistant to the fungus. But as the keratin is normally shed, the fungus enters new, uninfected cells unless drug therapy continues. Long-term administration of griseofulvin does not prevent sensitivity or allergic reactions. As the body adjusts to a new substance over time, side effects are variable and do not necessarily decrease.

 CN: Pharmacological and parenteral therapies; CL: Apply


**59. 2.** The adult pinworm emerges from the rectum and colon at night onto the perianal area to lay its eggs. Itching and scratching introduces the eggs to the hands, from where they can easily reinfect the child or infect others. Nightclothes and bed linens can be sources of infection. The eggs can also be transmitted by dust in the home. Although transmission through contaminated food and water supplies is possible, it is rare. Contaminated animals can spread histoplasmosis and salmonella. The spread of infections by toilet seats has not been supported by research.

 CN: Physiological adaptation; CL: Apply

**60. 3.** The care of a child with chickenpox focuses primarily on preventing infection in the lesions. The lesions cause severe itching, and organisms are ordinarily introduced into the lesion through scratching. Acid-base imbalance rarely occurs with chickenpox. Malnutrition is a chronic problem associated with the ingestion of an inadequate diet over a long period. It is not associated with chickenpox. Secondary infection in the lesions, not the respiratory tract, is most common.

 CN: Physiological adaptation;  
CL: Synthesize


**61. 3.** A child with 20/60 vision sees at 20 feet what those with 20/20 vision see at 60 feet. A visual acuity of 20/200 is considered to be the boundary of legal blindness.

 CN: Physiological adaptation;  
CL: Analyze

**62. 1.** Children who have temper tantrums should be ignored as long as they are safe. They should not receive either positive or negative reinforcement to avoid perpetuating the behavior. Temper tantrums are a toddler's way of achieving independence.

 CN: Health promotion and maintenance;  
CL: Evaluate


**63. 3.** Although children may be influenced by their peers and smell and appearance of foods may be important, children are most likely to be influenced by the example and atmosphere provided by their parents. Coaxing and badgering a child to eat most likely will aggravate poor eating habits.

 CN: Health promotion and maintenance;  
CL: Apply


**64. 3.** Girls experience the onset of adolescence about 1 to 2 years earlier than boys. The reason for this is not understood.

 CN: Health promotion and maintenance;  
CL: Apply


**65. 1.** The cause of infectious mononucleosis is thought to be the Epstein-Barr virus. No precautionary measures are recommended for clients with mononucleosis. The virus is believed to be spread only by direct intimate contact.

 CN: Physiological adaptation;  
CL: Synthesize

**66. 2.** Mononucleosis usually has an insidious onset, with fatigue and the inability to maintain usual activity levels as the most common symptoms. The lymph nodes are typically enlarged, and the spleen also may be enlarged. Fever and a sore throat often accompany mononucleosis. A persistent non-productive cough can follow an upper respiratory tract infection. A blush-like generalized skin rash is more characteristic of rubella.

 CN: Physiological adaptation;  
CL: Analyze

**67. 1.** After receiving the MMR vaccine, the person develops a mild form of the disease, stimulating the body to develop immunity. Administration to a pregnant adolescent early in pregnancy puts the fetus at risk for deformity or spontaneous abortion. Some authorities recommend withholding the immunization for rubella until after puberty because a woman does not always know when she is pregnant and a fetus could be placed in jeopardy. However, the risk of contracting the disease is not lower at this age. There is no difference in the reaction to the vaccine at this age or in an older child. Swelling of the joints is a rare complication of the rubella vaccine.

 CN: Pharmacological and parenteral therapies; CL: Apply

## Managing Care Quality and Safety

**68. 3.** Under HIPAA, 18-year-olds have the right to medical privacy and their medical records may not be disclosed to their parents without their permission. However, the adolescent must be made aware of the fact that information is sent to third party payers for the purpose of reimbursement. Those payers send the primary insurer, in this case the parent, a statement of benefits. HIPAA protects the right to medical privacy of all 18-year-olds regardless of their educational status. Even if parents are responsible for payment, they may not view the client's chart without the consent of the adolescent.

 CN: Management of care; CL: Apply

**69. 2.** The CDC is the federal body that is ultimately responsible for vaccination recommendations for adults and children. A division of the CDC, the Advisory Committee on Immunization Practices, reviews vaccination evidence and updates recommendation on a yearly basis. The CDC publishes current vaccination catch-up schedules that are readily available on their website. The lack of vaccinations is a strong indicator that the child probably does not have a primary care provider. If consulted, the pharmacist would most likely have to review the CDC guidelines that are equally available to the nurse. Reading the manufacturer's inserts for multiple vaccines would be time consuming and synthesis of the information could possibly lead to errors.

 CN: Management of care; CL: Apply

**70. 2.** Any unusual event that occurs after the administration of a vaccination should be reported. Reporting the incident through the Vaccine Adverse Event Reporting System (VAERS), a joint program from the FDA and CDC, helps to identify any new safety concerns. A high fever, with or without a seizure, that occurs within 6 weeks of vaccination may have been caused by the vaccine. A febrile seizure is considered a moderate reaction that warrants caution with future chicken pox vaccination. Reporting the incident to the manufacturer does not help build the same body of knowledge as reporting the problem through the national surveillance system.

 CN: Safety and infection control;  
CL: Synthesize

**71. 4.** An adolescent's body is undergoing rapid changes. Adolescence is a time of integrating these rapidly occurring physical changes into the self-concept to achieve the developmental task of a positive self-identity. Thus, most adolescents spend much time worrying about their personal appearance. This behavior is not abnormal narcissism, a method of procrastination, or a way of testing the parents' limits.

 CN: Health promotion and maintenance;  
CL: Analyze

## TEST 2

# The Child with Respiratory Health Problems

- The Client with Tonsillitis
- The Client with Otitis Media
- The Client with Foreign Body Aspiration
- The Client with Asthma
- The Client with Cystic Fibrosis and Bronchopneumonia
- The Client with Sudden Infant Death Syndrome
- The Client Who Requires Immediate Care and Cardiopulmonary Resuscitation
- The Client with Croup
- The Client with Bronchiolitis or Pharyngitis
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Tonsillitis

1. The nurse is inspecting the child's throat (see figure). The nurse should:



- 1. Remove the tongue blade from the child's hands after he has experienced what it feels like in his mouth.
- 2. Ask the child to hold the tongue blade with both hands in his lap while the nurse uses another tongue blade.
- 3. Have the parent hold the child with arms restrained.
- 4. Guide the tongue blade while the child is holding it to depress the tongue to visualize the throat.

2. The nurse has identified a priority nursing diagnosis of *Anxiety* related to surgery for a 4-year-old preparing for a tonsillectomy. The nurse should tell the child:

- 1. "You won't have so many sore throats after your tonsils are removed."
- 2. "The doctor will put you to sleep so you don't feel anything."
- 3. "Show me how to give the doll an I.V."
- 4. "When it is done you will get to see your mommy and get a Popsicle."

3. The nurse identifies a nursing diagnosis of *Risk for perioperative-positioning injury* related to the surgical procedure for a school-age child scheduled for a tonsillectomy. Which of the following is an expected outcome for this nursing diagnosis?

- 1. The child is able to tell about the surgery and recovery.
- 2. The child remains on nothing-by-mouth (NPO) status for the designated preoperative period.
- 3. The child and family demonstrate an understanding of the procedure.
- 4. The child knows the parents will not leave.

4. After a tonsillectomy and adenoidectomy, which of the following findings should alert the nurse to suspect early hemorrhage in a 5-year-old child?

- 1. Drooling of bright red secretions.
- 2. Pulse rate of 95 bpm.
- 3. Vomiting of 25 mL of dark brown emesis.
- 4. Blood pressure of 95/56 mm Hg.

**5.** After teaching the parents of a preschooler who has undergone a tonsillectomy and adenoidectomy about appropriate foods to give the child after discharge, which of the following, if stated by the parents as appropriate foods, indicates successful teaching?

- 1. Meat loaf and uncooked carrots.
- 2. Pork and noodle casserole.
- 3. Cream of chicken soup and orange sherbet.
- 4. Hot dog and potato chips.

**6.** A nurse is teaching the parents of a preschooler about the possibility of post-operative hemorrhage after a tonsillectomy and adenoidectomy. The nurse should explain that the risk is greatest at which of the following times?

- 1. 1 to 3 days after surgery.
- 2. 4 to 6 days after surgery.
- 3. 7 to 10 days after surgery.
- 4. 11 to 14 days after surgery.

### The Client with Otitis Media

**7.** An adolescent female is prescribed amoxicillin for an ear infection. The nurse should teach the adolescent about the risks associated with her concurrent use of:

- 1. Antacids.
- 2. Oral contraceptives.
- 3. Multiple vitamins.
- 4. Protein shakes.

**8.** A 2-year-old child returns to the clinic after completing a 10-day course of amoxicillin prescribed to relieve an infection in his right ear. After completing the medication, the child has become fussy and has a low-grade fever. On physical examination, his right tympanic membrane is bulging and he is tugging at his ear. The nurse should:

- 1. Suggest to the mother that a decongestant may help the child.
- 2. Tell the mother the health care provider will probably repeat the 10-day course of amoxicillin.
- 3. Suggest that the child should see an ear, nose, and throat specialist for myringotomy tubes.
- 4. Report the assessment to the health care provider with the probability that another antibiotic will be used for a 10-day course.

**9.** A toddler is scheduled to have tympanostomy tubes inserted. When approaching the toddler for the first time, which of the following should the nurse do?

- 1. Talk to the mother first so that the toddler can get used to the new person.
- 2. Hold the toddler so that the toddler becomes more comfortable.
- 3. Walk over and pick the toddler up right away so that the mother can relax.
- 4. Pick up the toddler and take the child to the play area so that the mother can rest.

**10.** After insertion of bilateral tympanostomy tubes in a toddler, which of the following instructions should the nurse include in the child's discharge plan for the parents?

- 1. Insert ear plugs into the canals when the child bathes.
- 2. Blow the nose forcibly during a cold.
- 3. Administer the prescribed antibiotic while the tubes are in place.
- 4. Disregard any drainage from the ear after 1 week.

### The Client with Foreign Body Aspiration

**11.** After teaching the parents of a toddler about commonly aspirated foods, which of the following foods, if identified by the parents as easily aspirated, would indicate the need for additional teaching?

- 1. Popcorn.
- 2. Raw vegetables.
- 3. Round candy.
- 4. Crackers.

**12.** A toddler who has been treated for a foreign body aspiration begins to fuss and cry when the parents attempt to leave the hospital for an hour. The parents will be returning to take the toddler home. As the nurse tries to take the child out of the crib, the child pushes the nurse away. The nurse interprets this behavior as indicating separation anxiety involving which of the following?

- 1. Protest.
- 2. Despair.
- 3. Regression.
- 4. Detachment.

**13.** After teaching the parents of an 18-month-old who was treated for a foreign body obstruction about the three cardinal signs indicative of choking, the nurse determines that the teaching has been successful when the parents state that a child is choking when he or she cannot speak, turns blue, and does which of the following?

- 1. Vomits.
- 2. Gasps.
- 3. Gags.
- 4. Collapses.

## The Client with Asthma

**14.** An 11-year-old is admitted for treatment of an asthma attack. Which of the following indicates immediate intervention is needed?

- 1. Thin, copious mucous secretions.
- 2. Productive cough.
- 3. Intercostal retractions.
- 4. Respiratory rate of 20 breaths/minute.

**15.** A 12-year-old client with asthma is receiving I.V. hydrocortisone, ampicillin, and theophylline. The client vomits after breakfast and lunch, is very irritable, and has a heart rate of 120 beats/minute. The nurse should:

- 1. Offer small amounts of clear liquids.
- 2. Inform the primary health care provider that the child is having an allergic reaction to the ampicillin.
- 3. Hold the next dose of theophylline and inform the primary health care provider of the vomiting.
- 4. Administer oxygen to decrease the heart rate.

**16.** A 12-year-old with asthma wants to exercise. Which of the following activities should the nurse suggest to improve her breathing?

- 1. Soccer.
- 2. Swimming.
- 3. Track.
- 4. Gymnastics.

**17.** When preparing the teaching plan for the mother of a child with asthma, which of the following should the nurse include as signs to alert the mother that her child is having an asthma attack?

- 1. Secretion of thin, copious mucus.
- 2. Tight, productive cough.
- 3. Wheezing on expiration.
- 4. Temperature of 99.4° F (37.4° C).

**18.** Which assessment findings should lead the nurse to suspect that a toddler is experiencing respiratory distress? Select all that apply.

- 1. Coughing.
- 2. Respiratory rate of 35 breaths/minute.
- 3. Heart rate of 95 beats/minute.
- 4. Restlessness.
- 5. Malaise.
- 6. Diaphoresis.

**19.** A 10-year-old child who is 5' 4" (138 cm) tall with a history of asthma uses an inhaled bronchodilator only when needed. He takes no other medications routinely. His best peak expiratory flow rate is 270 L/minute. The child's current peak flow reading is 180 L/minute. The nurse interprets this reading as indicating which of the following?

- 1. The child's asthma is under good control, so the routine treatment plan should continue.
- 2. The child needs to start a short-acting inhaled beta<sub>2</sub>-agonist medication.
- 3. This is a medical emergency requiring a trip to the emergency department for treatment.
- 4. The child needs to begin treatment with inhaled cromolyn sodium (Intal) for asthma control.

**20.** An adolescent complains of chest pain and goes to the school nurse. The nurse determines that the teenager has a history of asthma but has had no problems for years. Which of the following should the nurse do next?

- 1. Call the adolescent's parent.
- 2. Have the adolescent lie down for 30 minutes.
- 3. Obtain a peak flow reading.
- 4. Give two puffs of a short-acting bronchodilator.

**21.** A 7-year-old child with a history of asthma controlled without medications is referred to the school nurse by the teacher because of persistent coughing. Which of the following should the nurse do first?

- 1. Obtain the child's heart rate.
- 2. Give the child a nebulizer treatment.
- 3. Call a parent to obtain more information.
- 4. Have a parent come and pick up the child.

**22.** When developing a teaching plan for the mother of an asthmatic child concerning measures to reduce allergic triggers, which of the following suggestions should the nurse include:

- 1. Keep the humidity in the home between 50% and 60%.
- 2. Have the child sleep in the bottom bunk bed.
- 3. Use a scented room deodorizer to keep the room fresh.
- 4. Vacuum the carpet once or twice a week.

**23.** After discussing asthma as a chronic condition, which of the following statements by the father of a child with asthma best reflects the family's positive adjustment to this aspect of the child's disease?

- 1. "We try to keep him happy at all costs; otherwise, he has an asthma attack."
- 2. "We keep our child away from other children to help cut down on infections."
- 3. "Although our child's disease is serious, we try not to let it be the focus of our family."
- 4. "I'm afraid that when my child gets older, he won't be able to care for himself like I do."

**24.** An 8-year-old child with asthma states, “I want to play some sports like my friends. What can I do?” The nurse responds to the child based on the understanding of which of the following?

- 1. Physical activities are inappropriate for children with asthma.
- 2. Children with asthma must be excluded from team sports.
- 3. Vigorous physical exercise frequently precipitates an asthmatic episode.
- 4. Most children with asthma can participate in sports if the asthma is controlled.

### The Client with Cystic Fibrosis and Bronchopneumonia

**25.** A 9-month-old child with cystic fibrosis does not like taking pancreatic enzyme supplement with meals and snacks. The mother does not like to force the child to take the supplement. The most important reason for the child to take the pancreatic enzyme supplement with meals and snacks is:

- 1. The child will become dehydrated if the supplement is not taken with meals and snacks.
- 2. The child needs these pancreatic enzymes to help the digestive system absorb fats, carbohydrates, and proteins.
- 3. The child needs the pancreatic enzymes to aid in liquefying mucus to keep the lungs clear.
- 4. The child will experience severe diarrhea if the supplement is not taken as prescribed.

**26.** A client’s diagnosis of cystic fibrosis was made 13 years ago, and he has since been hospitalized several times. On the latest admission, the client has labored respirations, fatigue, malnutrition, and failure to thrive. Which nursing actions are most important initially?

- 1. Placing the client on bed rest and ordering a blood gas analysis.
- 2. Ordering a high-calorie, high-protein, low-fat, vitamin-enriched diet and pancreatic granules.
- 3. Applying an oximeter and initiating respiratory therapy.
- 4. Inserting an I.V. line and initiating antibiotic therapy.

**27.** A nurse is planning a diet for a client with cystic fibrosis. Which of the following foods should **not** be included in the meal plan?

- 1. Roasted chicken.
- 2. Fried scallops.
- 3. Milk shake.
- 4. Egg omelet.

**28.** A child with cystic fibrosis is receiving gentamicin. Which of the following nursing actions is **most** important?

- 1. Monitoring intake and output.
- 2. Obtaining daily weights.
- 3. Monitoring the client for indications of constipation.
- 4. Obtaining stool samples for hemocult testing.

**29.** When developing the plan of care for a child with cystic fibrosis (CF) who is scheduled to receive postural drainage, the nurse should anticipate performing postural drainage at which of the following times?

- 1. After meals.
- 2. Before meals.
- 3. After rest periods.
- 4. Before inhalation treatments.

**30.** When teaching the parents of an older infant with cystic fibrosis (CF) about the type of diet the child should consume, which of the following would be appropriate?

- 1. Low-protein diet.
- 2. High-fat diet.
- 3. Low-carbohydrate diet.
- 4. High-calorie diet.

**31.** At a follow-up appointment after being hospitalized, an adolescent with a history of cystic fibrosis (CF) describes his stools to the nurse. Which of the following descriptions should the nurse interpret as indicative of continued problems with malabsorption?

- 1. Soft with little odor.
- 2. Large and foul-smelling.
- 3. Loose with bits of food.
- 4. Hard with streaks of blood.

**32.** When developing a recreational therapy plan of care for a 3-year-old child hospitalized with pneumonia and cystic fibrosis, which of the following toys would be appropriate?

- 1. 100-piece jigsaw puzzle.
- 2. Child’s favorite doll.
- 3. Fuzzy stuffed animal.
- 4. Scissors, paper, and paste.

**33.** Which of the following, if described by the parents of a child with cystic fibrosis (CF), indicates that the parents understand the underlying problem of the disease?

- 1. An abnormality in the body’s mucus-secreting glands.
- 2. Formation of fibrous cysts in various body organs.
- 3. Failure of the pancreatic ducts to develop properly.
- 4. Reaction to the formation of antibodies against streptococcus.

- 34.** Which of the following outcome criteria would the nurse develop for a child with cystic fibrosis who has a nursing diagnosis of *Ineffective airway clearance* related to increased pulmonary secretions and inability to expectorate?
- 1. Respiratory rate and rhythm within expected range.
  - 2. Absence of chills and fever.
  - 3. Ability to engage in age-related activities.
  - 4. Ability to tolerate usual diet without vomiting.

- 35.** A school-age child with cystic fibrosis asks the nurse what sports she can become involved in as she becomes older. Which of the following activities would be appropriate for the nurse to suggest?
- 1. Swimming.
  - 2. Track.
  - 3. Baseball.
  - 4. Javelin throwing.

### The Client with Sudden Infant Death Syndrome

- 36.** When explaining to parents how to reduce the risk of Sudden Infant Death Syndrome (SIDS) the nurse should teach about which of the following measures? Select all that apply.
- 1. Maintain a smoke-free environment.
  - 2. Use a wedge for side-lying positions.
  - 3. Breast-feed the baby.
  - 4. Place the baby on his back to sleep.
  - 5. Use bumper pads over the bedrails.
  - 6. Have the baby sleep in the parent's bed.

- 37.** Which one of the following children is at **most** risk for sudden infant death syndrome (SIDS)?

- 1. Infant who is 3 months old.
- 2. 2-year-old who has apnea lasting up to 5 seconds.
- 3. First-born child whose parents are in their early forties.
- 4. 6-month-old who has had two bouts of pneumonia.

- 38.** Parents bring their child to the emergency department because the child has stopped breathing. A nurse obtains a brief history of events occurring before and after the parents found the infant not breathing. Which of the following questions should the nurse ask the parents **first**?

- 1. "Was the infant sleeping while wrapped in a blanket?"
- 2. "Was the infant lying on his stomach?"
- 3. "What did the infant look like when you found him?"
- 4. "When had you last checked on the infant?"

- 39.** When planning a visit to the parents of an infant who died of sudden infant death syndrome (SIDS) at home, the nurse should visit the parents at which of the following times?

- 1. A few days after the funeral.
- 2. Two weeks after the funeral.
- 3. As soon as the parents are ready to talk.
- 4. As soon after the infant's death as possible.

- 40.** When developing the ongoing plan of care for the parents whose infant died of sudden infant death syndrome (SIDS), the nurse should plan to accomplish which of the following on the second home visit?

- 1. Allow the parents to express their feelings.
- 2. Have the parents gain an understanding of the disease.
- 3. Assess the impact of the infant's death on their other children.
- 4. Deal with issues such as having other children.

### The Client Who Requires Immediate Care and Cardiopulmonary Resuscitation

- 41.** A child has just ingested about 10 adult-strength acetaminophen (Tylenol) pills. The mother brings the child to the emergency department. What should the nurse do? Place the interventions in the order of priority from first to last.

1. Administer activated charcoal.

2. Assess the airway.

3. Reassure the mother.

4. Check serum acetaminophen levels.

5. Obtain information about how the child obtained the pills.

6. Complete a physical examination.



**42.** On finding a child who is not breathing, which of the following should the nurse do **first**?

- 1. Clear the airway.
- 2. Begin mouth-to-mouth resuscitation.
- 3. Initiate oxygen therapy.
- 4. Start chest compressions.

**43.** Which of the following breathing rates should the nurse use when performing rescue breathing during cardiopulmonary resuscitation for a 5-year-old?

- 1. 10 breaths/minute.
- 2. 12 breaths/minute.
- 3. 15 breaths/minute.
- 4. 20 breaths/minute.

**44.** The nurse begins CPR on a 5-year-old unresponsive client. When the emergency response team arrives, the child continues to have no respiratory effort but has a heart rate of 50 with cyanotic legs. The team should next:

- 1. Discontinue compressions but continue administering breaths with a bag-mask device.
- 2. Establish an intravenous line with a large bore needle while preparing the defibrillator.
- 3. Begin 2-person CPR at a ratio of 2 breaths to 15 compressions.
- 4. Begin 2-person CPR at a ratio of 2 breaths to 30 compressions.

**45.** As part of a health education program, the nurse teaches a group of parents CPR. The nurse determines that the teaching had been effective when a parent states:

- 1. "If I am by myself, I should call for help before starting CPR."
- 2. "I should compress the chest using 2-3 fingers."
- 3. "I should deliver chest compression at a rate of 100 per minute."
- 4. "If I can't get the breaths to make the chest rise, I should administer abdominal thrusts."

**46.** When performing cardiopulmonary resuscitation (CPR), which of the following indicates that external chest compressions are effective?

- 1. Mottling of the skin.
- 2. Pupillary dilation.
- 3. Palpable pulse.
- 4. Cool, dry skin.

**47.** A nurse walks into the room just as a 10-month-old infant places an object in his mouth and starts to choke. After opening the infant's mouth, which of the following should the nurse do next to clear the airway?

- 1. Use blind finger sweeps.
- 2. Deliver back slaps and chest thrusts.
- 3. Apply four subdiaphragmatic abdominal thrusts.
- 4. Attempt to visualize the object.

**48.** When preparing to deliver back slaps to an infant who is choking on a foreign body, in which of the following positions should the nurse position the infant?

- 1. Head down and lower than the trunk.
- 2. Head up and raised above the trunk.
- 3. Head to one side and even with the trunk lower than the head.
- 4. Head parallel to the nurse and supported at the buttocks.

**49.** A 6-month old infant has had a cardiac arrest and the rapid response team has been paged. The nurse arrives in the client's room and observes a physician assistant (PA) administering CPR to an infant (see figure). To assist the PA with CPR, the nurse should:



- 1. Tell the PA to use the heel of the hand on the infant's sternum.
- 2. Place one hand on the infant's sternum for chest compressions while the PA ventilates the lungs at a rate of one breath to every 5 compressions.
- 3. Obtain an Ambu bag and give breaths at a rate of 2 breaths per 15 compressions.
- 4. Encircle the infant's chest with the thumbs on top to provide compression while the PA uses an Ambu bag to administer rescue 4 breaths after every 15 compressions.

**50.** When teaching the parents of an infant how to perform back slaps to dislodge a foreign body, which of the following should the nurse tell the parents to use to deliver the blows?

- 1. Palm of the hand.
- 2. Heel of the hand.
- 3. Fingertips.
- 4. Entire hand.

**51.** While the nurse is delivering abdominal thrusts to a 6-year old who is choking on a foreign body, the child begins to cry. Which of the following should the nurse do next? Synthesize

- 1. Tap or gently shake the shoulders.
- 2. Deliver back slaps.
- 3. Perform a blind finger sweep of the mouth.
- 4. Observe the child closely.

### The Client with Croup

**52.** A three-year-old is brought into the emergency department in her mother's arms. The child's mouth is open and she is drooling and lethargic. Her mother states that she became ill suddenly within the past 2 hours. What should the nurse do **first**?

- 1. Draw blood cultures for complete blood count.
- 2. Start an intravenous line.
- 3. Inspect the child's throat with a tongue blade.
- 4. Maintain the child in an undisturbed, upright position.

**53.** The father of a 16-month-old child calls the clinic because the child has a low-grade fever, cold symptoms, and a hoarse cough. Which of the following should the nurse suggest that the father do?

- 1. Offer extra fluids frequently.
- 2. Bring the child to the clinic immediately.
- 3. Count the child's respiratory rate.
- 4. Use a hot air vaporizer.

**54.** A 21-month-old child admitted with the diagnosis of croup now has a respiratory rate of 48 breaths/minute, a heart rate of 120 bpm, and a temperature of 100.8° F (38.2° C) rectally. The nurse is having difficulty calming the child. Which of the following should the nurse do next?

- 1. Administer acetaminophen (Tylenol).
- 2. Notify the physician immediately.
- 3. Allow the toddler to continue to cry.
- 4. Offer clear fluids every few minutes.

### The Client with Bronchiolitis or Pharyngitis

**55.** A child has viral pharyngitis. The nurse should advise the parents to do which of the following? Select all that apply.

- 1. Use a cool mist vaporizer.
- 2. Offer a soft-to-liquid diet.
- 3. Administer amoxicillin.
- 4. Administer acetaminophen.
- 5. Place the child on secretion precautions.

**56.** A father brings his 3-month-old infant to the clinic, reporting that the infant has a cold, is having trouble breathing, and "just doesn't seem to be acting right." Which of the following actions should the nurse do **first**?

- 1. Check the infant's heart rate.
- 2. Weigh the infant.
- 3. Assess the infant's oxygen saturation.
- 4. Obtain more information from the father.

**57.** While the nurse is working in a homeless shelter, assessment of a 6-month-old infant reveals a respiratory rate of 52 breaths/minute, retractions, and wheezing. The mother states that her infant was doing fine until yesterday. Which of the following actions would be **most** appropriate?

- 1. Administer a nebulizer treatment.
- 2. Send the infant for a chest radiograph.
- 3. Refer the infant to the emergency department.
- 4. Provide teaching about cold care to the mother.

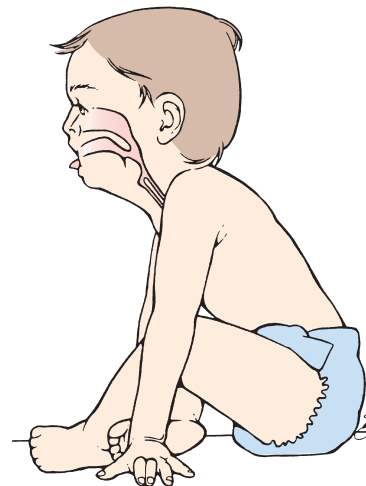
**58.** An infant is being treated at home for bronchiolitis. Which of the following should the nurse teach the parent about home care? Select all that apply.

- 1. Offering small amounts of fluids frequently.
- 2. Allowing the infant to sleep prone.
- 3. Calling the clinic if the infant vomits.
- 4. Writing down how much the infant drinks.
- 5. Performing chest physiotherapy every 4 hours.
- 6. Watching for difficulty breathing.

**59.** In preparation for discharge, the nurse teaches the mother of an infant diagnosed with bronchiolitis about the condition and its treatment. Which of the following statements by the mother indicates successful teaching?

- 1. "I need to be sure to take my child's temperature every day."
- 2. "I hope I don't get a cold from my child."
- 3. "Next time my child gets a cold I need to listen to the chest."
- 4. "I need to wash my hands more often."

**60.** The nurse observes an 18 month old who has been admitted with a respiratory tract infection (see figure). The nurse should **first**:



- 1. Position the child supine
- 2. Call the rapid response team
- 3. Offer the child a carbonated drink
- 4. Place the child in a croup tent

## Managing Care Quality and Safety

**61.** A charge nurse is making assignments for a group of children on a pediatric unit. The nurse should avoid assigning the same nurse to care for a 2-year-old with respiratory syncytial virus (RSV) and:

- 1. An 18-month-old with RSV.
- 2. A 9-year-old 8 hours post-appendectomy.
- 3. A 1-year-old with a heart defect.
- 4. A 6-year-old with sickle cell crisis.

**62.** The nurse is preparing to administer the last dose of ceftriaxone (Rocephin) before discharge to a 1-year-old but finds the I.V. has occluded. The nurse should:

- 1. Restart the I.V.
- 2. Administer the medication intramuscularly.
- 3. Arrange for early discharge.
- 4. Contact the prescriber to request an order change.

**63.** A nurse administers ranitidine (Zantac) instead of cetirizine (Zyrtec) to an 8-year-old with asthma. The client has suffered no adverse effects. The nurse tells the charge nurse of the incident but fears disciplinary action from reporting the error. The charge nurse should tell the nurse:

- 1. "If you do not report the error, I will have to."
- 2. "Reporting the error helps to identify system problems to improve client safety."
- 3. "Notify the client's physician to see if she wants this reported."
- 4. "This is not a serious mistake so reporting it will not affect your position."

**64.** A 12-year-old with cystic fibrosis is being treated in the hospital for pneumonia. The physician is calling in a telephone order for ampicillin. The nurse should do which of the following? Select all that apply.

- 1. Ask the unit clerk to listen on the speaker phone with the nurse and write down the order.
- 2. Ask the physician to come to the hospital and write the order on the chart.
- 3. Repeat the order to the physician.
- 4. Ask the physician to confirm that the order is correct as understood by the nurse.
- 5. Ask the nursing supervisor to cosign the telephone order as transcribed by the nurse.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Tonsillitis

**1. 4.** If the child does not stick out his tongue so the nurse can visualize the throat, it is appropriate to use a tongue blade. Having the child participate by holding the tongue blade while the nurse guides it to facilitate visualization of the throat is appropriate technique. It is not useful to remove the tongue blade or have the child hold it because the nurse will need to use the tongue blade to depress the tongue. It is preferable to engage the child's cooperation before asking the parent to restrain the child.

🔑 CN: Physiological adaptation; CL: Analyze

**2. 4.** When preparing a child for a procedure the nurse should use neutral words, focus on sensory experiences, and emphasize the positive aspects at the end. Being reunited with parents and having an ice pop would be considered pleasurable events. Children this age fear bodily harm. To reduced anxiety, the nurse should use the word "fixed" instead of "removed" to describe what is being done to the tonsils. Using the terms "put to sleep" and "I.V." may be threatening. Additionally, directing a play experience to focus on I.V. insertion may be counterproductive as the child may have little recollection of this aspect of the procedure.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**3. 2.** The most appropriate outcome for a nursing diagnosis of *Risk for perioperative-positioning injury* related to the surgical procedure would be that the child remains NPO for the designated period of time before surgery, thereby minimizing the risk of aspiration during the surgery. Ability to tell about the surgery and demonstrating an understanding of the procedure are appropriate outcomes for a nursing diagnosis of *Deficient knowledge*. Knowing that the parents will not leave is associated with a nursing diagnosis of *Anxiety* or *Fear* related to separation from support systems or an unfamiliar environment.

🔑 CN: Reduction of risk potential;  
CL: Synthesize


**4. 1.** After a tonsillectomy and adenoidectomy, drooling bright red blood is considered an early sign of hemorrhage. Often, because of discomfort in the throat, children tend to avoid swallowing; instead, they drool. Frequent swallowing would also be an indication of hemorrhage because the child attempts to clear the airway of blood by swallowing. Secretions may be slightly blood-tinged because of a small amount of oozing after surgery. However, bright red secretions indicate bleeding. A pulse rate of 95 bpm is within the normal range for a 5-year-old child, as is a blood pressure of 95/56 mm Hg. A small amount of blood that is partially digested, and therefore dark brown, is often present in post-operative emesis.

 CN: Reduction of risk potential;  
CL: Analyze

**5. 3.** For the first few days after a tonsillectomy and adenoidectomy, liquids and soft foods are best tolerated by the child while the throat is sore. Children typically do not chew their food thoroughly, and solid foods are to be avoided because they are difficult to swallow. Although meat loaf would be considered a soft food, uncooked carrots would not be. Pork is frequently difficult to chew. Foods that have sharp edges, such as potato chips, are contraindicated because they are hard to chew and may cause more throat discomfort.

 CN: Basic care and comfort; CL: Evaluate

**6. 3.** The risk of hemorrhage from a tonsillectomy is greatest when the tissue begins sloughing and the scabs fall off. This typically happens 7 to 10 days after a tonsillectomy.

 CN: Safety and infection control;  
CL: Apply

### The Client with Otitis Media

**7. 2.** When a person is taking amoxicillin as well as an oral contraceptive it renders the contraceptive less effective. Because pregnancy can occur in such a situation, the nurse should advise the client to use additional means of birth control during the time she is taking the antibiotic. There are no risks associated with the concurrent use of amoxicillin and antacids, vitamins, or food.

 CN: Psychosocial adaptation; CL: Apply

**8. 4.** Treatment of otitis media involves antibiotic therapy for 10 days and then a follow-up check of the ears by the health care provider. If the infection is not cleared, the health care provider will restart the client on another antibiotic. The bulging tympanic membrane and continued pain suggest that an infection remains. A decongestant may help

to drain the eustachian tubes, but it would not clear the infection. Repeating the same antibiotic that didn't clear the infection during the first course of treatment would probably not be helpful if taken for another 10 days. Myringotomy tubes are not indicated with just one ear infection.

 CN: Health promotion and maintenance;  
CL: Synthesize

**9. 1.** Toddlers should be approached slowly, because they are wary of strangers and need time to get used to someone they do not know. The best approach is to ignore them initially and to focus on talking to the parents. The child will likely resist being held by a stranger, so the nurse should not pick up or hold the child until the child indicates a readiness to be approached or the mother indicates that it is okay.

 CN: Health promotion and maintenance;  
CL: Synthesize

**10. 1.** Placing ear plugs in the ears will prevent contaminated bathwater from entering the middle ear through the tympanostomy tube and causing an infection. Blowing the nose forcibly during a cold causes organisms to ascend through the eustachian tube, possibly leading to otitis media. It is not necessary to administer antibiotics continuously to a child with a tympanostomy tube. Antibiotics are appropriate only when an ear infection is present. Drainage from the ear may be a sign of middle ear infection and should be reported to the health care provider.

 CN: Reduction of risk potential;  
CL: Create


### The Client with Foreign Body Aspiration

**11. 4.** Crackers, because they crumble and easily dissolve, are not commonly aspirated. Because children commonly eat popcorn hulls or pieces that have not popped, popcorn can be easily aspirated. Toddlers frequently do not chew their food well, making raw vegetables a commonly aspirated food. Round candy is often difficult to chew and comes in large pieces, making it easily aspirated.

 CN: Health promotion and maintenance;  
CL: Evaluate

**12. 1.** Young children have specific reactions to separation and hospitalization. In the protest stage, the toddler physically and verbally attacks anyone who attempts to provide care. Here, the child is fussing and crying and visibly pushes the nurse away. In the despair stage, the toddler becomes withdrawn and obviously depressed (e.g., not

engaging in play activities and sleeping more than usual). Regression is a return to a developmentally earlier phase because of stress or crisis (e.g., a toddler who could feed himself before this event is not doing so now). Denial or detachment occurs if the toddler's stay in the hospital without the parent is prolonged because the toddler settles in to the hospital life and denies the parents' existence (e.g., not reacting when the parents come to visit).


 CN: Psychosocial adaptation;  
CL: Analyze

**13. 4.** The three cardinal signs indicating that a child is truly choking and requires immediate life-saving interventions include inability to speak, blue color (cyanosis), and collapse. Vomiting does not occur while a child is unable to breathe. Once the object is dislodged, however, vomiting may occur. Gasping, a sudden intake of air, indicates that the child is still able to inhale. When a child is choking, air is not being exchanged, so gagging will not occur.


 CN: Reduction of risk potential;  
CL: Evaluate

### The Client with Asthma

**14. 3.** Intercostal retractions indicate an increase in respiratory effort, which is a sign of respiratory distress. During an asthma attack, secretions are thick, the cough is tight, and respiration is difficult (and shortness of breath may occur). If mucous secretions are copious but thin, the client can expectorate them, which indicates an improvement in the condition. If the cough is productive it means the bronchospasms and the inflammation have been resolved to the extent that the mucus can be expectorated. A respiratory rate of 20 breaths/minute would be considered normal and no intervention would be needed.

 CN: Physiological adaptation;  
CL: Analyze


**15. 3.** The therapeutic level of theophylline is 10 to 20 mcg/m. A toxic level of theophylline can cause vomiting, irritability, headache, and tachycardia. Oral rehydration may be helpful if the vomiting had created enough of a fluid volume deficit to elevate the heart rate, but this is unlikely since the client has an I.V. Allergic reactions to ampicillin usually include rash, urticaria, respiratory distress, and hypotension, not tachycardia and vomiting. Although the child's heart rate could indicate hypoxia, none of the other signs indicate a need for oxygen.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**16. 2.** Swimming is appropriate for this child because it requires controlled breathing, assists in maintaining cardiac health, enhances skeletal muscle strength, and promotes ventilation and perfusion. Stop-and-start activities, such as soccer, track, and gymnastics, commonly trigger symptoms in asthmatic clients.

 CN: Health promotion and maintenance;  
CL: Synthesize

**17. 3.** The child who is experiencing an asthma attack typically demonstrates wheezing on expiration initially. This results from air moving through narrowed airways secondary to bronchoconstriction. The child's expiratory phase is normally longer than the inspiratory phase. Expiration is passive as the diaphragm relaxes. During an asthma attack, secretions are thick and are not usually expelled until the bronchioles are more relaxed. At the beginning of an asthma attack the cough will be tight but not productive. Fever is not always present unless there is an infection that may have triggered the attack.

 CN: Physiological adaptation;  
CL: Analyze

**18. 1, 2, 4, 6.** Coughing, especially at night and in the absence of an infection, is a common symptom of asthma. Early signs of respiratory distress include restlessness, tachypnea, tachycardia, and diaphoresis. Other signs also include hypertension, nasal flaring, grunting, wheezing, and intercostal retractions. A heart rate of 95 bpm is normal for a toddler. Malaise typically does not indicate respiratory distress.

 CN: Physiological adaptation;  
CL: Analyze

**19. 2.** The peak flow of 180 L/minute is in the yellow zone, or 50% to 80% of the child's personal best. This means that the child's asthma is not well controlled, thereby necessitating the use of a short-acting beta<sub>2</sub>-agonist medication to relieve the bronchospasm. A peak flow reading greater than 80% of the child's personal best (in this case, 220 L/minute or better) would indicate that the child's asthma is in the green zone or under good control. A peak flow reading in the red zone, or less than 50% of the child's personal best (135 L/minute or less), would require notification of the health care provider or a trip to the emergency department. Cromolyn sodium (Intal) is not used for short-term treatment of acute bronchospasm. It is used as part of a long-term therapy regimen to help desensitize mast cells and thereby help to prevent symptoms.

 CN: Reduction of risk potential;  
CL: Evaluate

**20. 3.** Complaints of chest pain in children and adolescents are rarely cardiac. With a history of asthma, the most likely cause of the chest pain is related to the asthma. Therefore, the nurse should check the adolescent's peak flow reading to evaluate the status of the air flow. Calling the adolescent's parent would be appropriate, but this would be done after the nurse obtains the peak flow reading and additional assessment data. Having the adolescent lie down may be an option, but more data need to be collected to help establish a possible cause. Because the adolescent has not experienced any asthma problems for a long time, it would be inappropriate for the nurse to administer a short-acting bronchodilator at this time.

 CN: Reduction of risk potential;  
CL: Synthesize

**21. 3.** Because persistent coughing may indicate an asthma attack and a 7-year-old child would be able to provide only minimal history information, it would be important to obtain information from the parent. Although determining the child's heart rate is an important part of the assessment, it would be done after the history is obtained. More information needs to be obtained before giving the child a nebulizer treatment. Although it may be necessary for the parent to come and pick up the child, a thorough assessment including history information should be obtained first.


 CN: Reduction of risk potential;  
CL: Synthesize

**22. 1.** To help reduce allergic triggers in the home, the nurse should recommend that the humidity level be kept between 50% and 60%. Doing so keeps the air moist and comfortable for breathing. When air is dry, the risk for respiratory infections increase. Too high a level of humidity increases the risk for mold growth. Typically, the child with asthma should sleep in the top bunk bed to minimize the risk of exposure to dust mites. The risk of exposure to dust mites increases when the child sleeps in the bottom bunk bed because dust mites fall from the top bed, settling in the bottom bed. Scented sprays should be avoided because they may trigger an asthmatic episode. Ideally, carpeting should be avoided in the home if the child has asthma. However, if it is present, carpeting in the child's room should be vacuumed often, possibly daily, to remove dust mites and dust particles.

 CN: Reduction of risk potential;  
CL: Create

**23. 3.** Positive adjustment to a chronic condition requires placing the child's illness in its proper perspective. Children with asthma need to be treated as normally as possible within the scope of

the limitations imposed by the illness. They also need to learn how to manage exacerbations and then resume as normal a life as possible. Trying to keep the child happy at all costs is inappropriate and can lead to the child's never learning how to accept responsibility for behavior and get along with others. Although minimizing the child's risk for exposure to infections is important, the child needs to be with his or her peers to ensure appropriate growth and development. Children with a chronic illness need to be involved in their care so that they can learn to manage it. Some parents tend to overprotect their child with a chronic illness. This overprotectiveness may cause a child to have an exaggerated feeling of importance or later, as an adolescent, to rebel against the overprotectiveness and the parents.


 CN: Psychosocial adaptation;  
CL: Evaluate

**24. 4.** Physical activities are beneficial to asthmatic children, physically and psychosocially. Most children with asthma can engage in school and sports activities that are geared to the child's condition and within the limits imposed by the disease. The coach and other team members need to be aware of the child's condition and know what to do in case an attack occurs. Those children who have exercise-induced asthma usually use a short-acting bronchodilator before exercising.

 CN: Health promotion and maintenance;  
CL: Apply


### The Client with Cystic Fibrosis and Bronchopneumonia

**25. 2.** The child must take the pancreatic enzyme supplement with meals and snacks to help absorb nutrients so he can grow and develop normally. In cystic fibrosis, the normally liquid mucus is tenacious and blocks three digestive enzymes from entering the duodenum and digesting essential nutrients. Without the supplemental pancreatic enzyme, the child will have voluminous, foul, fatty stools due to the undigested nutrients and may experience developmental delays due to malnutrition. Dehydration is not a problem related to cystic fibrosis. The pancreatic enzymes have no effect on the viscosity of the tenacious mucus. Diarrhea is not caused by failing to take the pancreatic enzyme supplement.

 CN: Pharmacological and parenteral therapies; CL: Apply

**26. 3.** Clients with cystic fibrosis commonly die from respiratory problems. The mucus in the lungs is tenacious and difficult to expel, leading to lung infections and interference with oxygen and


carbon dioxide exchange. The client will likely need supplemental oxygen and respiratory treatments to maintain adequate gas exchange, as identified by the oximeter reading. The child will be on bed rest due to respiratory distress. However, although blood gases will probably be ordered, the oximeter readings will be used to determine oxygen deficit and are, therefore, more of a priority. A diet high in calories, proteins, and vitamins with pancreatic granules added to all foods ingested will increase nutrient absorption, and help the malnutrition; however, this intervention is not the priority at this time. Inserting an I.V. to administer antibiotics is important, and can be done after ensuring adequate respiratory function.

 CN: Physiological adaptation;  
CL: Synthesize


**27. 2.** Fried scallops are high in fat, and fats are difficult for a client with cystic fibrosis to digest; scallops are also not commonly preferred by most children. Clients with cystic fibrosis commonly lack calories and protein because their bodies do not absorb nutrients. Nutrients are not absorbed because tenacious mucus blocks key digestive enzymes from entering the digestive system. Thus, a diet rich in proteins and carbohydrates is essential for these clients. Roasted chicken and an egg omelet are high in protein and help with growth and development. The milk shake is high in carbohydrate and protein.

 CN: Health promotion and maintenance;  
CL: Apply

**28. 1.** Monitoring intake and output is the most important nursing action when administering an aminoglycoside, such as gentamicin, because a decrease in output is an early sign of renal damage. Daily weight monitoring is not indicated when the client is receiving an aminoglycoside. Constipation and bleeding are not adverse effects of aminoglycosides.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**29. 2.** Postural drainage, which aids in mobilizing the thick, tenacious secretions commonly associated with CF, is usually performed before meals to avoid the possibility of vomiting or regurgitating food. Although the child with CF needs frequent rest periods, this is not an important factor in scheduling postural drainage. However, the nurse would not want to interrupt the child's rest period to perform the treatment. Inhalation treatments are usually given before postural drainage to help loosen secretions.

 CN: Reduction of risk potential;  
CL: Apply

**30. 4.** CF affects the exocrine glands. Mucus is thick and tenacious, sticking to the walls of the pancreatic and bile ducts and eventually causing obstruction. Because of the difficulty with digestion and absorption, a high-calorie, high-protein, high-carbohydrate, moderate-fat diet is indicated.

 CN: Physiological adaptation; CL: Apply


**31. 2.** In children with CF, poor digestion and absorption of foods, especially fats, results in frequent bowel movements that are bulky, large, and foul-smelling. The stools also contain abnormally large quantities of fat, which is called *steatorrhea*. An adolescent experiencing good control of the disease would describe soft stools with little odor. Stool described as loose with bits of food indicates diarrhea. Stool described as hard with streaks of blood may indicate constipation.

 CN: Physiological adaptation;  
CL: Analyze

**32. 2.** The child's favorite doll would be a good choice of toys. The doll provides support and is familiar to the child. Although a 3-year-old may enjoy puzzles, a 100-piece jigsaw puzzle is too complicated for an ill 3-year-old child. In view of the child's lung pathology, a fuzzy stuffed animal would not be advised because of its potential as a reservoir for dust and bacteria, possibly predisposing the child to additional respiratory problems. Scissors, paper, and paste are not appropriate for a 3-year-old unless the child is supervised closely.


 CN: Health promotion and maintenance;  
CL: Create

**33. 1.** CF is characterized by a dysfunction in the body's mucus-producing exocrine glands. The mucus secretions are thick and sticky rather than thin and slippery. The mucus obstructs the bronchi, bronchioles, and pancreatic ducts. Mucus plugs in the pancreatic ducts can prevent pancreatic digestive enzymes from reaching the small intestine, resulting in poor digestion and poor absorption of various food nutrients. Fibrous cysts do not form in various organs. Cystic fibrosis is an autosomal recessive inherited disorder and does not involve any reaction to the formation of antibodies against streptococcus.

 CN: Physiological adaptation;  
CL: Evaluate

**34. 1.** After treatment, the client outcome would be that respiratory status would be within normal limits, as evidenced by a respiratory rate and rhythm within expected range. Absence of

chills and fever, although related to an underlying problem causing the respiratory problem (e.g., the infection), do not specifically relate to the respiratory problem of ineffective airway clearance. The child's ability to engage in age-related activities may provide some evidence of improved respiratory status. However, this outcome criterion is more directly related to a nursing diagnosis of *Activity intolerance*. Although the child's ability to tolerate his or her usual diet may indirectly relate to respiratory function, this outcome is more specifically related to a nursing diagnosis of *Imbalanced nutrition: Less than body requirements*, which may or may not be related to the child's respiratory status.

 CN: Physiological adaptation;  
CL: Evaluate

**35. 1.** Swimming would be the most appropriate suggestion because it coordinates breathing and movement of all muscle groups and can be done on an individual basis or as a team sport. Because track events, baseball, and javelin throwing usually are performed outdoors, the child would be breathing in large amounts of dust and dirt, which would be irritating to her mucous membranes and pulmonary system. The strenuous activity and increased energy expenditure associated with track events, in conjunction with the dust and possible heat, would play a role in placing the child at risk for an upper respiratory tract infection and compromising her respiratory function.

 CN: Health promotion and maintenance;  
CL: Synthesize

### The Client with Sudden Infant Death Syndrome

**36. 1, 3, 4.** Exposure to environmental tobacco increases the risk for SIDS. Sleeping on the back and breast-feeding both decrease the risk of SIDS. The side-lying position is not recommended for sleep. It is recommended that babies be dressed in sleepers and that cribs are free of blankets, pillows, bumper pads, and stuffed animals. Co-bedding with parents is not recommended as parents may roll on the child.


 CN: Safety and infection control;  
CL: Create

**37. 1.** The highest incidence of SIDS occurs in infants between ages 2 and 4 months. About 90% of SIDS occurs before the age of 6 months. Apnea lasting longer than 20 seconds has also been


associated with a higher incidence of SIDS. SIDS occurs with higher frequency in families where a child in the family has already died of SIDS, but the age of the parents has not been shown to contribute to SIDS. A respiratory infection such as pneumonia has not been shown to cause a higher incidence of SIDS.

 CN: Health promotion and maintenance;  
CL: Analyze


**38. 3.** Because this is an especially disturbing and upsetting time for the parents, they must be approached in a sensitive manner. Asking what the infant looked like when found allows the parents to verbalize what they saw and felt, thereby helping to minimize their feelings of guilt without implying any blame, neglect, wrongdoing, or abuse. Asking if the child was wrapped in a blanket or lying on his stomach, or when the parents last checked on the infant, implies that the parents did something wrong or failed in their care of the infant, thus blaming them for the event.

 CN: Physiological adaptation;  
CL: Analyze

**39. 4.** The community health nurse should visit as soon after the death as possible, because the parents may need help to deal with the sudden, unexpected death of their infant. Parents often have a great deal of guilt in these situations and need to express their feelings to someone who can provide counseling.

 CN: Psychosocial adaptation;  
CL: Synthesize

**40. 1.** The goal of the second home visit is to help the parents express their feelings more openly. Many parents are reluctant to express their grief and need help. The goal of the first visit is to help the parents understand the disease and what happened. The first visit also provides time to help the parents understand that they are not to blame. Although it is important to assess the impact of SIDS on siblings, this is not the primary goal for the second visit. However, the nurse must be flexible in case problems involving this area arise. Typically, parents are unable to deal with decisions such as having other children during the second visit because they are grieving for the child that they lost. This topic may be discussed later in the course of care.

 CN: Psychosocial adaptation;  
CL: Synthesize



## The Client Who Requires Immediate Care and Cardiopulmonary Resuscitation

41.

2. Assess the airway.

1. Administer activated charcoal.


3. Reassure the mother.

6. Perform a physical exam.


5. Obtain a history of the incident.

4. Check serum acetaminophen levels.


Immediate care of the child who has ingested acetaminophen is to ensure airway, breathing, and circulation. Next, the nurse should administer activated charcoal. Acetylcysteine (Mucomyst) may also be used as an antidote. When the child is stable, the nurse should reassure the mother. Next, the nurse should perform a physical exam to assess the child for other health problems, and then obtain further information about how the child obtained the aspirin. The serum acetaminophen level should be obtained 4 hours after ingestion.

 CN: Safety and infection control;  
CL: Synthesize

**42. 1.** When breathlessness is determined, the priority nursing action is to clear the airway. This action alone may reestablish spontaneous respiration. If the client does not begin breathing, mouth-to-mouth resuscitation is initiated. Oxygen therapy would not be initiated at this time, because the child is not breathing. Also, administering oxygen therapy would interfere with providing mouth-to-mouth resuscitation. Chest compressions are begun only after the client is determined to be pulseless.


 CN: Physiological adaptation;  
CL: Synthesize

**43. 1.** Rescue breaths should be delivered slowly at a volume that makes the chest rise and fall. For a 5-year-old child, the rate is 10 breaths per minute. If the nurse is also administering chest compressions, the rate is 2 breaths for every 15 compressions.


 CN: Physiological adaptation; CL: Apply

**44. 3.** CPR is done on children for heart rate of less 60 with signs of poor perfusion. Rescuers should use a 15:2 compression to ventilation ratio for 2-rescuer CPR for a child. Breaths without


compressions are indicated only for respiratory arrests where the heart rate remains above 60. The AED/defibrillator should be used as soon as it is ready, but rescuers should not discontinue compressions until the device is ready for use. The ratio for 2-person CPR in adults is 30:2.

 CN: Physiological adaptation;  
CL: Synthesize

**45. 3.** To maintain the best perfusion, it is recommended that compressions be given at a rate of 100 per minute in a 30 compression to 2 breath ratio for one rescuer CPR. Children still are more likely to have had a respiratory arrest than a cardiac arrest and are more likely to respond to opening the airway and rescue breaths. Therefore, it is recommended that unless the collapse was witnessed, a sole rescuer should attempt 5 cycles of CPR before leaving to call for help. Using 2-3 fingers for chest compressions is recommended for infant CPR only. Abdominal thrusts are no longer recommended for unconscious victims.

 CN: Physiological adaptation;  
CL: Evaluate

**46. 3.** With CPR, effectiveness of external chest compressions is indicated by palpable peripheral pulses, the disappearance of mottling and cyanosis, the return of pupils to normal size, and warm, dry skin. To determine whether the victim of cardiopulmonary arrest has resumed spontaneous breathing and circulation, chest compressions must be stopped for 5 seconds at the end of the first minute and every few minutes thereafter.

 CN: Physiological adaptation;  
CL: Evaluate

**47. 2.** The nurse should use mechanical force-back slaps and chest thrusts—in an attempt to dislodge the object. Blind finger sweeps are not appropriate in infants and children because the foreign body may be pushed back into the airway. Subdiaphragmatic abdominal thrusts are not used for infants age 1 year or younger because of the risk of injury to abdominal organs. If the object is not visible when opening the mouth, time is wasted in looking for it. Action is required to dislodge the object as quickly as possible.

 CN: Reduction of risk potential;  
CL: Apply

**48. 1.** To deliver back slaps, the nurse should place the infant face down, straddled over the nurse's arm, with the head lower than the trunk and the head supported. This position, together with the back slaps, facilitates dislodgment and removal of a foreign object and minimizes aspiration if vomiting occurs. Placing the infant with the head up and raised above the trunk would not aid in dislodging

and removing the foreign object. In addition, this position places the infant at risk for aspiration should vomiting occur. Placing the head to one side may minimize the risk of aspiration. However, it would not help with removal of an object that is dislodged by the back slaps. Placing the infant with the head parallel to the nurse and supported at the buttocks is more appropriate for burping the infant.

 CN: Physiological adaptation; CL: Apply


**49. 3.** The nurse should first obtain an Ambu bag and assist with CPR by giving breaths at a rate of 2 breaths per 15 compressions. The PA is using correct technique by using 2 to 3 fingers on the chest to administer chest compressions; The heel of both hands is used for older children and adolescents; the thumbs are used for premature infants. The compression to breath rate in 2- person CPR is 15 to 2.

 CN: Management of care; CL: Apply

**50. 2.** Back slaps are delivered rapidly and forcefully with the heel of the hand between the infant's shoulder blades. Slowly delivered back slaps are less likely to dislodge the object. Using the heel of the hand allows more force to be applied than when using the palm or the whole hand, increasing the likelihood of loosening the object. The fingertips would be used to deliver chest compressions to an infant younger than 1 year of age.

 CN: Physiological adaptation; CL: Apply


**51. 4.** Crying indicates that the airway obstruction has been relieved. No additional thrusts are needed. However, the child needs to be observed closely for complications, including respiratory distress. Tapping or shaking the shoulders is used initially to determine unresponsiveness in someone who appears unconscious. Delivering chest or back slaps could jeopardize the child's now-patent airway. Because the obstruction has been relieved, there is no need to sweep the child's mouth. Additionally, blind finger sweeps are contraindicated because the object may be pushed further back, possibly causing a complete airway obstruction.

 CN: Physiological adaptation;  
CL: Synthesize


### The Client with Croup

**52. 4.** This child is in severe respiratory distress with the potential for complete airway obstruction. The nurse should refrain from disturbing the child at this time to avoid irritating the epiglottis and causing it to completely obstruct the child's airway. The child may be intubated or undergo a tracheotomy. However, initially, the child should be kept as calm as possible with as little disruption as possible.


Any attempt to restrain the child, draw blood, insert an I.V., or examine her throat could result in total airway obstruction.

 CN: Physiological adaptation;  
CL: Synthesize

**53. 1.** The toddler is exhibiting cold symptoms. A hoarse cough may be part of the upper respiratory tract infection. The best suggestion is to have the father offer the child additional fluids at frequent intervals to help keep secretions loose and membranes moist. There is no evidence presented to suggest that the child needs to be brought to the clinic immediately. Although having the father count the child's respiratory rate may provide some additional information, it may lead the father to suspect that something is seriously wrong, possibly leading to undue anxiety. A hot air vaporizer is not recommended. However, a cool mist vaporizer would cause vasoconstriction of the respiratory passages, making it easier for the child to breathe and loosening secretions.


 CN: Physiological adaptation;  
CL: Synthesize

**54. 2.** The nurse may be having difficulty calming the child because the child is experiencing increasing respiratory distress. The normal respiratory rate for a 21-month-old is 25 to 30 breaths/minute. The child's respiratory rate is 48 breaths/minute. Therefore the physician needs to be notified immediately. Typically, acetaminophen is not given to a child unless the temperature is 101° F (38.6° C) or higher. Letting the toddler cry is inappropriate with croup because crying increases respiratory distress. Offering fluids every few minutes to a toddler experiencing increasing respiratory distress would do little, if anything, to calm the child. Also, the child would have difficulty coordinating breathing and swallowing, possibly increasing the risk of aspiration.

 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Bronchiolitis or Pharyngitis


**55. 1, 2, 4.** Viral pharyngitis is treated with symptomatic, supportive therapy. Treatment includes use of a cool mist vaporizer, feeding a soft or liquid diet, and administration of acetaminophen for comfort. Viral infections do not respond to antibiotic administration. The child does not need to be on secretion precautions because viral pharyngitis is not contagious.

 CN: Psychosocial adaptation;  
CL: Synthesize

**56. 3.** In an infant with these symptoms, the first action by the nurse would be to obtain an oxygen saturation reading to determine how well the infant is oxygenating, which is valuable information for an infant with trouble breathing. Because the father probably can provide no other information, checking the heart rate would be the second action done by the nurse. Then the nurse would obtain the infant's weight.

 CN: Reduction of risk potential;  
CL: Synthesize

**57. 3.** Based on the assessment findings of increased respiratory rate, retractions, and wheezing, this infant needs further evaluation, which could be obtained in an emergency department. Without a definitive diagnosis, administering a nebulizer treatment would be outside the nurse's scope of practice unless there was an order for such a treatment. Sending the infant for a radiograph may not be in the nurse's scope of practice. The findings need to be reported to a physician who can then determine whether or not a chest radiograph is warranted. The infant is exhibiting signs and symptoms of respiratory distress and is too ill to send out with just instructions on cold care for the mother.


 CN: Physiological adaptation;  
CL: Synthesize

**58. 1, 6.** An infant with bronchiolitis will have increased respirations and will tire more quickly, so it is best and easiest for the infant to take fluids more often in smaller amounts. The parents also would be instructed to watch for signs of increased difficulty breathing, which signal possible complications. Healthy infants and even those with bronchiolitis should sleep in the supine position. Calling the clinic for an episode of vomiting would not be necessary. However, the parents would be instructed to call if the infant cannot keep down any fluids for a period of more than 4 hours. Parents would not need to record how much the infant drinks. Chest physiotherapy is not indicated because it does not help and further irritates the infant.

 CN: Basic care and comfort; CL: Create

**59. 4.** Handwashing is the best way to prevent respiratory illnesses and the spread of disease. Bronchiolitis, a viral infection primarily affecting the bronchioles, causes swelling and mucus accumulation of the lumina and subsequent hyperinflation of the lung with air trapping. It is transmitted primarily by direct contact with respiratory secretions as a result of eye-to-hand or nose-to-hand contact or from contaminated fomites. Therefore, handwashing minimizes the risk for transmission. Taking the child's temperature is not appropriate in most cases. As long as the child is getting better, taking the temperature will not be helpful. The mother's

statement that she hopes she doesn't get a cold from her child does not indicate understanding of what to do after discharge. For most parents, listening to the child's chest would not be helpful because the parents would not know what they were listening for. Rather, watching for an increased respiratory rate, fever, or evidence of poor eating or drinking would be more helpful in alerting the parent to potential illness.


 CN: Physiological adaptation;  
CL: Evaluate

**60. 4.** The child is in respiratory distress and is sitting in a position to relieve the airway obstruction; the nurse should provide a humidified environment with a croup tent with cool mist to facilitate breathing and liquefy secretions. The child should remain sitting to facilitate breathing; the nurse should allow the child to determine the most comfortable position. After the child is breathing normally, the nurse can offer fluids; the physician also may order intravenous fluids. The nurse can call the rapid response team if the respiratory distress is not relieved by using a croup tent or other vital signs changes indicate further distress.

 CN: Reduction of risk potential;  
CL: Synthesize

## Managing Care Quality and Safety


**61. 3.** RSV may be spread through both direct and indirect contact. While contact and standard precautions should be employed, a measure to further decrease the risk of nosocomial infections is to avoid assigning the same nurse caring for an RSV client to a client at risk for infection. Children 2 years of age and younger are most at risk for RSV, especially if they have other chronic problems such as a heart defect. From an infection control perspective, pairing 2 clients with RSV is ideal. RSV infections are unlikely to pose a serious problem in older children.

 CN: Safety and infection control;  
CL: Synthesize

**62. 4.** Restarting an I.V. for 1 dose of a medication may not be in the infant's best interest when the medication can be given in an alternate form. The prescriber should be contacted to determine I.M. or P.O. options. Rocephin may be given I.M., but changing the route of a medication administration requires an order. Failing to complete an entire course of antibiotics contributes to the emergence of antibiotic resistance and would rarely be the best option.

 CN: Management of care; CL: Synthesize

**63. 2.** Client safety is enhanced when the emphasis on medication errors is to determine the root cause. All errors should be reported so systems can identify patterns which contribute to errors. Here, the similar names probably contributed to the error. The nurse who commits the error knows all the relevant information and is in the best position to report it. While the physician should be notified, it is a nursing responsibility to report errors not a physician choice. Relating mistakes to a nurse's position focuses on personal blame.

 CN: Safety and infection control;  
CL: Synthesize

**64. 3, 4.** To ensure client safety in obtaining telephone orders, the order must be received by a registered nurse. The nurse should write the order, read the order back to the physician, and receive confirmation from the physician that the order is correct. It is not necessary to ask the unit clerk to listen to the order, to require the physician to come to the hospital to write the order on the chart, or to have the nursing supervisor cosign the telephone order.

 CN: Safety and infection control;  
CL: Synthesize

**TEST  
3**

## The Child with Cardiovascular and Hematologic Health Problems

- The Client Undergoing a Cardiac Catheterization
- The Client with a Congenital Heart Defect
- The Client with Rheumatic Fever
- The Client with Kawasaki Disease
- The Client with Sickle Cell Anemia
- The Client with Iron Deficiency Anemia
- The Client with Hemophilia
- The Client with Leukemia
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client Undergoing a Cardiac Catheterization

**1.** The nurse caring for a 7-year-old child who has undergone a cardiac catheterization 2 hours ago finds the dressing and bed saturated with blood. The nurse should **first**:

- 1. Assess the vital signs.
- 2. Reinforce the dressing.
- 3. Apply pressure just above the catheter insertion site.
- 4. Notify the physician.

**2.** A 4-year-old has been scheduled for a cardiac catheterization. To help prepare the family the nurse should:

- 1. Advise the family to bring the child to the hospital for a tour a week in advance.
- 2. Explain that the child will need a large bandage after the procedure.
- 3. Discourage bringing favorite toys that might become associated with pain.
- 4. Explain that the child may get up as soon as the vital signs are stable.

**3.** When teaching the parents of a child with a ventricular septal defect who is scheduled for a cardiac catheterization, the nurse explains that this procedure involves the use of which of the following?

- 1. Ultra-high-frequency sound waves.
- 2. Catheter placed in the right femoral vein.
- 3. Cutdown procedure to place a catheter.
- 4. General anesthesia.

**4.** When developing the discharge teaching plan for the parents of a child who has undergone a cardiac catheterization for ventricular septal defect, which of the following should the nurse expect to include?

- 1. Restriction of the child's activities for the next 3 weeks.
- 2. Use of sponge baths until the stitches are removed.
- 3. Use of prophylactic antibiotics before receiving any dental work.
- 4. Maintenance of a pressure dressing until a return visit with the physician.

### The Client with a Congenital Heart Defect

**5.** Discharge teaching for a 3-month-old infant with a cardiac defect who is to receive digoxin (Lanoxin) should include which of the following? Select all that apply.

- 1. Give the medication at regular intervals.
- 2. Mix the medication with a small volume of breast milk or formula.
- 3. Repeat the dose one time if the child vomits immediately after administration.
- 4. Notify the primary care provider of poor feeding or vomiting.
- 5. Make up any missed doses as soon as realized.
- 6. Notify the primary care provider if more than 2 consecutive doses are missed.
- 7. Keep medication in a safe place, preferably a locked cabinet.
- 8. Induce vomiting if there is an accidental overdose.

**6.** An 18-month-old with a congenital heart defect is to receive digoxin twice a day. The nurse should instruct the parents about which of the following?

- 1. Digoxin enables the heart to pump more effectively with a slower and more regular rhythm.
- 2. Signs of toxicity include loss of appetite, vomiting, increased pulse, and visual disturbances.
- 3. Digoxin is absorbed better if taken with meals.
- 4. If the child vomits within 15 minutes of administration, the dosage should be repeated.

**7.** Twelve hours after cardiac surgery, the nurse is assessing a 3-year-old who weighs 15 kg. The nurse should notify the surgeon about which of the following clinical finding?

- 1. A urine output of 60 mL in 4 hours.
- 2. Strong peripheral pulses in all four extremities.
- 3. Fluctuations of fluid in the collection chamber of the chest drainage system.
- 4. Alterations in levels of consciousness.

**8.** A child diagnosed with tetralogy of Fallot becomes upset, crying and thrashing around when a blood specimen is obtained. The child's color becomes blue and the respiratory rate increases to 44 breaths/minute. Which of the following actions should the nurse do **first**?

- 1. Obtain an order for sedation for the child.
- 2. Assess for an irregular heart rate and rhythm.
- 3. Explain to the child that it will only hurt for a short time.
- 4. Place the child in a knee-to-chest position.

**9.** When teaching a preschool-age child how to perform coughing and deep-breathing exercises before corrective surgery for tetralogy of Fallot, which of the following teaching and learning principles should the nurse address **first**?

- 1. Organizing information to be taught in a logical sequence.
- 2. Arranging to use actual equipment for demonstrations.
- 3. Building the teaching on the child's current level of knowledge.
- 4. Presenting the information in order from simplest to most complex.

**10.** When assessing a child after heart surgery to correct tetralogy of Fallot, which of the following should alert the nurse to suspect a low cardiac output?

- 1. Bounding pulses and mottled skin.
- 2. Altered level of consciousness and thready pulse.
- 3. Capillary refill of 2 seconds and blood pressure of 96/67 mm Hg.
- 4. Extremities warm to the touch and pale skin.

**11.** A child has had open heart surgery to repair a tetralogy of Fallot with a patch. The nurse should instruct the parents to:

- 1. Notify all health care providers before invasive procedures for the next 6 months.
- 2. Maintain adequate hydration of at least 10 glasses of water a day.
- 3. Provide for frequent rest periods and naps during the first 4 weeks.
- 4. Restrict the ingestion of bananas and citrus fruit.

**12.** As part of the preoperative teaching for the family of a child undergoing a tetralogy of Fallot repair, the nurse tells the family upon returning to the pediatric floor that the child may:

- 1. Be placed on a reduced sodium diet.
- 2. Have an activity restriction for several days.
- 3. Be assigned to an isolation room.
- 4. Have visits limited to a select few.

**13.** After surgery to correct a tetralogy of Fallot, the child's parents express concern to the nurse that their 4-year-old child wants to be held more frequently than usual. The nurse recommends:

- 1. Introducing a new skill.
- 2. Play therapy.
- 3. Encouraging the behavior.
- 4. Having the volunteer hold the child.

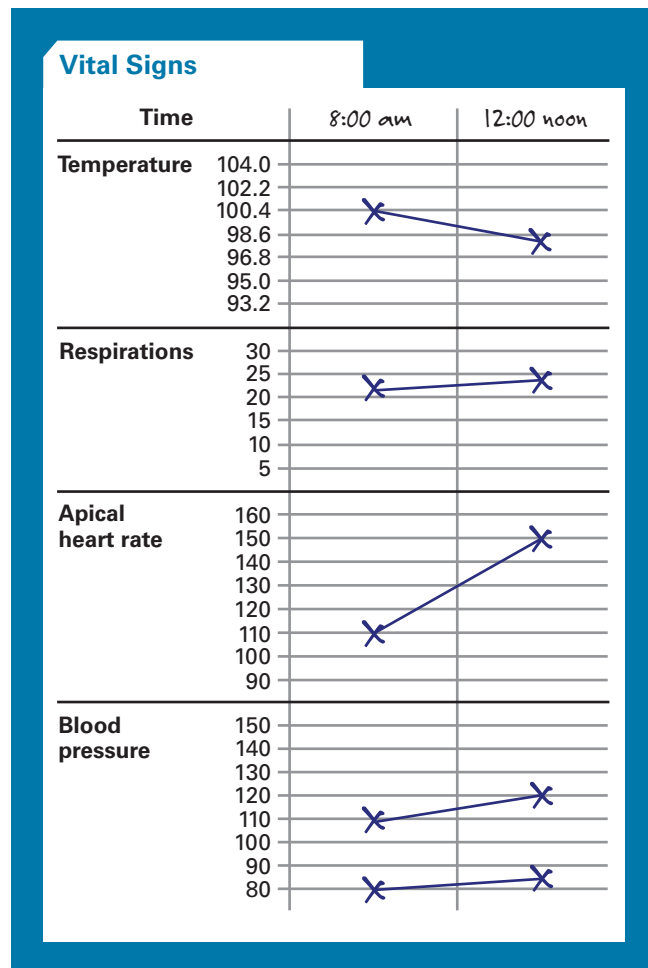
**14.** The mother of a child hospitalized with tetralogy of Fallot tells the nurse that the child's 3-year-old sibling has become quiet and shy and demonstrates more than a usual amount of genital curiosity since this child's hospitalization. The nurse should tell the mother:

- 1. "This behavior is very typical for a 3-year-old."
- 2. "This may be how your child expresses feeling a need for attention."
- 3. "This may be an indication that your child may have been sexually abused."
- 4. "This may be a sign of depression in your child."

## The Client with Rheumatic Fever

**15.** A 13-year-old has been admitted with a diagnosis of rheumatic fever and is on bed rest. He complains of a sore throat. His joints are painful and swollen. He has a red rash on his trunk and is experiencing aimless movements of his extremities. Use the chart below to determine what the nurse should do first.

- 1. Report the heart rate to the physician.
- 2. Apply lotion to the rash.
- 3. Splint the joints to relieve the pain.
- 4. Request an order for medication to treat the elevated temperature.



**16.** A nurse is planning care for a 12-year-old with rheumatic fever. The nurse should teach the parents to:

- 1. Observe the child closely.
- 2. Allow the child to participate in activities that will not tire him.
- 3. Provide for adequate periods of rest between activities.
- 4. Encourage someone in the family to be with the child 24 hours a day.

**17.** A 12-year-old with rheumatic fever has a history of long-term aspirin use. Which statement by the client indicates that the nurse should notify the health care provider?

- 1. "I hear ringing in my ears."
- 2. "Is it alright to put lotion on my itchy skin?"
- 3. "My stomach hurts after I take that medicine."
- 4. "These pills make me cough."

**18.** Which of the following should the nurse expect to include in the plan of care for a child who is diagnosed with rheumatic fever and carditis and admitted to the hospital?

- 1. Ensuring continuous parental presence at the child's bedside.
- 2. Providing the child with periods of rest.
- 3. Encouraging participation in age-appropriate activities.
- 4. Advising the child to eat as much as possible.

**19.** Which of the following outcomes indicates that the activity restriction necessary for a 7-year-old child with rheumatic fever during the acute phase has been effective?

- 1. Joints demonstrate absence of permanent injury.
- 2. The resting heart rate is between 60 and 100 bpm.
- 3. The child exhibits a decrease in chorea movements.
- 4. The subcutaneous nodules over the joints are no longer palpable.

**20.** Which of the following initial physical findings indicate the development of carditis in a child with rheumatic fever?

- 1. Heart murmur.
- 2. Low blood pressure.
- 3. Irregular pulse.
- 4. Anterior chest wall pain.

**21.** The primary health care provider orders pulse assessments through the night for a 12-year-old child with rheumatic fever who has a daytime heart rate of 120. The nurse explains to the mother that this is to evaluate if the elevated heart rate is caused by:

- 1. The morning digitalis.
- 2. Normal activity during waking hours.
- 3. A warmer daytime environment.
- 4. Normal variations in day and evening hours.

**22.** Which of following should the nurse perform to help alleviate a child's joint pain associated with rheumatic fever?

- 1. Maintaining the joints in an extended position.
- 2. Applying gentle traction to the child's affected joints.
- 3. Supporting proper alignment with rolled pillows.
- 4. Using a bed cradle to avoid the weight of bed linens on joints.

### The Client with Kawasaki Disease

**23.** When developing the plan of care for a newly admitted 2-year-old child with the diagnosis of Kawasaki disease, which of the following should be the priority?

- 1. Taking vital signs every 6 hours.
- 2. Monitoring intake and output every hour.
- 3. Minimizing skin discomfort.
- 4. Providing passive range-of-motion exercises.

**24.** A child with Kawasaki disease is receiving low dose aspirin. The mother calls the clinic and states that the child has been exposed to influenza. Which recommendations should the nurse make? Select all that apply.

- 1. Increase fluid intake.
- 2. Stop the aspirin.
- 3. Keep the child home from school.
- 4. Watch for fever.
- 5. Weigh the child daily.

**25.** A 16-month-old child diagnosed with Kawasaki disease (KD) is very irritable, refuses to eat, and exhibits peeling skin on the hands and feet. The nurse should do which of the following first?

- 1. Apply lotion to the hands and feet.
- 2. Offer foods the toddler likes.
- 3. Place the toddler in a quiet environment.
- 4. Encourage the parents to get some rest.

**26.** Which of the following should the nurse include when completing discharge instructions for the parents of a 12-month-old child diagnosed with Kawasaki disease (KD) and being discharged to home?

- 1. Offer the child extra fluids every 2 hours for 2 weeks.
- 2. Take the child's temperature daily for several days.
- 3. Check the child's blood pressure daily until the follow-up appointment.
- 4. Call the physician if the irritability lasts for 2 more weeks.

### The Client with Sickle Cell Anemia

**27.** A 14-year-old girl with sickle cell disease has her fourth hospitalization for sickle cell crisis. Her family is planning a ski vacation in the mountains. What should the nurse tell the parents?

- 1. Encourage them to go on the trip.
- 2. Go on the trip, but find a sitter for the 14-year-old.
- 3. Suggest the trip be postponed until next year.
- 4. Explain that the high altitude may cause a crisis.

**28.** The nurse is teaching the parents of a child with sickle cell disease. To instruct them on how to prevent sickle cell crisis, she should include which instruction?

- 1. Restrict the child's fluid intake to less than 1 quart per day.
- 2. Drink at least 2 quarts of fluids per day.
- 3. Stay away from other teenagers.
- 4. Avoid physical activity.

**29.** The nurse explains to the parents of a 1-year-old child admitted to the hospital in sickle cell crisis that the local tissue damage the child has on admission is caused by which of the following?

- 1. Autoimmune reaction complicated by hypoxia.
- 2. Lack of oxygen in the red blood cells.
- 3. Obstruction to circulation.
- 4. Elevated serum bilirubin concentration.

**30.** The mother asks the nurse why her child's hemoglobin was normal at birth but now the child has S hemoglobin. Which of the following responses by the nurse is appropriate?

- 1. "The placenta bars passage of the hemoglobin S from the mother to the fetus."
- 2. "The red bone marrow does not begin to produce hemoglobin S until several months after birth."
- 3. "Antibodies transmitted from you to the fetus provide the newborn with temporary immunity."
- 4. "The newborn has a high concentration of fetal hemoglobin in the blood for some time after birth."

**31.** Which of the following is the priority nursing diagnosis during a toddler's vasoocclusive sickle cell crisis?

- 1. *Ineffective coping* related to presence of a life-threatening disease.
- 2. *Decreased cardiac output* related to abnormal hemoglobin formation.
- 3. *Pain* related to tissue anoxia.
- 4. *Excess fluid volume* related to infection.



### The Client with Iron Deficiency Anemia

**32.** Which of the following actions indicates that the parents of a 12-month-old with iron deficiency anemia understand how to administer iron supplements? Select all that apply.

- 1. They administer iron supplements in combination with fruit juice.
- 2. They administer iron supplements with meals.
- 3. They report dark stools.
- 4. They brush the child's teeth after administering the iron supplements.
- 5. They decrease dietary intake of foods fortified with iron.

**33.** A mother asks the nurse if her child's iron deficiency anemia is related to the child's frequent infections. The nurse responds based on the understanding of which of the following?

- 1. Little is known about iron deficiency anemia and its relationship to infection in children.
- 2. Children with iron deficiency anemia are more susceptible to infection than are other children.
- 3. Children with iron deficiency anemia are less susceptible to infection than are other children.
- 4. Children with iron deficiency anemia are equally as susceptible to infection as are other children.

**34.** Which statements by the mother of a toddler should lead the nurse to suspect that the child is at risk for iron deficiency anemia? Select all that apply.

- 1. "He drinks over three cups of milk per day."
- 2. "I can't keep enough apple juice in the house; he must drink over 10 oz per day."
- 3. "He refuses to eat more than two different kinds of vegetables."
- 4. "He doesn't like meat, but he will eat small amounts of it."
- 5. "He sleeps 12 hours every night and takes a 2-hour nap."

**35.** Which of the following foods should the nurse encourage the mother to offer to her child with iron deficiency anemia?

- 1. Rice cereal, whole milk, and yellow vegetables.
- 2. Potato, peas, and chicken.
- 3. Macaroni, cheese, and ham.
- 4. Pudding, green vegetables, and rice.

### The Client with Hemophilia

**36.** What is the most appropriate method to use when drawing blood from a child with hemophilia?

- 1. Use finger punctures for lab draws.
- 2. Be prepared to administer platelets for prolonged bleeding.
- 3. Apply heat to the extremity before venipunctures.
- 4. Schedule all labs to be drawn at one time.

**37.** A diagnosis of hemophilia A is confirmed in an infant. Which of the following instructions should the nurse provide the parents as the infant becomes more mobile and starts to crawl?

- 1. Administer one-half of a children's aspirin for a temperature higher than 101° F (38.3° C).
- 2. Sew thick padding into the elbows and knees of the child's clothing.
- 3. Check the color of the child's urine every day.
- 4. Expect the eruption of the primary teeth to produce moderate to severe bleeding.

**38.** A child with hemophilia presents with a burning sensation in the knee and reluctance to move the body part. The nurse collaborates with the care team to provide factor replacement and:

- 1. Administer an aspirin-containing compound.
- 2. Institute Rest, Ice, Compression, and Elevation (RICE).
- 3. Begin physical therapy with active range of motion.
- 4. Initiate skin traction.

**39.** Because of the risks associated with administration of factor VIII concentrate, the nurse should teach the child's family to recognize and report which of the following?

- 1. Yellowing of the skin.
- 2. Constipation.
- 3. Abdominal distention.
- 4. Puffiness around the eyes.

**40.** The mother tells the nurse she will be afraid to allow her child with hemophilia to participate in sports because of the danger of injury and bleeding. After explaining that physical fitness is important for children with hemophilia, which of the following activities should the nurse suggest as ideal?

- 1. Snow skiing.
- 2. Swimming.
- 3. Basketball.
- 4. Gymnastics.

## The Client with Leukemia

**41.** A 15-year-old has been admitted to the hospital with the diagnosis of acute lymphocytic leukemia. Which of the following signs and symptoms require the most immediate nursing intervention?

- 1. Fatigue and anorexia.
- 2. Fever and petechiae.
- 3. Swollen neck lymph glands and lethargy.
- 4. Enlarged liver and spleen.

**42.** A 12-year-old with leukemia is receiving cyclophosphamide (Cytosan). The nurse should assess for the adverse effect of:

- 1. Photosensitivity.
- 2. Ataxia.
- 3. Cystitis.
- 4. Cardiac arrhythmias.

**43.** After teaching the parents of a child newly diagnosed with leukemia about the disease, which of the following descriptions given by the mother best indicates that she understands the nature of leukemia?

- 1. "The disease is an infection resulting in increased white blood cell production."
- 2. "The disease is a type of cancer characterized by an increase in immature white blood cells."
- 3. "The disease is an inflammation associated with enlargement of the lymph nodes."
- 4. "The disease is an allergic disorder involving increased circulating antibodies in the blood."

**44.** Laboratory findings indicate that a child with leukemia is also anemic. The nurse interprets this finding as most likely resulting from which of the following?

- 1. Inadequate dietary folic acid intake.
- 2. Decreased red blood cell production.
- 3. Increased destruction of red blood cells by lymphocytes.
- 4. Progressive replacement of bone marrow with scar tissue.

**45.** Which of the following statements should the nurse use to describe to the parents why their child with leukemia is at risk for infections?

- 1. "Play activities are too strenuous."
- 2. "Vitamin C intake is reduced over a period of time."
- 3. "The number of red blood cells is inadequate for carrying oxygen."
- 4. "Immature white blood cells are incapable of handling an infectious process."

**46.** Which of the following beverages should the nurse plan to give a child with leukemia to relieve nausea?

- 1. Orange juice.
- 2. Weak tea.
- 3. Plain water.
- 4. A carbonated beverage.

**47.** Which of the following medication orders to help relieve discomfort in a child with leukemia should the nurse question?

- 1. Acetaminophen (Tylenol).
- 2. Acetaminophen with codeine (Tylenol with Codeine).
- 3. Ibuprofen (Motrin).
- 4. Propoxyphene hydrochloride (Darvon).

**48.** After teaching a child with leukemia scheduled for a bone marrow aspiration about the procedure, the nurse determines that the teaching has been successful when the child identifies which of the following as the site for the aspiration?

- 1. Right lateral side of the right wrist.
- 2. Middle of the chest.
- 3. Distal end of the thigh.
- 4. Back of the hipbone.

**49.** The nurse and parents are planning for the discharge of a child with leukemia who is receiving dactinomycin (actinomycin D) and vincristine (Oncovin). The nurse should teach the parents to:

- 1. Encourage increased fluid intake.
- 2. Keep the child out of the sun.
- 3. Monitor the child's heart rate.
- 4. Observe the child for drowsiness.

**50.** After doing well for a period of time, a child with leukemia develops an overwhelming infection. The child's death is imminent. Which of the following statements offers the nurse the best guide in making plans to assist the parents in dealing with their child's imminent death?

- 1. Knowing that the prognosis is poor helps prepare relatives for the death of children.
- 2. Relatives are especially grieved when a child does well at first but then declines rapidly.
- 3. Trust in health care personnel is most often destroyed by a death that is considered untimely.
- 4. It is more difficult for relatives to accept the death of an older child than that of a toddler.

**51.** A 12-year-old with leukemia will be taking vincristine. The nurse should encourage the child to eat what kind of diet?

- 1. High-residue.
- 2. Low-residue.
- 3. Low-fat.
- 4. High-calorie.

**52.** A 10-year-old with leukemia is taking immunosuppressive drugs. To maintain health the nurse should instruct the child and parents to:

- 1. Continue with immunizations.
- 2. Not receive any live attenuated vaccines.
- 3. Receive vitamin and mineral supplements.
- 4. Stay away from peers.

**53.** A nurse is teaching the family of an 8-year-old boy with acute lymphocytic leukemia about appropriate activities. Which of the following activities should the nurse recommend?

- 1. Home schooling.
- 2. Restriction from participating in athletic activities.
- 3. Avoiding trips to the shopping mall.
- 4. Being treated as “normal” as much as possible.

### Managing Care Quality and Safety

**54.** A transfusion of packed red blood cells has been ordered for a 1-year-old with a sickle cell anemia. The infant has a 25 gauge I.V. infusing dextrose with sodium and potassium. Using the Situation, Background, Assessment, Recommendation (SBAR) method of communication, the nurse contacts the physician and recommends:

- 1. Starting a second I.V. with a 22 gauge catheter to infuse normal saline with the blood.
- 2. Using the existing I.V., but changing the fluids to normal saline for the transfusion.
- 3. Replacing the I.V. with a 22 gauge catheter to infuse the ordered fluids.
- 4. Starting a second I.V. with a 25 gauge catheter to infuse normal saline with the transfusion.

**55.** An infant has been transferred from the ICU to the pediatric floor after undergoing surgery to correct a heart defect. Which tasks can the nurse delegate to the licensed practical nurse (LPN)? Select all that apply.

- 1. Administering oral medications.
- 2. Administering I.V. morphine.
- 3. Obtaining vital signs.
- 4. Recording the input and output.
- 5. Administering blood products.
- 6. Morning hygiene.
- 7. Circulation checks.
- 8. Discharge teaching.

**56.** The nurse is assisting with conscious sedation for a 6-year-old undergoing a bone marrow biopsy. The nurse’s **most** important responsibility during the procedure is to:

- 1. Administer the topical anesthetic.
- 2. Keep the parents informed.
- 3. Monitor the client.
- 4. Record the procedure.

**57.** The nurse is transferring a child who has had open heart surgery from the pediatric intensive care unit to the pediatric unit. The child’s blood pressure has been fluctuating but has been stable during the last 2 hours. The nurse from the pediatric intensive care unit should include which of the following information in the report to the nurse on the pediatric unit? Select all that apply.

- 1. Medications being used.
- 2. Current vital signs.
- 3. Potential for blood pressure to drop.
- 4. Drip rate for the intravenous infusion.
- 5. Time of the most recent dose of pain medication.

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

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

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.


### The Client Undergoing a Cardiac Catheterization

**1. 3.** Direct pressure is the first measure that should be used to control bleeding. Taking the vital signs will not control the bleeding. This should be done while another person is being sent to notify the physician. The dressing can be reinforced after the bleeding has been contained.

🔑 CN: Reduction of risk potential;  
CL: Synthesize

**2. 2.** The catheter insertion site will be covered with a bandage. This is important for preschool children to know as they are very concerned about bodily harm. The best time to prepare a preschool child for an invasive procedure is the night before. Bringing a favorite toy to the hospital will help decrease the child’s anxiety. To prevent bleeding,

the child will be expected to keep the extremity straight for 4 to 6 hours after the procedure, either in bed or on the parent's lap.

 CN: Psychosocial adaptation;  
CL: Synthesize

**3. 2.** In children, cardiac catheterization usually involves a right-sided approach because septal defects permit entry into the left side of the heart. The catheter is usually inserted into the femoral vein through a percutaneous puncture. Echocardiography involves the use of ultra-high-frequency sound waves. A cutdown procedure is rarely used. The catheterization is usually performed under local, not general, anesthesia with sedation.

 CN: Reduction of risk potential;  
CL: Apply

**4. 3.** Prophylactic antibiotics are suggested for children with heart defects before dental work is done to reduce the risk of bacterial infection. Typically, activities are not restricted after a cardiac catheterization. A percutaneous approach is used to insert the catheter, so stitches are not necessary. Showering or bathing is allowed as usual. The pressure dressing will be removed before the child is discharged.

 CN: Reduction of risk potential;  
CL: Create


### The Client with a Congenital Heart Defect

**5. 1, 4, 6, 7.** To achieve optimal therapeutic levels, digoxin should be given at regular intervals without variation, usually every 12 hours. Vomiting and poor feeding are signs of toxicity. If more than two consecutive doses are missed, interventions may be needed to assure therapeutic drug levels. Accidental ingestion of digoxin may be life-threatening and parents should be advised on safe storage practices. The medication should not be mixed with any other fluid as refusal may result in inaccurate intake of the medication. Taking make-up doses, or taking the medication at times other than scheduled, may adversely affect serum levels. Parents should be advised to call poison control in the case of any accidental medication overdose.

 CN: Pharmacological and parenteral therapies; CL: Create

**6. 1.** Digoxin's effect is to slow the rate of the electrical conduction through the heart and increase the strength of the heart's contraction. Signs of toxicity include anorexia and decreased heart rate. Digoxin should be taken 1 hour before meals or


2 hours after meals in order to obtain better absorption of the drug. If the child vomits within 15 minutes of administration, the dose should not be repeated because it is not known how much of the medication has been absorbed.

 CN: Psychosocial adaptation;  
CL: Apply

**7. 4.** Clinical signs of low cardiac output and poor tissue perfusion include pale, cool extremities, cyanosis or mottled skin, delayed capillary refill, weak, thready pulses, oliguria, and alterations in level of consciousness. An adequate urine output for a child over 1 year should be 1 mL/kg/hour. Therefore 60 mL/4 hr is satisfactory. Strong peripheral pulses indicate adequate cardiac output. Drainage from the chest tube should show fluctuation in the drainage compartment of the chest drainage system. The fluid level normally fluctuates as proof that the apparatus is airtight. On about the third postoperative day, the fluctuation ceases indicating the lungs have fully expanded.


 CN: Physiological adaptation;  
CL: Synthesize

**8. 4.** The child is experiencing a tet or hypoxic episode. Therefore the nurse should place the child in a knee-to-chest position. Flexing the legs reduces venous flow of blood from the lower extremities and reduces the volume of blood being shunted through the interventricular septal defect and the overriding aorta in the child with tetralogy of Fallot. As a result, the blood then entering the systemic circulation has a higher oxygen content, and dyspnea is reduced. Flexing the legs also increases vascular resistance and pressure in the left ventricle. An infant often assumes a knee-to-chest position in the crib, or the mother learns to put the infant over her shoulder while holding the child in a knee-to-chest position to relieve dyspnea. If this position is ineffective, then the child may need a sedative. Once the child is in the position, the nurse may assess for an irregular heart rate and rhythm. Explaining to the child that it will only hurt for a short time does nothing to alleviate the hypoxia.


 CN: Physiological adaptation;  
CL: Synthesize

**9. 3.** Before developing any teaching program for a child, the nurse's first step is to assess the child to determine what is already known. Most older preschool children have some understanding of a condition present since birth. However, the child's interest will soon be lost if familiar material is repeated too often. The nurse can then organize the information in a sequence, because there are several steps to be demonstrated. These exercises do not require the use of equipment. The nurse should judge the amount and complexity of the information


to be provided, based on the child's current knowledge and response to teaching.

 CN: Physiological adaptation;  
CL: Synthesize


**10. 2.** With a low cardiac output and subsequent poor tissue perfusion, signs and symptoms would include pale, cool extremities; cyanosis; weak, thready pulses; delayed capillary refill; and decrease in level of consciousness.

 CN: Physiological adaptation;  
CL: Analyze

**11. 1.** Children who have undergone open heart surgery with a patch are at risk for infection, especially subacute bacterial endocarditis (SBE), for the first 6 months following surgery. The newest evidence-based guidelines suggest once the patch has epithelialized, these precautions are no longer necessary. Therefore, parents are instructed about SBE precautions including the need to notify providers before invasive procedures so antibiotics can be prescribed for that time period. Having the child drink a very large amount of water may lead to fluid overload. Children gear their rest schedule to their activities making it unnecessary to schedule frequent rest periods. Bananas and citrus fruit are high in potassium, but there is no evidence provided that the child has an elevated serum potassium requiring restriction.


 CN: Physiological adaptation;  
CL: Synthesize

**12. 1.** Because of the hemodynamic changes that occur with open heart surgery repair, particularly with septal defects, transient congestive heart failure may develop. Therefore, the child's sodium intake typically is restricted to 2 to 3 g/day. Activity restrictions are inappropriate. Typically the child is encouraged to walk the halls and unit. Risk for infection after the repair is the same as any post-operative client, therefore isolation is not necessary. The child may be placed in a room with other children who are not contagious. Visitors are not restricted unless the pediatric unit has restrictive visiting policies.


 CN: Physiological adaptation;  
CL: Synthesize

**13. 2.** The child is exhibiting regression. During periods of stress, children frequently revert to behaviors that were comforting in earlier developmental stages; play therapy is one way to help the child cope with the stress. Teaching a new skill most likely would add more stress. Parents should be instructed to praise positive behaviors and ignore regressive behaviors rather than calling attention to them through encouragement or discouragement. Having someone else hold the child does

not encourage coping with the stress or promoting appropriate development.


 CN: Psychosocial adaptation;  
CL: Synthesize

**14. 2.** According to Erikson, the central psychosocial task of a preschooler is to develop a sense of industry versus guilt. Any environmental situation may affect the child. In this situation the sibling is probably feeling less attention from the mother and trying to resolve the conflict in an inappropriate way. Three-year-olds are usually active and outgoing. These behaviors represent a change. Data are not sufficient to suggest the child has been exposed to a sexual experience. Symptoms of depression would include withdrawal and fatigue.


 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Rheumatic Fever

**15. 1.** The child's heart rate of 150 bpm is significantly above its rate at the time of his admission. The nurse must notify the physician. The increase in heart rate may indicate carditis, a possible complication of rheumatic fever that can cause serious and life-long effects on the heart. The physician will intervene with medication and cardiac monitoring. While lotion may soothe the itching, the most important action for the nurse is to notify the physician of the increased heart rate. Splinting will not help the inflammation that is causing the painful joints. The painful joints migrate and will subside with time. The temperature is not elevated at this time, and does not require intervention.


 CN: Physiological adaptation;  
CL: Synthesize

**16. 3.** The nurse should teach the parents to provide for sufficient periods of rest to decrease the client's cardiac workload. The client's condition does not warrant close observation unless cardiac complications develop. The child's activity level will be based on the results of the sedimentation rate, c-reactive protein, heart rate, and cardiac function. The family does not need to be with the client 24 hours a day unless carditis develops and his condition deteriorates.

 CN: Basic care and comfort;  
CL: Synthesize

**17. 1.** Tinnitus is an adverse effect of prolonged aspirin therapy and the child should be examined by a health care provider for hearing loss. Itchy skin commonly accompanies the rash associated with rheumatic fever and the nurse can encourage lotion use. The nurse teaches clients to take aspirin with


food or milk to avoid abdominal discomfort. The nurse can also address the fact that coughing after ingesting aspirin can be caused by inadequate fluid intake during administration.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**18. 2.** The nurse should encourage and plan to provide periods of rest for the child with rheumatic fever and carditis to allow the heart to rest. The parents should be made to feel that they can come and go as they need to. The child is not in critical condition, so the parents do not need to be present at the child's bedside continuously. The child should be allowed to participate in nonstrenuous activities that avoid overtaxing the heart, thus allowing the heart time to rest. There is no reason to encourage the child to eat as much as possible; in fact, overeating should be discouraged because it taxes the heart muscle.

 CN: Physiological adaptation; CL: Create

**19. 2.** During the acute phase of rheumatic fever, the heart is inflamed and every effort is made to reduce the work of the heart. Bedrest with limited activity is necessary to prevent heart failure. Therefore, the most reliable indicator that activity restriction has been effective is a resting heart rate between 60 and 100 bpm, normal for a 7-year-old child. No permanent damage to the joints occurs with rheumatic fever. The chorea movements associated with rheumatic fever are self-limited and usually disappear in 1 to 3 months. They are unrelated to activity restrictions. Subcutaneous nodules that occur over joint surfaces also resolve over time with no treatment. Therefore, they are not appropriate for evaluating the effectiveness of activity restrictions.


 CN: Physiological adaptation;  
CL: Evaluate

**20. 1.** In rheumatic fever, the connective tissue of the heart becomes inflamed, leading to carditis. The most common signs of carditis are heart murmurs, tachycardia during rest, cardiac enlargement, and changes in the electrical conductivity of the heart. Heart murmurs are present in about 75% of all clients during the first week of carditis and in 85% of clients by the third week. Signs of carditis do not include hypotension or chest pain. The client may have a rapid pulse, but it is usually not irregular.

 CN: Physiological adaptation;  
CL: Analyze

**21. 2.** An above-average pulse rate that is out of proportion to the degree of activity is an early sign of heart failure in a client with rheumatic fever. The sleeping pulse is used to determine whether the mild tachycardia persists during sleep (inactivity)

or whether it is a result of daytime activities. The environmental temperature would need to be quite warmer before it could influence the heart rate. Digitalis lowers the heart rate, so the rate would be decreased during the daytime.

 CN: Reduction of risk potential;  
CL: Analyze

**22. 4.** For a child with arthritis associated with rheumatic fever, the joints are usually so tender that even the weight of bed linens can cause pain. Use of a bed cradle is recommended to help remove the weight of the linens on painful joints. Joints need to be maintained in good alignment, not positioned in extension, to ensure that they remain functional. Applying gentle traction to the joints is not recommended because traction is usually used to relieve muscle spasms, not typically associated with rheumatic fever. Supporting the body in good alignment and changing the client's position are recommended, but these measures are not likely to relieve pain.

 CN: Reduction of risk potential;  
CL: Synthesize

## The Client with Kawasaki Disease

**23. 2.** Cardiac status must be monitored carefully in the initial phase of KD because the child is at high risk for congestive heart failure (CHF). Therefore, the nurse needs to assess the child frequently for signs of CHF, which would include respiratory distress and decreased urine output. Vital signs would be obtained more often than every 6 hours because of the risk of CHF. Although minimizing skin discomfort would be important, it does not take priority over monitoring the child's hourly intake and output. Passive range-of-motion exercises would be done if the child develops arthritis.


 CN: Physiological adaptation; CL: Create

**24. 2, 4.** Aspirin needs to be stopped because of its possible link to Reye's syndrome. Additionally, the parents need to watch for signs and symptoms of influenza. Children with influenza frequently present with fever, cold symptoms, and gastrointestinal symptoms. Increasing the child's fluid intake and weighing the child daily are not needed at this time because the child is not ill. Keeping the child home from school is not necessary, because the child is not ill and has already been exposed.

 CN: Reduction of risk potential;  
CL: Synthesize

**25. 3.** One of the characteristics of children with KD is irritability. They are often inconsolable. Placing the child in a quiet environment may help quiet

the child and reduce the workload of the heart. Although peeling of the skin occurs with KD, the child's irritability takes priority over applying lotion to the hands and feet. Children with KD usually are not hungry and do not eat well regardless of what is served. There is no indication that the parents need rest. Additionally, in this situation, the child takes priority over the parents.

 CN: Physiological adaptation;  
CL: Synthesize

**26. 2.** The child's temperature should be taken daily for several days after discharge, because recurrent fever may develop. Offering the child fluids every 2 hours is not necessary. Doing so increases the child's risk for CHF. Checking the child's blood pressure at home usually is not included as part of the discharge instructions because, by the time of discharge, the child is considered stable and the risk for cardiac problems is minimal. Most children with KD recover fully. Irritability may last for 2 months after discharge.

 CN: Physiological adaptation; CL: Create

### The Client with Sickle Cell Anemia

**27. 4.** High altitude causes deoxygenation, which might precipitate a crisis. In clients with sickle cell anemia, cells sickle when the client experiences any situation where increased demand for oxygen is needed, such as in an infection or dehydration, or when low oxygen concentration is experienced, such as in high altitudes or deep sea diving. Crises can commonly be prevented by maintaining hydration. It would be unsafe to encourage the family, or to say nothing about taking the client to high altitude areas, but giving the parents adequate information will allow them to make an appropriate decision. Postponing the trip or leaving the child at home does not address the immediate concern for the child's health.

 CN: Health promotion and maintenance;  
CL: Synthesize


**28. 2.** Increasing fluid intake and being well hydrated will help prevent cell stasis in the small vessels. Restricting fluids causes stasis of red blood cells and promotes obstruction and increases the chance of sickling with hypoxia and pain to the part that is involved. Clients with sickle cell disease should stay away from others who have infections. When the spleen of a client who has sickle cell disease has become fibrotic and nonfunctional, the client is more susceptible to infections. Clients with sickle cell disease should not avoid physical activity as long as the client stays well hydrated.

 CN: Health promotion and maintenance;  
CL: Synthesize


**29. 3.** Characteristic sickle cells tend to cause "log jams" in capillaries. This results in poor circulation to local tissues, leading to ischemia and necrosis. The basic defect in sickle cell disease is an abnormality in the structure of the red blood cells. The erythrocytes are sickle-shaped, rough in texture, and rigid. Sickle cell disease is an inherited disease, not an autoimmune reaction. Elevated serum bilirubin concentrations are associated with jaundice, not sickle cell disease.

 CN: Physiological adaptation; CL: Apply

**30. 4.** Sickle cell disease is an inherited disease that is present at birth. However, 60% to 80% of a newborn's hemoglobin is fetal hemoglobin, which has a structure different from that of hemoglobin S or hemoglobin A. Sickle cell symptoms usually occur about 4 months after birth, when hemoglobin S begins to replace the fetal hemoglobin. The gene for sickle cell disease is transmitted at the time of conception, not passed through the placenta. Some hemoglobin S is produced by the fetus near term. The fetus produces all its own hemoglobin from the earliest production in the first trimester. Passive immunity conferred by maternal antibodies is not related to sickle cell disease, but this transmission of antibodies is important to protect the infant from various infections during early infancy.

 CN: Physiological adaptation;  
CL: Apply

**31. 3.** For the child in sickle cell crisis, *Pain* is the priority nursing diagnosis because the sickled cells clump and obstruct the blood vessels, leading to occlusion and subsequent tissue ischemia. Although *Ineffective coping* may be important, it is not the priority. *Decreased cardiac output* is not a problem with this type of vasoocclusive crisis. Typically, a sickle cell crisis can be precipitated by a fluid volume deficit or dehydration.

 CN: Physiological adaptation;  
CL: Analyze

### The Client with Iron Deficiency Anemia

**32. 1, 4.** Parent teaching concerning a child with iron deficiency anemia should include directions about giving iron combined with fruit juice, in divided doses, between meals, and with a dropper for a 12-month-old or through a straw for older toddlers. Iron stains teeth; so brushing the teeth and administering liquid iron through a dropper or straw are necessary to prevent staining the teeth. Iron should not be given with milk, antacids, or tea and should be administered on an empty stomach. Iron will cause the stool to become black or green,

which is normal and does not need to be reported. However, light-colored stools indicate the iron is not being absorbed and should be reported.

 CN: Psychosocial adaptation;  
CL: Evaluate


**33. 2.** Children with iron deficiency anemia are more susceptible to infection because of marked decreases in bone marrow functioning with microcytosis.

 CN: Physiological adaptation; CL: Apply

**34. 1, 2.** Toddlers should have between two and three cups of milk per day and 8 oz of juice per day. If they have more than that, then they are probably not eating enough other foods, including iron-rich foods that have the needed nutrients. Food preferences vary among children. It is acceptable for the child to refuse foods as long as the diet is balanced and contains adequate calories. The child is obtaining a normal amount of sleep.

 CN: Basic care and comfort;  
CL: Evaluate

**35. 2.** Potatoes, peas, chicken, green vegetables, and rice cereal contain significant amounts of iron and therefore would be recommended. Milk and yellow vegetables are not good iron sources. Rice by itself also is not a good source of iron. Macaroni, cheese, and ham are not high in iron. While pudding (made with fortified milk) and green vegetables contain some iron, the better diet has protein and iron from the chicken and potato.

 CN: Physiological adaptation;  
CL: Apply


### The Client with Hemophilia

**36. 4.** Coordinating labs to minimize sticks reduces trauma and the risk of bleeding. Finger sticks in general are more painful and associated with more bleeding than venipunctures. In hemophilia, platelets are typically normal. Heat would increase vasodilatation and increase bleeding.

 CN: Reduction of risk potential;  
CL: Apply

**37. 2.** As the hemophilic infant begins to acquire motor skills, the risk of bleeding increases because of falls and bumps. Such injuries can be minimized by padding vulnerable joints. Aspirin is contraindicated because of its antiplatelet properties, which increase the infant's risk for bleeding. Because genitourinary bleeding is not a typical problem in children with hemophilia, urine testing is not indicated. Although some bleeding may occur with tooth eruption, it does not normally cause moderate


to severe bleeding episodes in children with hemophilia.

 CN: Safety and infection control;  
CL: Synthesize

**38. 2.** The child is displaying symptoms of bleeding in the joint and factor replacement is indicated. The RICE method is used additionally as a supportive measure to help control the bleeding. Aspirin containing compounds contribute to bleeding and should never be used to control pain. Physical therapy is instituted after the acute bleeding to prevent further damage. Orthopedic traction is considered in some rare cases during the rehabilitation phase, but not the acute phase.

 CN: Physiological adaptation;  
CL: Synthesize

**39. 1.** Because factor VIII concentrate is derived from large pools of human plasma, the risk of hepatitis is always present. Clinical manifestations of hepatitis include yellowing of the skin, mucous membranes, and sclera. Use of factor VIII concentrate is not associated with constipation, abdominal distention, or puffiness around the eyes.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**40. 2.** Swimming is an ideal activity for a child with hemophilia because it is a noncontact sport. Many noncontact sports and physical activities that do not place excessive strain on joints are also appropriate. Such activities strengthen the muscles surrounding joints and help control bleeding in these areas. Noncontact sports also enhance general mental and physical well-being. Falls and subsequent injury to the child may occur with snow skiing. Basketball is a contact sport and therefore increases the child's risk for injury. Gymnastics is a very strenuous sport. Gymnasts frequently have muscle and joint injuries that result in bleeding episodes.

 CN: Health promotion and maintenance;  
CL: Apply

### The Client with Leukemia


**41. 2.** Fever and petechiae associated with acute lymphocytic leukemia indicate a suppression of normal white blood cells and thrombocytes by the bone marrow and put the client at risk for other infections and bleeding. The nurse should initiate infection control and safety precautions to reduce these risks. Fatigue is a common symptom of leukemia due to red blood cell suppression. Although the client should be told about the need for rest and meal planning, such teaching is not the priority




intervention. Swollen glands and lethargy may be uncomfortable but they do not require immediate intervention. An enlarged liver and spleen do require safety precautions that prevent injury to the abdomen; however, these precautions are not the priority.

 CN: Reduction of risk potential;  
CL: Analyze

**42. 3.** Cystitis is a potential adverse effect of cyclophosphamide. The client should be monitored for pain on urination. Photosensitivity, ataxia, and cardiac arrhythmias are not adverse effects associated with cyclophosphamide.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**43. 2.** Leukemia is a neoplastic, or cancerous, disorder of blood-forming tissues that is characterized by a proliferation of immature white blood cells. Leukemia is not an infection, inflammation, or allergic disorder.

 CN: Physiological adaptation;  
CL: Evaluate

**44. 2.** The anemia seen in children with leukemia is caused by the bone marrow's overproduction of immature white blood cells at the expense of producing red blood cells and platelets. In this client, anemia is not caused by an inadequate intake of iron but, rather, by insufficient red blood cells. The anemia is not caused by destruction of red blood cells by lymphocytes or by the replacement of bone marrow with scar tissue.

 CN: Reduction of risk potential;  
CL: Analyze

**45. 4.** In leukemia, the number of normal white blood cells that are capable of fighting an infection is decreased. Although there is an increased number of immature white blood cells, they are unable to combat infection. Therefore, a child with leukemia is subject to infection. The major morbidity and mortality factor associated with leukemia is infection resulting from the presence of granulocytopenia. While increased activity may cause fatigue, it does not put the child at risk for infection. Vitamin C intake should not decrease if the child has adequate dietary intake. Decreased red blood cells are not directly caused by infection.


 CN: Reduction of risk potential;  
CL: Apply

**46. 4.** Carbonated beverages ordinarily are the best tolerated when a child feels nauseated. Many children find cola drinks especially easy to tolerate, but noncola beverages are also recommended. Orange juice usually is not tolerated well because of its high acid content. Tea may also be too acidic

and many children do not like tea. Water does not relieve nausea.

 CN: Reduction of risk potential;  
CL: Apply


**47. 3.** Ibuprofen prolongs bleeding time and is contraindicated in clients with leukemia. Non-narcotic drugs other than ibuprofen or aspirin, such as acetaminophen (Tylenol), may be prescribed to control pain. Narcotic analgesics, such as acetaminophen with codeine or propoxyphene hydrochloride, may be required when pain is severe.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**48. 4.** Although bone marrow specimens may be obtained from various sites, the most commonly used site in children is the posterior iliac crest, the back of the hipbone. This area is close to the body's surface but removed from vital organs. The area is large, so specimens can easily be obtained. For infants, the proximal tibia and the posterior iliac crest are used. The middle of the chest or sternum is the usual site for bone marrow aspiration in an adult. The wrist, chest, and thigh are not sites from which to obtain bone marrow specimens.

 CN: Reduction of risk potential;  
CL: Evaluate

**49. 1.** Dactinomycin and vincristine both cause nausea and vomiting. Oral fluids are encouraged, and antiemetics are given to prevent dehydration. Avoiding sun exposure is not necessary because photosensitivity is not associated with these drugs. Heart rate changes and drowsiness also are not associated with either of these two drugs.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**50. 2.** It has been found that parents are more grieved when optimism is followed by defeat. The nurse should recognize this when planning various ways to help the parents of a dying child. It is not necessarily true that knowing about a poor prognosis for years helps prepare parents for a child's death. Death is still a shock when it occurs. Trust in health care personnel is not necessarily destroyed when a death is untimely if the family views the personnel as having done all that was possible. It is not more difficult for parents to accept the death of an older child than that of a younger child.

 CN: Psychosocial adaptation;  
CL: Synthesize

**51. 1.** Vincristine may cause constipation, so the client should be encouraged to eat a high-residue (fiber) diet. The other diets do not help with constipation that can occur while receiving vincristine.

 CN: Physiological adaptation; CL: Apply

**52. 2.** Children who are immunosuppressed should not receive any live attenuated vaccines. Clients who are immunosuppressed and are given live attenuated vaccines such as measles, mumps, rubella and oral polio vaccine can develop severe forms of the diseases for which they are being immunized, which can result in death. Inactivated vaccines may be given if necessary, but the client is not able to adequately produce needed antibodies and it is recommended that immunizations be delayed for 3 months after the immunosuppressive drugs have been discontinued. Vitamin and mineral supplements are not normally given in conjunction with immunosuppressive drugs. When the client is immunosuppressed, the client should avoid only persons who have an infection.

 CN: Health promotion and maintenance; CL: Synthesize

**53. 4.** Any child with a chronic illness should be treated as normally as possible. Unless the child has severe bone marrow depression, he should be allowed to go to school with others and can go to the mall. If the child is in remission, athletic activities are allowed.

 CN: Health promotion and maintenance; CL: Synthesize

### Managing Care Quality and Safety

**54. 2.** The best evidence indicates that a catheter as small as 27 gauge may safely be used for transfusion in children, but blood must be infused with normal saline, not dextrose. A 1-year-old should be able to maintain their blood glucose for the 2 hour duration of the infusion without the need for a second I.V.

 CN: Management of care; CL: Synthesize

**55. 1, 3, 4, 6.** The RN's scope of practice includes assessment, planning, implementing, and evaluation. Only aspects of care implementation may be delegated to the LPN and the exact skills which may be delegated vary by state and institution. In general, LPNs have been trained to perform the tasks of administering oral medications, performing hygiene,


and recording the intake and output. LPNs may also take vital signs to gather data, but the nurse must interpret the data. Administering I.V. morphine requires assessment of the client's respiratory status before, during, and after the procedure. While institutions may allow for LPNs to monitor vital signs during a transfusion, a nurse would be in the best position to assess for a transfusion reaction. Circulation checks are assessments the nurses should complete. Discharge teaching requires an evaluation of learning and thus should be done by the nurse.

 CN: Management of care; CL: Synthesize


**56. 3.** During conscious sedation the client may lose protective reflexes and adequate respiratory and cardiac function may be impaired. At every procedure there must be one health care professional whose sole responsibility is to monitor the client. Topical agents must be given in advance of the procedure to be effective. During the procedure, the nurse would not leave the child to speak with parents. While the procedure would be documented according to the facility's protocols, proper monitoring of the client is the intervention most associated with reducing risks.

 CN: Reduction of risk potential; CL: Apply

**57. 1, 2, 3, 4, 5.** The report made when nurses are "handing off" a client from one nursing unit to another must include information about the condition of the client, potential for changes in the client's condition, current medications, and care and services received.

 CN: Safety and infection control; CL: Synthesize

**58. 4.** Safety standards require the use of two identifiers prior to medication administration. A parent can be used as the second identifier. Many young children will only answer to a nick name that does not coincide with the medical identification band or may answer to any name. It is common for children on a pediatric floor to go into each other's rooms. A small child may not know their birth date.

 CN: Safety and infection control; CL: Synthesize

TEST  
4

## The Child with Health Problems of the Upper Gastrointestinal Tract

- The Client with Cleft Lip and Palate
- The Client with Tracheoesophageal Fistula
- The Client with an Anorectal Anomaly
- The Client with Pyloric Stenosis
- The Client with Intussusception
- The Client with Inguinal Hernia
- The Client with Hirschsprung's Disease
- The Client with Diarrhea, Gastroenteritis, or Dehydration
- The Client with Appendicitis
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Cleft Lip and Palate

1. The nurse is caring for a child who has just returned from surgery for repair of a cleft lip. In which order, from first to last, should the nurse do the following?

1. Maintain a clear and adequate airway.

2. Maintain sufficient fluid and caloric intake.

3. Provide emotional comfort to the child.

4. Apply elbow restraints.

5. Teach the parents proper feeding methods.


2. When developing the plan of care for an infant with a cleft lip before corrective surgery is performed, which of the following should be a priority?

- 1. Maintaining skin integrity in the oral cavity.
- 2. Using techniques to minimize crying.
- 3. Altering the usual method of feeding.
- 4. Preventing the infant from putting fingers in the mouth.

3. Which of the following measures would be **most** effective in helping the infant with a cleft lip and palate to retain oral feedings?

- 1. Burp the infant at frequent intervals.
- 2. Feed the infant small amounts at one time.
- 3. Place the end of the nipple far to the back of the infant's tongue.
- 4. Maintain the infant in a lying position while feeding.

4. When teaching the mother of an infant who has undergone surgical repair of a cleft lip how to care for the suture line, the nurse demonstrates how to remove formula and drainage. Which of the following solutions should the nurse use?

- 1. Mouthwash.
- 2. Povidone-iodine (Betadine) solution.
- 3. A mild antiseptic solution.
- 4. Half-strength hydrogen peroxide.

**5.** After teaching the parent of an infant who has had a surgical repair for a cleft lip about the use of elbow restraints at home, the nurse determines that the teaching has been successful when the parent states which of the following?

- 1. “We will keep the restraints on continuously except when checking the skin under them for redness.”
- 2. “We will keep the restraints on during the day while he is awake, but take them off when we put him to bed at night.”
- 3. “After we get home, we won’t have to use the restraints because our child does not suck on his hands or fingers.”
- 4. “We will be sure to keep the restraints on all the time until we come to see the physician for a follow-up visit.”

**6.** The parent of an infant with a cleft lip and palate asks the nurse when the infant’s cleft palate will be repaired. The nurse responds by stating that the first repair of a cleft palate is usually done at which of the following times?

- 1. Before the eruption of teeth.
- 2. When the child weighs approximately 10 kg (22 lb).
- 3. Before the development of speech.
- 4. After the child learns to drink from a cup.

**7.** On the second postoperative day after repair of a cleft palate, which of the following should the nurse use to feed a toddler?

- 1. Cup.
- 2. Straw.
- 3. Rubber-tipped syringe.
- 4. Large-holed nipple.

**8.** Immediately on return to the nursing unit after surgical repair of a cleft palate, in which of the following positions should the nurse place the child?

- 1. On the back with the head in a position of comfort.
- 2. In low Fowler’s position with the head turned to the side.
- 3. Lying on the abdomen with the head turned to the side.
- 4. In reverse Trendelenburg with the head tilted forward.

## The Client with Tracheoesophageal Fistula

**9.** The parents report that their 1-day-old is drooling and having choking episodes with excessive amounts of mucus and color changes, especially during feedings. When contacting the physician about these symptoms the nurse should request:

- 1. A referral to a lactation consultant.
- 2. That the physician further assess the client.
- 3. An order for an x-ray with orogastric catheter placement.
- 4. A serum blood glucose level per laboratory.

**10.** The parents of a child with a tracheoesophageal fistula express feelings of guilt about their baby’s anomaly. Which of the following approaches by the nurse would **best** support the parents?

- 1. Helping the parents accept their feelings as a normal reaction.
- 2. Explaining that the parents did nothing to cause the newborn’s defect.
- 3. Encouraging the parents to concentrate on planning their baby’s care.
- 4. Urging the parents to visit their newborn as often as possible.

**11.** After teaching the parents of a neonate diagnosed with a tracheoesophageal fistula (TEF) about this anomaly, the nurse determines that the teaching was successful when the father describes the condition as which of the following?

- 1. “The muscle below the stomach is too tight, causing the baby to vomit forcefully.”
- 2. “There is a blind upper pouch and an opening from the esophagus into the airway.”
- 3. “The lower bowel is lacking certain nerves to allow normal function.”
- 4. “A part of the bowel is on the outside without anything covering it.”

**12.** Which of the following would indicate that an infant with a tracheoesophageal fistula (TEF) needs suctioning?

- 1. Brassy cough.
- 2. Substernal retractions.
- 3. Decreased activity level.
- 4. Increased respiratory rate.

**13.** The nurse is administering gastrostomy feedings to an infant after surgery to correct a tracheoesophageal fistula (TEF). To prevent air from entering the stomach once the syringe barrel is attached to the gastrostomy tube the nurse should:

- 1. Unclamp the tube after pouring the complete amount of formula to be administered into the syringe barrel.
- 2. Pour all of the formula to be administered into the syringe barrel after opening the clamp.
- 3. Maintain a continuous flow of formula down the side of the syringe barrel once the clamp is opened.
- 4. Allow a small amount of formula to enter the stomach before pouring more formula into the syringe barrel.

**14.** After surgery to repair a tracheoesophageal fistula, an infant receives gastrostomy tube feedings. After feeding the infant by this method, the nurse cradles and rocks the infant for about 15 minutes, primarily to help accomplish which of the following?

- 1. Promote intestinal peristalsis.
- 2. Prevent regurgitation of formula.
- 3. Relieve pressure on the surgical site.
- 4. Associate eating with a pleasurable experience.

**15.** A newborn who had a surgical repair of a tracheoesophageal fistula (TEF) is started on oral feedings. Which of the following should the nurse include in the teaching plan for the mother about oral feedings?

- 1. They are better tolerated when larger, but less frequent feedings are offered.
- 2. They should be offered on a feeding schedule to help the infant accept the feedings more readily.
- 3. They are best accepted by the infant when offered by the same nurse or by the infant's mother.
- 4. They are best planned in conjunction with observations of the infant's behavior.

### The Client with an Anorectal Anomaly

**16.** After completing diagnostic testing, the surgeon has scheduled a newborn with the diagnosis of an imperforate anus for surgery the next day. The infant's parents are Catholic and do not want the surgery to take place unless the infant has first been baptized. The nurse asks the parents:

- 1. "Are you worried your baby might die?"
- 2. "Do you want me to help arrange the baptism?"
- 3. "Do you want to speak with the social worker?"
- 4. "Would you prefer to wait for the surgery?"

**17.** Which of the following should the nurse assess in a newborn diagnosed with an anorectal malformation? Select all that apply.

- 1. Abdominal distension.
- 2. Loose stools.
- 3. Vomiting.
- 4. Meconium in the urine.
- 5. Meconium stools.

**18.** While caring for a neonate with an imperforate anus, the nurse assesses the neonate's urine output for which of the following?

- 1. Meconium.
- 2. Blood.
- 3. Bile.
- 4. Acetone.

**19.** After teaching the mother of a neonate who has successfully undergone surgery to repair a low anorectal anomaly, the mother indicates that she understands her child's prognosis when she states which of the following?

- 1. "My child will need to wear protective pads until puberty."
- 2. "My child will need extra fluids to prevent constipation."
- 3. "My child will probably always need a high-fiber diet."
- 4. "My child has a good chance of being potty trained."

**20.** When the infant returns to the unit after imperforate anus repair, the nurse should place the infant in which of the following positions?

- 1. On the abdomen, with legs pulled up under the body.
- 2. On the back, with legs extended straight out.
- 3. Lying on the side with the hips elevated.
- 4. Lying on the back in a position of comfort.

**21.** The father of a neonate scheduled for gastrointestinal surgery asks the nurse how newborns respond to painful stimuli. Which of the following should be the nurse's **best** response?

- 1. "Newborns cry and cannot be distracted to stop crying."
- 2. "When faced with a pain, newborns try to roll away from it."
- 3. "Newborns typically move their whole body in response to pain."
- 4. "Pain causes the newborn to withdraw the affected part."

**22.** When developing the plan of care for a neonate who was diagnosed with an anorectal malformation and who subsequently underwent surgery, which of the following would be **most** helpful in facilitating parent–infant bonding?

- 1. Explaining to the parents that they can visit at any time.
- 2. Encouraging the parents to hold their infant.
- 3. Asking the parents to help monitor the infant's intake and output.
- 4. Helping the parents plan for their infant's discharge.

### The Client with Pyloric Stenosis

**23.** A 4-week-old infant admitted with the diagnosis of hypertrophic pyloric stenosis presents with a history of vomiting. The nurse should anticipate that the infant's vomitus would contain gastric contents and which of the following?

- 1. Bile and streaks of blood.
- 2. Mucus and bile.
- 3. Mucus and streaks of blood.
- 4. Stool and bile.

**24.** An infant is admitted to the pediatric unit with a diagnosis of hypertrophic pyloric stenosis after vomiting for several days. Which of the following nursing diagnoses should be the priority?

- 1. *Deficient fluid volume* related to prolonged vomiting.
- 2. *Ineffective airway clearance* related to impaired swallowing.
- 3. *Imbalanced nutrition: Less than body requirements* related to prolonged vomiting.
- 4. *Bowel incontinence* related to abdominal pain.

**25.** When an infant with pyloric stenosis is admitted to the hospital, which of the following should the nurse do **first**?

- 1. Weigh the infant.
- 2. Begin an intravenous infusion.
- 3. Switch the infant to an oral electrolyte solution.
- 4. Orient the mother to the hospital unit.

**26.** After teaching the mother of an infant with pyloric stenosis about the disease, which of the following, if stated by the mother as a cause, indicates effective teaching?

- 1. "An enlarged muscle below the stomach sphincter."
- 2. "A telescoping of the large bowel into the smaller bowel."
- 3. "A result of giving the baby more formula than is necessary."
- 4. "A result of my baby taking the formula too quickly."

**27.** A newborn admitted with pyloric stenosis is lethargic and has poor skin turgor. The primary care provider has ordered I.V. fluids of dextrose water with sodium and potassium. The baby's admission potassium level is 3.4 Meq/L. The nurse should:

- 1. Notify the primary care provider.
- 2. Administer the ordered fluids.
- 3. Verify that the infant has urinated.
- 4. Have the potassium level redrawn.

**28.** When developing the plan of care for an infant with pyloric stenosis, the nurse identifies a nursing diagnosis of *Deficient fluid volume* related to prolonged vomiting. Which of the following parameters should the nurse expect to use when evaluating the client outcome?

- 1. Abdominal distention.
- 2. Weight loss.
- 3. Vomiting.
- 4. Respiratory effort.

**29.** After undergoing surgical correction of pyloric stenosis, an infant is returned to the room in stable condition. While standing by the crib, the mother says, "Perhaps if I had brought my baby to the hospital sooner, the surgery could have been avoided." Which of the following should be the nurse's **best** response?

- 1. "Surgery is the most effective treatment for pyloric stenosis."
- 2. "Try not to worry; your baby will be fine."
- 3. "Do you feel that this problem indicates that you are not a good mother?"
- 4. "Do you think that earlier hospitalization could have avoided surgery?"

**30.** After surgery to correct pyloric stenosis, the nurse instructs the parents about the postoperative feeding schedule for their infant. The parents exhibit understanding of these instructions when they state that they can start feeding the child within which of the following time frames?

- 1. 6 hours.
- 2. 8 hours.
- 3. 10 hours.
- 4. 12 hours.

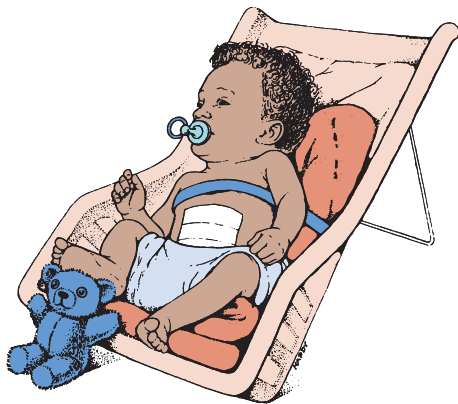
**31.** Immediately after the first oral feeding after corrective surgery for pyloric stenosis, a 4-week-old infant is fussy and restless. Which of the following actions would be **most** appropriate at this time?

- 1. Encourage the parents to hold the infant.
- 2. Hang a mobile over the infant's crib.
- 3. Give the infant more to eat.
- 4. Give the infant a pacifier to suck on.

**32.** Which of the following behaviors exhibited by the parents of an infant with pyloric stenosis should the nurse correctly interpret as a positive indication of parental coping?

- 1. Telling the nurse that they have to get away for a while.
- 2. Discussing the infant's care realistically.
- 3. Repeatedly asking if their child is normal.
- 4. Exhibiting fear that they will disturb the infant.

**33.** A 6-month-old has had a pyloromyotomy to correct a pyloric stenosis. Three days after surgery, the parents have placed their infant in his own infant seat (see figure). The nurse should do which of the following?



- 1. Reposition the infant to the left side.
- 2. Ask the parents to put the infant back in his crib.
- 3. Remind the parents that the infant cannot use a pacifier now.
- 4. Tell the parents they have positioned their infant correctly.

### The Client with Intussusception

**34.** When assessing a 4-month-old infant diagnosed with possible intussusception, the nurse should expect the mother to relate which of the following about the infant's crying and episodes of pain?

- 1. Constant accompanied by leg extension.
- 2. Intermittent with knees drawn to the chest.
- 3. Shrill during ingestion of solids.
- 4. Intermittent while being held in the mother's arms.

**35.** When obtaining the nursing history from the mother of an infant with suspected intussusception, which of the following questions would be **most** helpful?

- 1. "What do the stools look like?"
- 2. "When was the last time your child urinated?"
- 3. "Is your child eating normally?"
- 4. "Has your child had any episodes of vomiting?"

**36.** A nasogastric tube inserted during surgery to correct an infant's intussusception is no longer freely removing gastric secretions. Which of the following should the nurse do next?

- 1. Aspirate the tube with a syringe.
- 2. Irrigate the tube with distilled water.
- 3. Increase the level of suction.
- 4. Rotate the tube.

**37.** Which of the following assessments should be the priority for an infant who has had surgery to correct an intussusception and is now at risk for development of a paralytic ileus postoperatively?

- 1. Measurement of urine specific gravity.
- 2. Auscultation of bowel sounds.
- 3. Inspection of the first stool passed.
- 4. Measurement of gastric output.

**38.** An infant is to be discharged after surgery for intussusception. In developing the discharge teaching plan, the nurse should tell the mother?

- 1. The infant will experience a change in the normal home routine.
- 2. The infant can return to the prehospital routine immediately.
- 3. The infant needs to ingest more calories at home than what was consumed in the hospital.
- 4. The infant will continue to experience abdominal cramping for a few days.

### The Client with Inguinal Hernia

**39.** When assessing an infant with suspected inguinal hernia, which of the following findings would be **most** significant?

- 1. The inguinal swelling is reddened, and the abdomen is distended.
- 2. The infant is irritable, and a thickened spermatic cord is palpable.
- 3. The inguinal swelling can be reduced, and the infant has a stool in the diaper.
- 4. The infant's diaper is wet with urine, and the abdomen is nontender.

**40.** The physician is able to reduce an infant's hernia and schedules the infant for a herniorrhaphy in 2 days. The mother asks the nurse why the surgery is not performed now. Which of the following responses indicates that the nurse understands the rationale for delaying the surgery?

- 1. "Delaying the surgery ensures that your infant will receive the proper preoperative preparation."
- 2. "We need to make sure that your infant receives nothing by mouth for at least 24 hours before the surgery."
- 3. "Waiting these 2 days helps to allow any edema and inflammation in the area to subside."
- 4. "Your infant needs to wear a truss for at least 24 hours before any surgery can be attempted."

**41.** Preoperatively, the nurse develops a plan to prepare a 7-month-old infant psychologically for a scheduled herniorrhaphy the next day. Which of the following should the nurse expect to implement to accomplish this goal?

- 1. Explaining the preoperative and postoperative procedures to the mother.
- 2. Having the mother stay with the infant.
- 3. Making sure the infant's favorite toy is available.
- 4. Allowing the infant to play with surgical equipment.

**42.** Which of the following instructions should the nurse expect to include in the discharge teaching plan for the parent of an infant who has had an inguinal herniorrhaphy?

- 1. Change diapers as soon as they become soiled.
- 2. Apply an abdominal binder.
- 3. Keep the incision covered with a sterile dressing.
- 4. Restrain the infant's hands.

**43.** A mother asks, "How should I bathe my baby now that he's had surgery for his inguinal hernia?" Which of the following instructions should the nurse give the mother?

- 1. "Clean his face and diaper area for 2 weeks."
- 2. "Use sterile sponges to cleanse the inguinal incision."
- 3. "Give him a sponge bath daily for 1 week."
- 4. "Give the infant full tub baths every day."

**44.** A male adolescent who underwent repair of an inguinal hernia earlier today and is getting ready to go home receives instructions about resuming physical activities. Which of the following statements would indicate that he has understood the instructions?

- 1. "I can start riding my bike next week."
- 2. "I have to skip physical education classes for 2 weeks."
- 3. "I can start wrestling again in 3 weeks."
- 4. "I can return to my weight-lifting class in 2 weeks."

### The Client with Hirschsprung's Disease

**45.** During physical assessment of a 4-month-old infant with Hirschsprung's disease, the nurse should **most** likely note which of the following?

- 1. Scaphoid-shaped abdomen.
- 2. Weight less than expected for height and age.
- 3. Cyanosis of the fingers and toes.
- 4. Hyperactive deep tendon reflexes.

**46.** An infant diagnosed with Hirschsprung's disease is scheduled to receive a temporary colostomy. When initially discussing the diagnosis and treatment with the parents, which of the following would be **most** appropriate?

- 1. Assessing the adequacy of their coping skills.
- 2. Reassuring them that their child will be fine.
- 3. Encouraging them to ask questions.
- 4. Giving them printed material on the procedure.

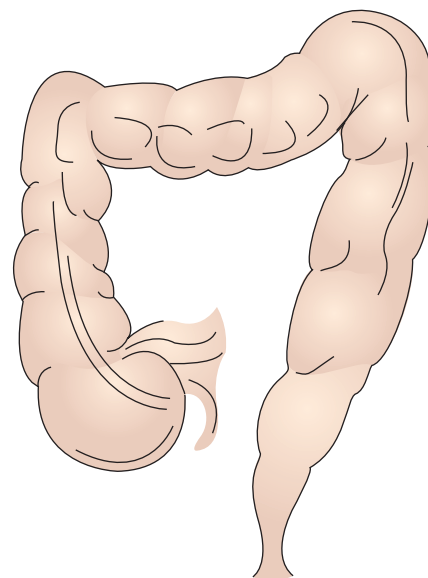
**47.** After teaching the parents of an infant diagnosed with Hirschsprung's disease, the nurse determines that the parents understand the diagnosis when the father states which of the following?

- 1. "There is no rectal opening for stool to pass."
- 2. "There is a tube between the trachea and esophagus."
- 3. "The nerves at the end of the large colon are missing."
- 4. "The muscle below the stomach is too tight."

**48.** When developing the preoperative plan of care for an infant with Hirschsprung's disease, which of the following should the nurse include?

- 1. Administering a tap water enema.
- 2. Inserting a gastrostomy tube.
- 3. Restricting oral intake to clear liquids.
- 4. Using povidone-iodine solution to prepare the perineum.

**49.** The nurse is showing the parent of a child with Hirschsprung's disease where the aganglionic area is located. Identify the area the nurse should point out as being aganglionic.





**50.** An infant diagnosed with Hirschsprung's disease undergoes surgery with the creation of a temporary colostomy. Which of the following statements by the parent regarding the colostomy indicates the need for further teaching?

- 1. "The colostomy is only temporary."
- 2. "The colostomy will give time for the nerves to return to normal."
- 3. "The colostomy may include two separate abdominal openings."
- 4. "Right after the procedure the stoma may appear purple."

**51.** When teaching the mother of an infant who has received a temporary colostomy for treatment of Hirschsprung's disease about how the stoma should normally appear, which of the following descriptions about the stoma's appearance should the nurse include in the teaching?

- 1. Becoming dark brown in 2 months.
- 2. Staying deep red in color.
- 3. Changing to several shades of pink.
- 4. Turning almost purple in color.

**52.** When teaching the parent of an infant with Hirschsprung's disease who received a temporary colostomy about the types of foods the infant will be able to eat, which of the following would the nurse recommend?

- 1. High-fiber diet.
- 2. Low-fat diet.
- 3. High-residue diet.
- 4. Regular diet.

**53.** An infant with Hirschsprung's disease is to be discharged 1 or 2 days after surgery to create a colostomy. After teaching the infant's parents about the overall effects of their infant's surgery, the nurse determines that the teaching has been effective when the parents state which of the following?

- 1. "His abdomen will be large for awhile."
- 2. "When he's ready, toilet training may be difficult."
- 3. "We need to limit his intake of dairy products."
- 4. "We will give him vitamin supplements until he is an adolescent."

## The Client with Diarrhea, Gastroenteritis, or Dehydration

**54.** A mother brings her 3-month-old child into the emergency department. The child is listless with dry mucous membranes, tenting of the skin on the forehead, a depressed fontanel, and a history of vomiting and diarrhea for the last 36 hours. In what order from first to last should the nurse implement the physician's orders?

1. Obtain vital signs and weight.

2. Insert an I.V. and infuse fluids.

3. Apply a urine collection bag.

4. Draw blood for laboratory tests.

**55.** A child is admitted with a tentative diagnosis of shigella. The nurse should do which of the following? Select all that apply.

- 1. Assess the child for nausea and vomiting.
- 2. Collect a stool specimen for white blood cells (WBCs).
- 3. Place the child on strict isolation.
- 4. Monitor the child for signs and symptoms of dehydration.
- 5. Initiate an intake and output record.

**56.** Which of the following would **most** likely alert the nurse to the possibility that a preschooler is experiencing moderate dehydration?

- 1. Deep, rapid respirations.
- 2. Diaphoresis.
- 3. Absence of tear formation.
- 4. Decreased urine specific gravity.

**57.** Which of the following would be an important assessment finding for an 8-month-old infant admitted with severe diarrhea?

- 1. Absent bowel sounds.
- 2. Pale yellow urine.
- 3. Normal skin elasticity.
- 4. Depressed anterior fontanel.

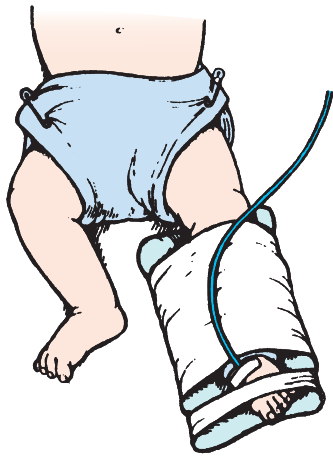
**58.** Which of the following would be the **best** activity for the nurse to include in the plan of care for an infant experiencing severe diarrhea?

- 1. Monitoring the total 8-hour formula intake.
- 2. Weighing the infant each day.
- 3. Checking the anterior fontanel every shift.
- 4. Monitoring abdominal skin turgor every shift.

**59.** The physician orders an intravenous infusion of 5% dextrose in 0.25 normal saline to be infused at 2 mL/kg/hour in an infant who weighs 9 lb. How many milliliters per hour of the solution should the nurse infuse? Round to one decimal.

\_\_\_\_\_ mL/hour.

**60.** The nurse is evaluating an infant who has an intravenous infusion secured to a sandbag (see figure). The nurse should:



- 1. Add tape to cover the toe.
- 2. Secure the right leg to a sandbag.
- 3. Check the infusion rate every hour.
- 4. Change the sandbag to an extremity restraint

**61.** Which of the following would be **most** appropriate for the nurse to teach the mother of a 6-month-old infant hospitalized with severe diarrhea to help her comfort her infant who is fussy?

- 1. Offering a pacifier.
- 2. Placing a mobile above the crib.
- 3. Sitting at crib side talking to the infant.
- 4. Turning the television on to cartoons.

**62.** Which of the following nursing diagnoses would be appropriate for the nurse to identify as a priority diagnosis for an infant just admitted to the hospital with a diagnosis of gastroenteritis?

- 1. *Pain* related to repeated episodes of vomiting.
- 2. *Deficient fluid volume* related to excessive losses from severe diarrhea.
- 3. *Impaired parenting* related to infant's loss of fluid.
- 4. *Impaired urinary elimination* related to increased fluid intake feeding pattern.

**63.** Which of the following should the nurse use to determine achievement of the expected outcome for an infant with severe diarrhea and a nursing diagnosis of *Deficient fluid volume* related to passage of profuse amounts of watery diarrhea?

- 1. Moist mucous membranes.
- 2. Passage of a soft, formed stool.
- 3. Absence of diarrhea for a 4-hour period.
- 4. Ability to tolerate intravenous fluids well.

**64.** Which of the following should the nurse include when teaching the father of an infant just admitted with gastroenteritis about initial treatment for his infant?

- 1. The infant will receive no liquids by mouth.
- 2. Intravenous antibiotics will be started.
- 3. The infant will be placed in a mist tent.
- 4. An iron-fortified formula will be used.

**65.** The nurse teaches the father of an infant hospitalized with gastroenteritis about the next step of the treatment plan once the infant's condition has been controlled. The nurse should determine that the father understands when he explains that which of the following will occur with his infant?

- 1. The infant will receive clear liquids for a period of time.
- 2. Formula and juice will be offered.
- 3. Blood will be drawn daily to test for anemia.
- 4. The infant will be allowed to go to the play-room.

**66.** The mother of a toddler who has just been admitted with severe dehydration secondary to gastroenteritis says that she cannot stay with her child because she has to take care of her other children at home. Which of the responses by the nurse would be **most** appropriate?

- 1. "You really shouldn't leave right now. Your child is very sick."
- 2. "I understand, but feel free to visit or call anytime to see how your child is doing."
- 3. "It really isn't necessary to stay with your child. We'll take very good care of him."
- 4. "Can you find someone to stay with your children? Your child needs you here."

**67.** A child is admitted to the pediatric unit with the diagnosis of severe gastroenteritis. To prevent spread of the disease the nurse should?

- 1. Institute standard precautions.
- 2. Place the child in a semiprivate room.
- 3. Serve meals with eating utensils that can be sterilized.
- 4. Single-bag all linens.

**68.** A 9-month-old is admitted because of dehydration. How should the nurse go about accurately monitoring fluid intake and output? Select all that apply.

- 1. Weighing and recording all wet diapers.
- 2. Obtaining a urine specific gravity measure.
- 3. Obtaining an accurate daily weight.
- 4. Restricting fluids prior to weighing the child.
- 5. Obtaining an accurate stool count.

**69.** The physician orders intravenous fluid replacement therapy with potassium chloride to be added for a child with severe gastroenteritis. Before adding the potassium chloride to the intravenous fluid, which of the following assessments would be **most** important?

- 1. Ability to void.
- 2. Passage of stool today.
- 3. Baseline electrocardiogram.
- 4. Serum calcium level.

**70.** Which of the following would alert the nurse to suspect that a child with severe gastroenteritis who has been receiving intravenous therapy for the past several hours may be developing circulatory overload?

- 1. A drop in blood pressure.
- 2. Change to slow, deep respirations.
- 3. Auscultation of moist crackles.
- 4. Marked increase in urine output.

**71.** The stool culture of a child with profuse diarrhea reveals *Salmonella* bacilli. After teaching the mother about the course of *Salmonella enteritidis*, which of the following statements by the mother indicates effective teaching?

- 1. "Some people become carriers and stay infectious for a long time."
- 2. "After the acute stage passes, the organism is usually not present in the stool."
- 3. "Although the organism may be alive indefinitely, in time it will be of no danger to anyone."
- 4. "If my child continues to have the organism in the stool, an antitoxin can help destroy the organism."

**72.** A child is started on a soft diet after having been on clear liquids following an episode of severe gastroenteritis. When helping the mother choose foods for her child, which of the following foods would be **most** appropriate?

- 1. Muffins and eggs.
- 2. Bananas and rice cereal.
- 3. Bran cereal and a bagel.
- 4. Pancakes and sausage.

**73.** A child undergoes rehydration therapy after having diarrhea and dehydration. A nurse is teaching the child's parents about dietary management. The nurse understands that the teaching plan has been successful when the parents tell the nurse that they will follow which type of diet?

- 1. Regular.
- 2. Clear liquid.
- 3. Full liquid.
- 4. Soft.

**74.** When obtaining a history from the parents of a child diagnosed with diarrhea due to *Salmonella*, the nurse should ask the parents if the child has been exposed to which of the following possible sources of infection?

- 1. Nonrefrigerated custard.
- 2. A pet canary.
- 3. Undercooked eggs.
- 4. Unwashed fruit.

**75.** On a home visit following discharge from the hospital after treatment for severe gastroenteritis, the mother tells the nurse that her toddler answers "No!" and is difficult to manage. After discussing this further with the mother, the nurse explains that the child's behavior is **most likely** the result of which of the following?

- 1. Beginning leadership skills.
- 2. Inherited personality trait.
- 3. Expression of individuality.
- 4. Usual lack of interest in everything.

**76.** The mother of a toddler hospitalized for episodes of diarrhea reports that when her toddler cannot have things the way she wants, she throws her legs and arms around, screams, and cries. The mother says, "I don't know what to do!" After teaching the mother about ways to manage this behavior, which of the following statements indicates that the nurse's teaching was successful?

- 1. "Next time she screams and throws her legs, I'll ignore the behavior."
- 2. "I'll allow her to have what she wants once in a while."
- 3. "I'll explain why she cannot have what she wants."
- 4. "When she behaves like this, I'll tell her that she is being a bad girl."

**77.** The mother of a toilet-trained toddler who was admitted to the hospital for severe gastroenteritis and subsequent dehydration and is now at home asks the nurse why the child still wets the bed. Which of the following should be the nurse's **best** response?

- 1. "Hospitalization is a traumatic experience for children. Regression is common and it takes time for them to return to their former behavior."
- 2. "The stress of hospitalization is hard for many children, but usually they have no problems when they return home."
- 3. "After returning home from being hospitalized, children still feel they should be the center of attention."
- 4. "Children do not feel comfortable in their home surroundings once they return home from being hospitalized."

## The Client with Appendicitis

**78.** A child is admitted with a diagnosis of possible appendicitis. The child is in acute pain. Which of the following nursing interventions would be appropriate prior to surgery to decrease pain? Select all that apply.

- 1. Offer an ice pack.
- 2. Apply a heating pad.
- 3. Encourage the child to assume a position of comfort.
- 4. Limit the child's activity.
- 5. Request an order for a cathartic.

**79.** A 7-year-old child is experiencing pain after an appendectomy. Which data collection tool should the nurse use to assess the pain?

- 1. Visual analog scale.
- 2. Short Form McGill Questionnaire.
- 3. Numerical pain scale.
- 4. FACES Pain Rating Scale.

**80.** A 7-year-old has had an appendectomy on November 12. He has had pain for the last 24 hours. There is an order to administer Tylenol with Codeine every 3 to 4 hours as needed. The nurse is beginning the shift and the child is requesting pain medication. The nurse reviews the chart below for pain history. Based on the information in the chart, what should the nurse do next?

- 1. Administer the Tylenol with Codeine.
- 2. Distract the child by giving him breakfast.
- 3. Instruct the child to take deep breaths and blow his pain away.
- 4. Assess the child again in 1 hour.

### Nurses Progress Notes

Date	Time	Progress Notes
11/12/07	03:00 pm	Tylenol with Codeine given PO. FACES pain scale changed from 5 to 2 within 15 minutes
11/12/07	06:00 pm	Tylenol with Codeine given PO. FACES pain scale changed from 5 to 2
11/12/07	09:30 pm	Tylenol with Codeine given PO. FACES pain scale changed from 5 to 2
11/13/07	01:00 am	Tylenol with Codeine given PO. FACES pain scale changed from 4 to 1
11/13/07	07:00 am	Client rates pain on FACES pain scale as 4

**81.** When obtaining the initial health history from a 10-year-old child with abdominal pain and suspected appendicitis, which of the following questions would be **most** helpful in eliciting data to help support the diagnosis?

- 1. "Where did the pain start?"
- 2. "What did you do for the pain?"
- 3. "How often do you have a bowel movement?"
- 4. "Is the pain continuous, or does it let up?"

**82.** When developing the plan of care for a school-age child with a suspected diagnosis of appendicitis who is complaining of severe abdominal pain, which of the following measures should the nurse expect to include in the child's plan of care?

- 1. Application of a heating pad.
- 2. Insertion of a rectal tube.
- 3. Application of an ice bag.
- 4. Administration of an intravenous narcotic.

**83.** Which of the following assessment findings should alert the nurse to suspect appendicitis in a male adolescent complaining of severe abdominal pain?

- 1. Abdomen appears slightly rounded.
- 2. Bowel sounds are heard twice in 2 minutes.
- 3. All four abdominal quadrants reveal tympany.
- 4. The client demonstrates a cremasteric reflex.

**84.** An adolescent male client scheduled for an emergency appendectomy is to be transferred directly from the emergency room to the operating room. Which of the following statements by the client should the nurse interpret as **most** significant?

- 1. "All of a sudden it doesn't hurt at all."
- 2. "The pain is centered around my navel."
- 3. "I feel like I'm going to throw up."
- 4. "It hurts when you press on my stomach."

**85.** Which of the following should be the priority assessment for an adolescent on return to the nursing unit after an appendectomy?

- 1. The dressing on the surgical site.
- 2. Intravenous fluid infusion site.
- 3. Nasogastric (NG) tube function.
- 4. Amount of pain.

**86.** An adolescent who has had an appendectomy and developed peritonitis has nausea. Which of the following should the nurse do **first**?

- 1. Administer an antiemetic.
- 2. Irrigate the nasogastric (NG) tube.
- 3. Notify the surgeon.
- 4. Take the blood pressure.

**87.** When developing the postoperative plan of care for an adolescent who has undergone an appendectomy for a ruptured appendix, in which of the following positions should the nurse expect to place the client during the early postoperative period?

- 1. The semi-Fowler's position.
- 2. Supine.
- 3. Lithotomy position.
- 4. Prone.

**88.** Which of the following is a normal response from an adolescent who has just returned to her room after an appendectomy?

- 1. "I'll need plastic surgery for this scar."
- 2. "I'm worried about the size of my scar."
- 3. "I don't want to have any pain."
- 4. "What will my boyfriend say about the scar?"

**89.** Which of the following client actions should the nurse judge to be a healthy coping behavior for a male adolescent after an appendectomy?

- 1. Insisting on wearing a T-shirt and gym shorts rather than pajamas.
- 2. Avoiding interactions with other adolescents on the nursing unit.
- 3. Refusing to fill out the menu, and allowing the nurse to do so.
- 4. Not taking telephone calls from friends so he can rest.

**90.** The nurse prepares to teach an adolescent scheduled for an appendectomy about what to expect. The adolescent says, "I would rather look this up on the Internet." The nurse should:

- 1. Explain that completing a teaching checklist is required by the hospital.
- 2. Help the client find information on the Internet.
- 3. Provide the client with written information instead.
- 4. Explain that information found on the Internet cannot be trusted.

### Managing Care Quality and Safety

**91.** The health care team has noticed an increase in I.V. infiltrations on the pediatric floor. As part of a Plan, Do, Study, Act quality improvement plan the team should do the following in which order?

1. Analyze the data.

2. Decide to monitor I.V. gauges.

3. Perform chart audits.

4. Write a new I.V. insertion policy.

**92.** The health care team wishes to establish a policy regarding sleep positions for infants with gastroesophageal reflux (GER). The **first** step should be to search for:

- 1. Policies from other hospitals.
- 2. Data from retrospective studies.
- 3. Published national standards.
- 4. Expert opinions.

**93.** The nurse is assisting another member of the health care team who is placing a peripherally inserted catheter in a 10-year-old with peritonitis from a ruptured appendix. The family is present in the treatment room to support the child. The nurse observes the other team member has contaminated a sterile glove. The nurse should:

- 1. Discuss the incident with the team member after the event.
- 2. Report the incident to the nursing unit manager.
- 3. Tell the team member the glove is contaminated.
- 4. Ask the family to leave before confronting the team member.

**94.** The hospital is responding to a mass casualty disaster with adult and pediatric victims. After re-allocating staff, the charge nurse on the pediatric floor should:

- 1. Ask parents to leave to free up the parent sleep areas for incoming victims.
- 2. Review the census for clients that are candidates for early discharge.
- 3. Initiate paper charting back-up.
- 4. Change taking all vital signs to every 8 hours.

**95.** Eight hours ago, an infant with Hirschsprung's disease had surgery to create a colostomy. Which of the following findings should alert the nurse to notify the physician immediately?

- 1. A 3-cm increase in abdominal circumference.
- 2. Periods of occasional fussiness.
- 3. Absence of bowel sounds since surgery.
- 4. Evidence of the infant's returning appetite.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Cleft Lip and Palate

1.

1. Maintain a clear and adequate airway.

4. Apply elbow restraints.

2. Maintain sufficient fluid and caloric intake.

3. Provide emotional comfort to the child.

5. Teach the parents proper feeding methods.

The nurse should first ensure that the child has a patent airway, because swelling and secretions following surgery can block the airway. Next, the nurse should restrain the infant's arms to keep him from rubbing with his hands or fingers on the incision line, which could cause scarring and damage to the incision. The child will need adequate nourishment and fluids as soon as he recovers from anesthesia. The nurse must comfort the child, and try to prevent him from crying as much as possible, because crying puts a strain on the suture line and can cause scarring. The nurse should involve the parents in the child's care and feeding as soon as possible after she has assessed the child's ability to safely ingest his feedings.

🔑 CN: Physiological adaptation;  
CL: Synthesize

2. 3. Before corrective surgery for a cleft lip, the infant needs to consume formula. Methods for feeding may need to be adjusted to fit the infant's needs, because the infant with a cleft lip experiences a decreased ability to suck, which interferes with the infant's ability to compress the nipple. A special feeder may be used to feed the infant to ensure adequate caloric intake. Problems with infection and skin integrity in the mouth are uncommon because the areas of the defect are not open areas. Although crying may cause the infant to swallow more air because of the defect, crying poses no harm to the

infant. There is no need to keep the infant's fingers out of the mouth preoperatively. The fingers will not harm the defect or cause an infection.

🔑 CN: Reduction of risk potential;  
CL: Synthesize

3. 1. An infant with a cleft lip and palate typically swallows large amounts of air while being fed and therefore should be burped frequently. The soft palate defect allows air to be drawn into the pharynx with each swallow of formula. The stomach becomes distended with air, and regurgitation, possibly with aspiration, is likely if the infant is not burped frequently. Feeding frequently, even in small amounts, would not prevent swallowing of large amounts of air. A nipple placed in the back of the mouth is likely to cause the infant to gag and aspirate. Holding the infant in a lying position during feedings can also lead to regurgitation and aspiration of formula. The infant should be fed in an upright position.

🔑 CN: Physiological adaptation;  
CL: Synthesize

4. 4. Half-strength hydrogen peroxide is recommended for cleaning the suture line after cleft lip repair. The bubbling action of the hydrogen peroxide is effective for removing debris. Normal saline also may be used. Mouthwashes frequently contain alcohol, which can be irritating. Also, mouthwashes are not as effective in removing debris as half-strength peroxide solutions are. Povidone-iodine solution is not used because the iodine contained in the solution can be absorbed through the skin, leading to toxicity. A mild antiseptic solution has some antibacterial properties but is ineffective in removing suture-line debris.

🔑 CN: Physiological adaptation; CL: Apply

5. 1. To keep the infant from disturbing the suture line by placing fingers or other objects in the mouth, either intentionally or accidentally, the restraints should be in place at all times. They should be removed for a short period, however, so that the underlying skin can be checked for any redness or breakdown. While the restraints are removed, the parents should be instructed to manually restrain the hands and arms.


🔑 CN: Reduction of risk potential;  
CL: Evaluate

6. 3. The optimal time for cleft palate repair depends on many factors. However, it is best done before speech develops and the child learns faulty speech habits as a result of the defect, usually before 12 to 15 months of age. Tooth eruption usually begins at about 6 months of age. The child should weigh about 10 kg (22 lb) at 6 months, but the important consideration is to schedule surgery before speech patterns begin to develop. An infant

may learn to start drinking from a cup as early as 6 to 7 months of age, possibly up to the first birthday.

 CN: Physiological adaptation; CL: Apply

**7. 1.** A cup is the preferred drinking or eating utensil after repair of a cleft palate. At the age when repair is done, the child is ordinarily able to drink from a cup. Use of a cup avoids having to place a utensil in the mouth, which would increase the potential for injury to the suture lines.

 CN: Physiological adaptation;  
CL: Synthesize

**8. 3.** Immediately after a surgical repair of a cleft palate, the child is placed on the abdomen with the head turned to the side to lessen the chance of aspiration by allowing secretions to drain out. Positioning the child on the back places the child at risk for aspiration should any regurgitation or vomiting occur, even in low Fowler's position with the head to the side or in reverse Trendelenburg position with the head tilted forward.


 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Tracheoesophageal Fistula


**9. 3.** The drooling and excessive mucus production is highly suggestive of a tracheoesophageal fistula. The initial diagnosis is made when an orogastric catheter cannot be passed to the stomach. A lactation consult would be warranted only after determining feedings were safe to continue. While cyanosis can be a sign of sepsis and hypoglycemia, the cyanosis is most likely related to the excessive secretions and airway patency.

 CN: Management of care; CL: Synthesize


**10. 1.** The parents of children born with defects often have feelings of guilt and ask what they might have done to cause the condition or how they might have avoided it. It is important to allow parents to express their feelings and to accept these feelings as normal reactions. Explaining that the parents are not at fault would not be appropriate until they have dealt with their feelings of guilt. Encouraging long-term planning generally is of little benefit to parents who are emotionally distraught. Additionally, the parents may interpret this as ignoring their feelings and confirming that they played a role in causing their child's anomaly. Urging the parents to visit their infant as often as possible would generally be of little help and could appear to the parents as though they are being "talked out" of their feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**11. 2.** Although a TEF can include several different structural anomalies, the most common type involves a blind upper pouch and a fistula from the esophagus into the trachea. Other types include a blind pouch at the end of the esophagus with no connection to the trachea and a normal trachea and esophagus with an opening that connects them. A tightened muscle below the stomach and projectile vomiting of normal amounts of formula are characteristic of pyloric stenosis. Aganglionic megacolon is a lack of autonomic parasympathetic ganglion cells in a portion of the lower intestine. Gastroschisis occurs when the bowel herniates through a defect in the abdominal wall and no membrane covers the exposed bowel.

 CN: Physiological adaptation;  
CL: Evaluate

**12. 2.** With a TEF, overflow of secretions into the larynx leads to laryngospasm. This obstruction to inspiration stimulates the strong contraction of accessory muscles of the thorax to assist the diaphragm in breathing. This produces substernal retractions. The laryngospasm that occurs with a TEF resolves quickly when secretions are removed from the oropharynx area. A brassy cough is related to a relatively constant laryngeal narrowing, usually caused by edema. It is not an indication of the need to suction. A decreased activity level and an increased respiratory rate in an infant with a TEF are usually the result of hypoxia, a relatively long-term and constant phenomenon in infants with a TEF.

 CN: Physiological adaptation;  
CL: Analyze

**13. 1.** The best way to prevent air from entering the stomach when feeding an infant through a gastrostomy tube is to open the clamp after all the formula has been placed in the syringe barrel. Doing so prevents air from mixing with the formula and thus being introduced into the stomach. Pouring all the formula into the barrel after opening the clamp, maintaining a continuous flow of formula down the side of the barrel after unclamping the tube, and allowing a small amount of formula to enter the stomach before adding more formula to the barrel permit air to enter the stomach.

 CN: Reduction of risk potential;  
CL: Apply

**14. 4.** The nurse can help meet the psychological needs of an infant being fed through a gastrostomy tube by rocking the infant after a feeding. The infant soon learns to associate eating with a pleasurable experience and learns to trust the caregiver. Rocking the infant will not promote peristalsis or prevent regurgitation. Holding the baby will not relieve pressure on the surgical site. However, holding the child right after feeding promotes comfort and pleasure.


 CN: Psychosocial adaptation; CL: Apply

**15. 4.** When initiating oral feedings after surgical repair of a TEF, it is best to follow a plan of care in conjunction with observation of the infant's needs and behavior. When the infant's needs and behavior are overlooked, plans are likely to be unsatisfactory and are more likely to meet the nurse's needs rather than the infant's needs. After a surgical procedure, infants initially tolerate small amounts of fluids offered more frequently better than larger amounts offered less often. Smaller amounts cause less bloating as the infant becomes used to feeding again. Although infants accept feedings more readily from their mother or from someone who feeds the infant repeatedly, the priority is to meet the infant's nutritional needs based on the infant's behavior.


 CN: Basic care and comfort; CL: Create

### The Client with an Anorectal Anomaly


**16. 2.** The nurse should honor the parent's belief system and help arrange to have the infant baptized. This may be done through the hospital's chaplaincy department or by the family's clergy. The parents may indeed be worried that the infant may die during surgery. Having the infant baptized would help address the family's spiritual needs. At this time there is an immediate need for chaplaincy, not social service. While surgery may be postponed briefly, the infant cannot begin feeding until an outlet for stool as been established. Therefore, it is not advisable to postpone the surgery for a prolonged period of time.

 CN: Psychosocial adaptation;  
CL: analyze

**17. 1, 3, 4.** Anorectal malformations present with lack of stool or evidence of meconium in the urine through a fistula. Meconium is not found in the stool. Because stool does not pass, abdominal distension and vomiting occur.


 CN: Physiological adaptation;  
CL: Analyze

**18. 1.** Passage of meconium in the urine is a sign of rectourinary fistula, in which the rectum and bladder communicate. Blood in the urine would suggest an infection. Bile is not found in the urine. Acetone in the urine would indicate excessive fat catabolism.


 CN: Physiological adaptation;  
CL: Analyze

**19. 4.** Children who undergo surgical correction for low anorectal anomalies as infants usually are continent. Fecal continence can be expected after successful correction of anal membrane atresia.

Therefore, this child probably has a good chance of being potty trained and will not need to wear protective pads. Extra fluids and a high-fiber diet are not required to prevent constipation. Children with high anorectal anomalies may or may not achieve continence.

 CN: Physiological adaptation;  
CL: Evaluate


**20. 3.** After surgical repair for an imperforate anus, the infant should be positioned either supine with the legs suspended at a 90-degree angle or on either side with the hips elevated to prevent pressure on the perineum. A neonate who is placed on the abdomen pulls the legs up under the body, which puts tension on the perineum, as does positioning the neonate on the back with the legs extended straight out.

 CN: Physiological adaptation;  
CL: Synthesize

**21. 3.** The neonate responds to pain with total body movement and brief, loud crying that ceases with distraction. After age 6 months, an infant reacts to pain with intense physical resistance and tries to escape by rolling away. A toddler reacts to pain by withdrawing the affected part.


 CN: Health promotion and maintenance;  
CL: Apply

**22. 2.** Encouraging the parents to hold their neonate promotes parent–infant attachment. Parent–infant bonding is based on a relationship that begins when the parent first touches the infant. Both the parents and the infant have predictable steps that they go through in this process. Explaining that the parents can visit at any time promotes bonding only if they do visit with, talk to, and hold the newborn. Asking the parents to help monitor intake and output at this time may be too anxiety-producing, thus interfering with bonding. Helping the parents plan for the infant's discharge involves them in the newborn's care and is important. However, it is not the first step in the development of bonding.

 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Pyloric Stenosis

**23. 3.** The vomitus of an infant with hypertrophic pyloric stenosis contains gastric contents, mucus, and streaks of blood. The vomitus does not contain bile or stool because the pyloric constriction is proximal to the ampulla of Vater.

 CN: Physiological adaptation;  
CL: Analyze




**24. 1.** Infants with pyloric stenosis usually have some degree of dehydration because of vomiting of the stomach contents. Therefore, a priority nursing diagnosis would be *Deficient fluid volume* related to prolonged vomiting. A nursing priority would be to restore fluid and electrolyte balance. Pyloric stenosis involves the pyloric valve distal to the stomach, not the respiratory tract. In addition, swallowing is not impaired with pyloric stenosis. Even though vomiting occurs, a normal infant should be able to protect the airway. Therefore, *Ineffective airway clearance* would be inappropriate. *Imbalanced nutrition: Less than body requirements* could be applicable but would not be the priority diagnosis. *Bowel incontinence* and abdominal pain are not typically associated with pyloric stenosis.

 CN: Physiological adaptation;  
CL: Analyze


**25. 1.** Unless the infant is in hypovolemic shock, obtaining a baseline weight is an important first action because the weight is used to calculate the child's fluid and electrolyte needs. The intravenous fluid rate and the amounts of electrolytes to be added to the fluid are based on the infant's weight. The weight also helps determine the infant's degree of dehydration. The intravenous infusion is initiated once the weight has been obtained. The child with pyloric stenosis typically experiences vomiting and is at risk for fluid volume deficit and metabolic acidosis. As a result, oral food and fluids are withheld and the infant is allowed nothing by mouth. Fluid replacement is given intravenously. Orientation can wait until treatment is under way.

 CN: Physiological adaptation;  
CL: Synthesize


**26. 1.** Pyloric stenosis involves hypertrophy of the pylorus muscle distal to the stomach and obstruction of the gastric outlet resulting in vomiting, metabolic acidosis, and dehydration. Telescoping of the bowel is called intussusception. Overfeeding, feeding too quickly, or underfeeding is not associated with pyloric stenosis.

 CN: Physiological adaptation;  
CL: Evaluate


**27. 3.** Normal serum potassium levels are 3.5 to 4.5 Meq/L. Elevated potassium levels can cause life threatening cardiac arrhythmias. The nurse must verify that the client has the ability to clear potassium through urination before administering the drug. Infants with pyloric stenosis frequently have low potassium levels due to vomiting. A level of 3.4 Meq/L is not unexpected and should be corrected with the ordered fluids. The lab value does not need to be redrawn as the findings are consistent with the infant's condition.

 CN: Pharmacological and parenteral therapies;  
CL: Synthesize


**28. 2.** For the client with a nursing diagnosis of *Deficient fluid volume* related to vomiting, the outcome would focus on restoration of fluid balance. Typically, the nurse would evaluate the client for evidence of dehydration. Parameters would include assessment of the client's weight for loss or decreased skin turgor. Abdominal distention is caused by the stenosis and is not relieved until the child has surgery. The child may have increased respiratory effort due to abdominal distention; however, to evaluate the outcome related to fluid deficit, the nurse should weigh the infant. The nurse should record the amount of emesis, but evaluation of the outcome is accomplished by weighing the infant.

 CN: Physiological adaptation;  
CL: Evaluate

**29. 4.** Restating or rephrasing a mother's response provides the opportunity for clarification and validation. It also helps to focus on what the mother is saying and address her concerns and feelings. Although surgery is the most effective treatment for pyloric stenosis, stating this ignores the mother's feelings and does not give her an opportunity to express them. Telling the mother not to worry also ignores the mother's feelings. Additionally, this type of statement gives the mother premature reassurance, which may turn out to be false. Asking the mother if she thinks the problem indicates that she is not a good mother implies such an idea. It does not allow her to express her concerns and feelings and therefore is not a therapeutic response.

 CN: Psychosocial adaptation;  
CL: Synthesize


**30. 1.** Clear liquids containing glucose and electrolytes are usually prescribed 4 to 6 hours after surgery. If vomiting does not occur, formula or breast milk then can be gradually substituted for clear liquids until the infant is taking normal feedings.

 CN: Physiological adaptation;  
CL: Evaluate

**31. 4.** Giving the infant a pacifier would help meet non-nutritive sucking needs and ensure oral gratification. Additionally, sucking aids in calming the infant. Holding the infant to decrease fussiness and restlessness is more effective in an older infant. Also, the reason for the infant's fussiness needs to be explored. Hanging a mobile over the crib frequently does not decrease fussiness. After surgery to correct pyloric stenosis, feeding the infant more formula would lead to vomiting, putting additional stress on the operative site.

 CN: Reduction of risk potential;  
CL: Synthesize

**32. 2.** The parents' ability to verbalize the infant's care realistically indicates that they are working through their fears and concerns. This behavior demonstrates an understanding of the infant's condition and needs. Without further data, the fact that the parents have to get away could be interpreted as ineffective coping, possibly suggesting that they are unable to handle the situation. Continuing to ask about the child's general condition even after answers have been given does not suggest effective coping. The parents are demonstrating that they are unsure of themselves as parents or are hoping for positive information. Exhibiting fear that they will disturb the infant does not suggest effective coping. This behavior indicates that they are uncertain or lack knowledge about infants.


 CN: Psychosocial adaptation;  
CL: Analyze

**33. 4.** Following pyloromyotomy the infant should be positioned with the head elevated and slightly on the right side to promote gastric emptying; the parents have positioned their infant correctly. The infant should be positioned on the right side, not the left side. When the child is in a crib, the head can be elevated and the infant can be propped on the right side. The infant can use a pacifier if needed.


 CN: Physiological adaptation;  
CL: Evaluate

### The Client with Intussusception

**34. 2.** The infant with intussusception experiences acute episodes of colic-like abdominal pain. Typically, the infant screams and draws the knees to the chest. Between these episodes of acute abdominal pain, the infant appears comfortable and normal. Feeding does not precipitate episodes of pain. Additionally, a 4-month-old infant typically would not be ingesting solid foods. Pain exhibited by crying that occurs when the infant is placed in a reclining position, as in the mother's arms, is not associated with intussusception. This type of cry may indicate that the infant wants attention, wants to be held, or needs to have a diaper change.

 CN: Physiological adaptation;  
CL: Analyze


**35. 1.** For the infant with intussusception, stools characteristically have the appearance of currant jelly because of the intestinal inflammation and hemorrhage resulting from intestinal obstruction. These stools occur later in the course of the disease process. Questions that focus on urination, vomiting, and food intake do not elicit information about the effects of intussusception.

 CN: Physiological adaptation;  
CL: Analyze

**36. 1.** The first action is to check the placement of the tube to ensure that it is in the correct position. To check tube position, the nurse should aspirate the tube with a syringe. A return of gastric contents indicates that the end of the tube is in the stomach. Another method is to inject a small amount of air while auscultating with a stethoscope over the epigastric area. The tube is irrigated with normal saline, not distilled water, and only after the position of the tube is confirmed. The suction level should not be increased, because doing so could damage the mucosa. Rotating the tube could irritate or traumatize the nasal mucosa.

 CN: Reduction of risk potential;  
CL: Synthesize

**37. 2.** Development of a paralytic ileus postoperatively is a functional obstruction of the bowel. Bowel sounds initially may be hyperactive, but then they diminish and cease. Measurement of urine specific gravity provides information about fluid and electrolyte status. The first stool and the amount of gastric output provide information about the return of gastric function.

 CN: Physiological adaptation;  
CL: Analyze

**38. 1.** Infants who have had an interruption in their normal routine and experiences, such as hospitalization and surgery, typically manifest behavior changes when discharged. The infant's normal routine has been significantly altered, so it will take time to reestablish another routine. Calorie requirements at home will continue to be the same as those in the hospital. The infant does not need more calories at home. The surgical procedure corrected the problems, so the infant should not continue to have abdominal cramping.

 CN: Physiological adaptation; CL: Create

### The Client with Inguinal Hernia


**39. 1.** Abdominal distention and a redness of the inguinal swelling are significant findings. Their presence in conjunction with area tenderness and inability to reduce the hernia indicate an incarcerated hernia. An incarcerated hernia can lead to strangulation, necrosis, and gangrene of the bowel. Other findings associated with strangulation include irritability, anorexia, and difficulty in defecation. Irritability is nonspecific and could be caused by various factors. A palpable, thickened spermatic cord on the affected side is diagnostic of inguinal hernia and would be an expected finding. A wet diaper indicates that urine is being excreted, a finding unrelated to inguinal hernia.

 CN: Physiological adaptation;  
CL: Analyze


**40. 3.** If nonoperative reduction is successful, delaying surgery for 2 to 3 days allows the edema and inflammation in the inguinal area to subside. Thus, the area to be operated will appear more normal, helping to decrease the risk of complications. The preoperative preparation for a herniorrhaphy is minimal and is not the reason for delaying the surgery. Typically, the infant is fed until a few hours before surgery to prevent dehydration. Trusses do not prevent incarceration, and there is no reason to use a truss preoperatively.

 CN: Physiological adaptation; CL: Apply


**41. 2.** The best way to prepare a 7-month-old infant psychologically for surgery is to have the primary caretaker stay with the child. Infants in the second 6 months of life commonly develop separation anxiety. Therefore, the priority in this case is to support the child by having the parent present. Teaching the mother what to expect may decrease her anxiety; this is important because infants sense anxiety and distress in parents, but the priority in this case is to have the parent present. Actual play and acting out life experiences are appropriate for preschool-age children. Allowing an infant to play with surgical equipment would be inappropriate and dangerous.

 CN: Psychosocial adaptation;  
CL: Synthesize

**42. 1.** Changing a diaper as soon as it becomes soiled helps prevent wound infection, the most common complication after inguinal hernia repair in an infant secondary to possible wound contamination with urine and stool. Because the surgical wound is unlikely to separate, an abdominal binder is unnecessary. The incision may or may not be covered with a dressing. If a dressing is not used, the physician may apply a topical spray to protect the wound. Restraining the infant's hands is unnecessary if the diaper is applied snugly. The infant would be unable to get the hands into the diaper close to the surgical site.

 CN: Safety and infection control;  
CL: Create

**43. 3.** The incision must be kept as clean and dry as possible. Therefore, daily sponge baths are given for about 1 week postoperatively. Cleaning the infant's face and diaper area should occur at least daily and continuously, not limited to a 2-week period. Because this type of surgery results in a wound that heals through primary intention, the skin will heal and cover the wound in 2 to 3 days. Therefore, it is not necessary to use sterile gauze to cleanse the incision; clean technique is acceptable. Because the incision must be kept as clean and dry, full tub baths are inappropriate.


 CN: Reduction of risk potential;  
CL: Synthesize

**44. 3.** Because of possible stress on the suture line, physical activities such as bicycle riding, physical education classes, weight-lifting, and wrestling are contraindicated for about 3 weeks.


 CN: Basic care and comfort; CL: Evaluate

## The Client with Hirschsprung's Disease

**45. 2.** Infants with Hirschsprung's disease typically display failure to thrive, with poor weight gain due to malabsorption of nutrients. Therefore, the nurse would expect to see a child who weighs less than that which is expected for height and age. A distended, rather than a scaphoid-shaped, abdomen would be noted. Cyanosis of fingers and toes is associated with congenital heart disease. Hyperactive deep tendon reflexes are associated with upper motor neuron problems, such as cerebral palsy.

 CN: Physiological adaptation;  
CL: Analyze

**46. 3.** By encouraging parents to ask questions during information-sharing sessions, the nurse can clarify misconceptions and determine the parents' understanding of information. A better understanding of what is happening allows the parents to feel some control over the situation. Assessing the adequacy of the parents' coping skills is important but secondary to encouraging them to express their concerns. The questions they ask and their interactions with the nurse may provide clues to the adequacy of their coping skills. The nurse should never give false reassurance to parents. At this point, there is no way for the nurse to know whether the child will be fine. Written materials are appropriate for augmenting the nurse's verbal communication. However, these are secondary to encouraging questions.


 CN: Psychosocial adaptation;  
CL: Synthesize

**47. 3.** The primary defect in Hirschsprung's disease is an absence of autonomic parasympathetic ganglion cells in the distal portion of the colon. Thus, the nerves at the end of the large colon are missing. Absence of a rectal opening refers to an imperforate anus. A tube between the trachea and esophagus refers to a tracheoesophageal fistula. Presence of a tight muscle below the stomach refers to pyloric stenosis.

 CN: Physiological adaptation;  
CL: Evaluate

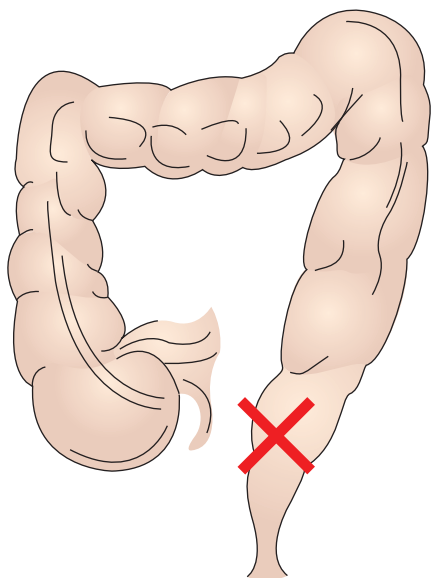
**48. 3.** Before intestinal surgery, dietary intake is limited to clear liquids for 24 to 48 hours. A clear liquid diet meets the child's fluid needs and avoids the formation of fecal material in the intestine.

Typically, repeated saline enemas, not tap water enemas, are given to empty the bowel. Soapsuds enemas are contraindicated for infants, as are tap water enemas. A nasogastric tube may be inserted for gastric decompression. Insertion of a gastrostomy tube is outside the scope of nursing practice. Because the perineal area is not involved in the surgery, it does not need to be prepared.


 CN: Physiological adaptation; CL: Create

**49.** In most instances, the absence of ganglionic innervation occurs in the lower portion of the sigmoid colon just above the anus.

 CN: Physiological adaptation; CL: Apply



**50. 2.** The goal of the surgery is to remove the aganglionic portion of the intestine. The remaining intestines should have normal innervation. Colostomies are used to relieve the obstruction and allow the remaining intestines to return to normal size. A temporary loop or double-barreled colostomy has stomas for both the proximal and distal portion of the bowel. The final surgical repair is usually done when the infant is around 20 lb. A new stoma is frequently swollen and bruised after surgery.

 CN: Physiological adaptation;  
CL: Evaluate

**51. 2.** Typically, the stoma should remain deep red in color as long as the infant has the colostomy. A dark-red to purplish color may indicate impaired circulation to the stoma.


 CN: Physiological adaptation; CL: Create

**52. 4.** A regular diet would be recommended for the child with a colostomy; no special diet is needed. High-fiber foods, such as fruits and vegetables, should be minimized because they increase the

bulk in the stool. Fat is necessary for brain growth in the first year of life. A high-residue diet would result in bulkier stools and increased gas production, which will collect in the colostomy bag. Therefore, a high-residue diet is not indicated.

 CN: Basic care and comfort; CL: Apply

**53. 2.** Toilet-training is commonly more difficult for children who have undergone surgery for Hirschsprung's disease than it is for other children. This is because of the trauma to the area and the associated psychological implications. Abdominal distention is an early sign of infection and therefore the parents need to report it to the physician. Typically, dietary restrictions are not required. Usually the infant is placed on an age-appropriate diet. Vitamin supplementation is not necessary if the infant's dietary intake is adequate.

 CN: Physiological adaptation;  
CL: Evaluate

### The Client with Diarrhea, Gastroenteritis, or Dehydration

#### 54.

1. Obtain vital signs and weight.

3. Apply a urine collection bag.

2. Insert an I.V. and infuse fluids as ordered.


4. Draw blood for laboratory tests.

The nurse should first obtain vital signs and evaluate the child for signs of shock or cardiac arrhythmias. The weight can also be obtained at this time to estimate the amount of fluid lost. The nurse should next apply the urine collection bag. As soon as possible after these steps, the nurse should insert an I.V. to replace lost fluids, electrolytes, and sugar to reduce the incidence of metabolic acidosis created by the lack of calorie intake and the loss of electrolytes. Blood should be drawn to assess the severity of electrolyte imbalance and other possible causes for the diarrhea and vomiting.

 CN: Physiological adaptation;  
CL: Synthesize

**55. 1, 2, 4, 5.** Shigella is caused by the *Shigella* organism. Clinical manifestations of shigella include fever, nausea and vomiting, some cramping, headache, seizures, rectal prolapse, and loose, watery stools containing pus, mucus, and blood. The nurse should assess the child for these symptoms on an ongoing basis. Shigella is spread via direct contact


with the organism, which is found in the stool. A stool specimen will show increased numbers of WBCs, blood, and mucus. Vomiting and loose stools can result in severe dehydration and electrolyte imbalance. Thus, the nurse should record intake, output, and daily weights. There is no need for strict isolation; masks are not needed as shigella is not transmitted by airborne methods.

 CN: Physiological adaptation;  
CL: Synthesize


**56. 3.** The absence of tears is typically found when moderate dehydration is observed as the body attempts to conserve fluids. Other typical findings associated with moderate dehydration include a dry mouth, sunken eyes, poor skin turgor, and an increased pulse rate. Deep, rapid respirations are associated with severe dehydration. Decreased perspiration, not diaphoresis, would be seen with moderate dehydration. The specific gravity of urine increases with decreased output in the presence of dehydration.

 CN: Reduction of risk potential;  
CL: Analyze

**57. 4.** An infant with severe diarrhea will experience some degree of dehydration. In an 8-month-old child, the anterior fontanel has not closed. Therefore, a depressed anterior fontanel would be an important finding. Additionally, the infant would exhibit dry mucous membranes, lethargy, hyperactive bowel sounds, dark urine, and sunken eyeballs. Skin turgor would be decreased or delayed (e.g., slow to return when pinched).

 CN: Reduction of risk potential;  
CL: Analyze

**58. 2.** Because an infant experiencing severe diarrhea is at high risk for *Deficient fluid volume*, the nurse needs to evaluate the infant's fluid balance status by weighing the infant at least every day. Body weight is the best indicator of hydration status because a higher proportion of an infant's body weight is water, compared with an adult. Initially, the infant with severe diarrhea is not allowed liquids but is given fluids intravenously. Therefore, monitoring the oral intake of formula is inappropriate. Although checking the anterior fontanel for depression or bulging provides information about hydration status, this method is not considered the best indicator of the infant's fluid balance. Monitoring skin turgor can provide information about fluid volume status. The abdomen is commonly used to assess skin turgor in an infant because it is a large surface area and can be accessed quickly. However, weight is the best indicator of fluid balance.

 CN: Physiological adaptation;  
CL: Synthesize

### 59. 8.2 mL/hour

$$2.2 \text{ lb/kg} = 9 \text{ lb}/X \text{ kg}$$

$$X = 9 \div 2.2$$

$$X = 4.09 \text{ kg, rounded to 4.1 kg}$$


$$4.1 \text{ kg} \times 2 \text{ mL/kg} = 8.2 \text{ mL/hour}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**60. 3.** The intravenous infusion is secured appropriately; the sandbag is used to limit movement of the leg. It is not necessary to also secure the uninjured extremity. The intravenous site should be visible; the nurse should not cover it with tape. The nurse should use an infusion pump with monitoring alarms, and check the infusion rate every hour.

 CN: Safety and infection control;  
CL: Evaluate

**61. 1.** Typically, an infant hospitalized with severe diarrhea receives fluid replacement intravenously rather than orally. Oral fluids and food are usually withheld. Although activities such as placing a mobile over the crib, speaking to the infant, or turning on the television may provide distraction for or help in calming the infant, a fussy infant receiving nothing by mouth is usually best comforted by providing a pacifier to satisfy sucking needs.

 CN: Health promotion and maintenance;  
CL: Synthesize

**62. 2.** Given this infant's history of gastroenteritis, the priority nursing diagnosis would be *Deficient fluid volume*. With gastroenteritis, vomiting and diarrhea occur, leading to the loss of fluids. This loss of fluids is problematic in infants because a higher proportion of their body weight is water. *Pain* is not a priority nursing diagnosis, although the nurse should continue to assess the infant for pain. There are no data to indicate impaired parenting. *Impaired urinary elimination* is related to the infant's fluid volume deficit resulting from vomiting and diarrhea associated with gastroenteritis. If the infant's fluid volume deficit is not corrected, then this nursing diagnosis may become the priority.

 CN: Physiological adaptation; CL: Analyze


**63. 1.** The outcome of moist mucous membranes indicates adequate hydration and fluid balance, showing that the problem of fluid volume deficit has been corrected. Although a normal bowel movement, ability to tolerate intravenous fluids, and an increasing time interval between bowel movements are all positive signs, they do not specifically address the problem of deficient fluid volume.

 CN: Physiological adaptation; CL: Analyze


**64. 1.** Children hospitalized with gastroenteritis are usually not allowed fluids by mouth to allow the gastrointestinal tract time to rest. Antibiotics are not indicated unless there is a bacterial infection. A mist tent would be used to treat respiratory disorders, not gastroenteritis. Once the infant is allowed oral intake, clear fluids are used initially.

 CN: Health promotion and maintenance;  
CL: Create

**65. 1.** The usual way to treat an infant hospitalized with gastroenteritis is to keep the infant nothing-by-mouth status to rest the gastrointestinal tract. The resulting fluid volume deficit is treated with intravenous fluids. When the infant's condition is controlled (e.g., when vomiting subsides), clear liquids are then started slowly. Formula and juice will be started once the infant's vomiting has subsided and the infant has demonstrated the ability to tolerate clear liquids for a period of time. In this situation, there is no need to test the infant's blood every day for anemia. Most likely, the infant's serum electrolyte levels would be monitored closely. Typically, an infant is placed in a private room because gastroenteritis is most commonly caused by a virus that is easily transmitted to others.


 CN: Physiological adaptation;  
CL: Evaluate

**66. 2.** The nurse's best course of action would be to support the mother. This is best done by conveying understanding and encouraging the mother to visit or call. Telling the mother that she shouldn't leave and that the child is very sick is critical and insensitive. Additionally, it implies guilt should the mother leave. Commenting that the child does not need anyone is not appropriate or true. Toddlers, in particular, need family members present because of the stresses associated with hospitalization. They experience separation anxiety, a normal aspect of development, and need constancy in their environment. Asking the mother to find someone else to stay with her children is inappropriate. The children at home also need the support of the mother and/or other family members to minimize the disruptions in family life resulting from the toddler's hospitalization and to maintain consistency.

 CN: Psychosocial adaptation;  
CL: Synthesize

**67. 1.** For the child with severe gastroenteritis, diarrhea is a problem; it exposes all persons caring for the child to possibly infectious body fluids. Subsequently, any other clients being cared for by these individuals are also at risk. Therefore, the nurse should institute standard precautions, including good handwashing and use of appropriate personal protective equipment (gowns, gloves, eye protection) to minimize the risk for exposure. Typically,


the child with severe gastroenteritis is placed in a private room until the causative organism is determined, to prevent transmission and protect others, including clients, families, and staff, from acquiring the infection. Because gastroenteritis is usually viral in origin and highly contagious, disposable eating utensils should be used to prevent transmission. For the child with gastroenteritis, double-bagging all linens is appropriate to prevent possible transmission from contaminated linens.

 CN: Safety and infection control;  
CL: Synthesize

**68. 1, 2, 3, 5.** Accurate intake and output recording includes noting all intake, including I.V. fluids; noting output, such as emesis and stool; weighing diapers; measuring weight daily; measuring urine specific gravity; monitoring serum electrolytes; and monitoring for signs of dehydration. Children who are dehydrated must receive sufficient fluid intake. Restricting fluids just prior to weighing the child will not alter the accuracy of the weight, and the nurse should continue to encourage fluids for this dehydrated child.

 CN: Management of care; CL: Analyze


**69. 1.** Potassium chloride is readily excreted in the urine. Before adding potassium chloride to the intravenous fluid, the nurse should ascertain whether the child can void; if not, potassium chloride may build up in the serum and cause hyperkalemia. An electrocardiogram could be done during intravenous potassium replacement therapy to evaluate for these changes. Having a stool daily is important but, because potassium is primarily excreted in the urine, the child's ability to void must be verified. Serum calcium levels do not indicate the child's ability to tolerate potassium replacement.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**70. 3.** An early sign of circulatory overload is moist rales or crackles heard when auscultating over the chest wall. Elevated blood pressure, engorged neck veins, a wide variation between fluid intake and output (with a higher intake than output), shortness of breath, increased respiratory rate, dyspnea, and cyanosis occur later.

 CN: Reduction of risk potential;  
CL: Analyze

**71. 1.** After having *Salmonella enteritidis*, some clients become chronic carriers of the causative organism and remain infectious for a long time as the organism continues to be shed from the body. During this time, the child is still considered infectious. No antitoxin is available to treat or prevent *Salmonella* infections.

 CN: Physiological adaptation;  
CL: Evaluate


**72. 2.** After clear liquids, the foods of choice are soft foods. These foods should be easily digested and low in fat. Additionally, the foods should be non-bulk-forming. Bananas and rice cereal are low in fat and easy to digest. Muffins and eggs, as well as sausage and pancakes, are typically high in fat and would be avoided. Although a bagel is low in fat, bran cereal is high in fiber and would be avoided because it may cause more diarrhea.

 CN: Basic care and comfort; CL: Synthesize

**73. 1.** Dietary management following rehydration for diarrhea and mild dehydration would include offering the child a regular diet. Following rehydration, there is no need for the child to be on a special diet, such as a clear liquid, full liquid, or soft diet.

 CN: Basic care and comfort; CL: Evaluate

**74. 3.** Diarrhea related to *Salmonella* bacilli is commonly spread by raw or undercooked fowl and eggs, pet turtles, and kittens. Food poisoning caused by *Staphylococcus* species is commonly spread by inadequately cooked or refrigerated custards, cream fillings, or mayonnaise. Psittacosis, a respiratory illness, may be spread by canaries. Contaminated, unwashed fruit is associated with typhoid fever (caused by *Salmonella typhi*), a disorder rarely seen in the United States.

 CN: Physiological adaptation;  
CL: Analyze

**75. 3.** The “no” behavior demonstrated by a toddler is typical of this age group as the child attempts to be self-assertive as an individual. The negativism does not demonstrate an inherited personality trait or disinterest. Rather, it reflects the developmental task of establishing autonomy. The toddler is attempting to exert control over the environment. It is too early to assess leadership qualities in a toddler.


 CN: Health promotion and maintenance;  
CL: Analyze

**76. 1.** The child is demonstrating behavior associated with temper tantrums, which are relatively frequent normal occurrences during toddlerhood as the child attempts to develop a sense of autonomy. The development of autonomy requires opportunities for the child to make decisions and express individuality. Ignoring the outbursts is probably the best strategy. Doing so avoids rewarding the behavior and helps the child to learn limits, promoting the development of self-control. However, the mother should intervene in a temper tantrum if the child is likely to injure herself. Allowing the child to have what she wants occasionally would typically add to the problems associated with temper tantrums,

because doing so rewards the behavior and prevents the child from developing self-control. Toddlers do not possess the capacity to understand explanations about behavior. Expressing disappointment in the child’s behavior or telling her that she is being a bad girl reinforces feelings of guilt and shame, thus interfering the child’s ability to develop a sense of autonomy.


 CN: Health promotion and maintenance;  
CL: Evaluate

**77. 1.** Hospitalization is a traumatic time for a child, and it takes some time to readjust to the home environment. The child may regress at home for a period until she feels comfortable. Children normally do not dislike their home environment; in fact, they usually are eager to get home to familiar surroundings where they feel safe.


 CN: Health promotion and maintenance;  
CL: Synthesize

### The Client with Appendicitis

**78. 1, 3, 4.** Cold is a vasoconstrictor and supplies some degree of anesthesia. The child is usually more comfortable on his side with his legs flexed to take the strain off the inflamed appendix. Limiting the child’s activity puts less stress on the inflamed appendix and lessens the discomfort. Heat increases circulation to an area, causing more engorgement and pain and, possibly, rupture of the appendix. Heat is contraindicated in any situation where rupture or perforation is a possibility. A cathartic is contraindicated when appendicitis is suspected. Increasing peristalsis can cause the appendix to rupture.

 CN: Physiological adaptation;  
CL: Synthesize

**79. 4.** The nurse should use the FACES Pain Rating Scale for children or cognitively impaired clients so that the client can use a picture to identify the pain. The visual analog and numerical scales are used with adults. The Short Form McGill Questionnaire allows the client to give simple descriptions of pain by sensation and perception, which is inappropriate for a child.


 CN: Basic care and comfort;  
CL: Analyze

**80. 1.** The nurse should administer the Tylenol with Codeine as the client indicates he is having pain. Although the child reports less severe pain, he is still experiencing pain. The nurse will also want the child to have less pain because he will need to be more active during the day. Assessing the child later will likely cause the pain to have increased

and be more difficult to manage. While distraction is appropriate for short-term pain, such as from a needlestick or pain that the child might be able to manage himself, postoperative pain should be relieved with medication.

 CN: Basic care and comfort;  
CL: Synthesize


**81. 1.** The most helpful question would be to determine the location of the pain when it started. The pain associated with appendicitis usually begins in the periumbilical area, then progresses to the right lower quadrant. After the nurse has determined the location of the pain, asking about what was done for the pain would be appropriate. Asking about the child's usual bowel movement pattern is a general question unrelated to child's condition. Children with appendicitis may have diarrhea or constipation. Additionally, knowledge about the child's usual pattern would not be a priority because the child with appendicitis typically is not hospitalized long enough to reestablish the normal pattern. Although the characteristics of the pain are important, asking if the pain is continuous or intermittent is vague and general because the pain could be associated with numerous conditions. With appendicitis, the client's pain may begin as intermittent, but it eventually becomes continuous.

 CN: Physiological adaptation;  
CL: Analyze


**82. 3.** Application of an ice bag may help to relieve pain by decreasing circulation to the area. A heating pad is contraindicated because heat may increase circulation to the appendix, possibly leading to rupture. Rectal tubes are contraindicated because they stimulate bowel motility and can exacerbate abdominal pain. Also, they would be ineffective because accumulation of gas in the lower bowel is not likely to be the cause of the child's discomfort. Because narcotics can mask the child's symptoms, such as pain and discomfort, and they also decrease bowel motility, they are not given until after a definitive diagnosis has been made.

 CN: Physiological adaptation; CL: Create


**83. 2.** Manifestations of appendicitis include decreased or absent bowel sounds. Normally, bowel sounds are heard every 10 to 30 seconds. Therefore, bowel sounds heard twice in 2 minutes suggests appendicitis. Normally, the contour of the male adolescent abdomen is flat to slightly rounded, and tympany is typically heard when auscultating over most of the abdomen. A cremasteric reflex is normal for male adolescents.

 CN: Physiological adaptation;  
CL: Analyze


**84. 1.** Sudden relief of pain in a client with appendicitis may indicate that the appendix has ruptured. Rupture relieves the pressure within the appendix but spreads the infection to the peritoneal cavity. Periumbilical pain (pain centered around the navel), vomiting, and abdominal tenderness on palpation are common findings associated with appendicitis.

 CN: Physiological adaptation;  
CL: Analyze


**85. 1.** The priority assessment after an appendectomy would be the dressing over the surgical site to determine whether there is any drainage or bleeding. The surgical dressing should be clean, dry, and intact. Once the dressing has been assessed, the nurse would assess the intravenous infusion site, assess the NG tube to be sure it is functioning, and finally, determine the degree of pain the client is experiencing.

 CN: Physiological adaptation;  
CL: Analyze

**86. 2.** After an appendectomy, the client who develops peritonitis typically has an NG tube in place. When a client complains of nausea, the nurse would first check to ensure that the NG tube is functioning correctly, because the client's nausea may be related to a blockage of the NG tube. If the tube is clogged, it can be irrigated with normal saline. An antiemetic may be given, but only after the nurse has determined that the NG tube is functioning properly. Postoperative orders usually include an antiemetic. Typically, the nurse would notify the surgeon if the client did not obtain relief from irrigation of the NG tube or administration of an ordered antiemetic. Although taking the client's blood pressure is an important postoperative nursing activity, it is unrelated to relieving the client's nausea.

 CN: Physiological adaptation;  
CL: Synthesize

**87. 1.** After an appendectomy for a ruptured appendix, assuming the semi-Fowler's or a right side-lying position helps localize the infection. These positions promote drainage from the peritoneal cavity and decrease the incidence of subdiaphragmatic abscess.

 CN: Physiological adaptation;  
CL: Synthesize


**88. 2.** Adolescents are concerned about the immediate state and functioning of their bodies. The adolescent needs to know whether any changes (e.g., illness, trauma, surgery) will alter her lifestyle or interfere with her quest for physical perfection.




Having a scar may be devastating to the adolescent. The need for plastic surgery cannot be determined at this point. The adolescent has just returned from surgery and has yet to see the scar. Healing has yet to occur. Typically scars become smaller and fade over time. The desire for no pain is unrealistic. Although adolescents are worried about pain and how they will respond, they typically are discharged within 24 hours after an appendectomy with pain well controlled by oral analgesics. The immediate concern of adolescents is the state and functioning of their bodies. After concerns about themselves, then adolescents are concerned about their peer group and their responses. Although the boyfriend's response will matter, this concern would be more common later in the course of the adolescent's recovery.

 CN: Health promotion and maintenance;  
CL: Analyze

**89. 1.** Adolescents struggle for independence and identity, needing to feel in control of situations and to conform with peers. Control and conformity are often manifested in appearance, including clothing, and this carries over into the hospital experience. The adolescent feels best when he is able to look and act as he normally does—for example, wearing a T-shirt and gym shorts. Adolescents normally want to interact with peers and commonly seek every opportunity to do so. Avoiding other adolescents on the nursing unit or not taking phone calls from friends might suggest ineffective coping behavior. Refusing to fill out the menu and allowing the nurse to do so demonstrates dependent behavior, not a healthy coping mechanism.

 CN: Psychosocial adaptation;  
CL: Analyze

**90. 2.** Part of providing client-centered care is to honor the client's preferred method of learning. The nurse should help the adolescent find accurate information about the procedure. By assisting with the information search the nurse can verify learning. Teaching straight from a checklist does not encourage customization. If the client has requested to use the Internet, it is unlikely that written information will be read. While it is true that some information on the Internet is not accurate, the nurse can take this opportunity to help the client learn how to determine if a source is reliable.

 CN: Psychosocial adaptation;  
CL: Synthesize

## Managing Care Quality and Safety

**91.**

**2.** Decide to monitor I.V. gauges.

**3.** Perform chart audits.

**1.** Analyze the data.

**4.** Write a new I.V. insertion policy.

Deciding what to study and how to do it is part of the planning process. Collecting data through chart audits is part of the “do” phase. Once the chart audits are complete the data may be “studied” or analyzed. The final step of the process, or the “act” phase, is to determine what should be done, which may include writing a new policy.

 CN: Reduction of risk potential;  
CL: Synthesize

**92. 3.** Published national standards are based on the best evidence and when available should serve as the foundation for nursing unit policies. Policies from other hospitals may or may not be evidence based. Retrospective studies and expert opinions should only be used to form policy when data from experimental studies or national standards are not available.

 CN: Reduction of risk potential;  
CL: Synthesize

**93. 3.** It is the responsibility of all health care members to protect the client. The provider may honestly not have realized that the glove was contaminated. Therefore, the nurse needs to alert the provider to the situation. Waiting until after the procedure to address the problem puts the child at unnecessary risk for infection. Asking the parents to leave could invoke anxiety in both the child and the parents. Alerting the provider does not need to be confrontational. If done with a calm approach, the result is most likely to be gratitude instead of embarrassment.

 CN: Reduction of risk potential;  
CL: Synthesize

**94. 2.** The charge nurse can anticipate needing beds for incoming victims. Any client who can go home should go home. Parents are a child's primary care giver and should not be asked to leave. If computers were not affected by the disaster, charting in the electronic health record is safer. Some routine

procedures are altered during a disaster, but clients who are unstable will still need frequent assessments; reducing vital sign frequency must be considered on a case-to-case basis.

 CN: Management of care; CL: Synthesize

**95. 1.** Abdominal circumference is measured to monitor for abdominal distention. An increase of 3 cm in 8 hours would require notification of the physician; it would indicate a substantial degree of abdominal distention, possibly from fluid or gas accumulation. Normally, after surgery, an infant experiences occasional periods of fussiness.

However, as long as the infant is able to be quiet by himself or with the aid of a pacifier, the physician does not need to be contacted. Absence of bowel sounds would be expected after surgery because of the effects of anesthesia. It takes approximately 48 hours for gastric motility to resume. Even if the infant displays evidence that he is hungry, fluids will not be offered until bowel sounds are heard, indicating a functioning gastrointestinal tract.

 CN: Reduction of risk potential;  
CL: Synthesize

**TEST**  
**5**

# The Child with Health Problems Involving Ingestion, Nutrition, or Diet

- The Client with Toxic Substance Ingestion
- The Client with Lead Poisoning
- The Client with Celiac Disease
- The Client with Phenylketonuria
- The Client with Colic
- The Client with Obesity
- The Client with Food Sensitivity
- The Client with Failure to Thrive
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Toxic Substance Ingestion

**1.** A toddler is brought to the emergency room after ingesting an undetermined amount of drain cleaner. The nurse should expect to assist with which of the following **first**?

- 1. Administering an emetic.
- 2. Performing a tracheostomy.
- 3. Performing gastric lavage.
- 4. Inserting an indwelling urinary (Foley) catheter.

**2.** After the acute stage following an ingestion of drain cleaner by a child, the nurse should be alert for the development of which of the following as a likely complication?

- 1. Tracheal stenosis.
- 2. Tracheal varices.
- 3. Esophageal strictures.
- 4. Esophageal diverticula.

**3.** The parents of a 3-year-old suspect that the child has recently ingested a large amount of acetaminophen. The child does not appear in immediate distress. The nurse should anticipate doing which of these interventions in order of priority, from first to last?

1. Draw acetaminophen serum levels.

2. Attempt to determine the exact time and amount of drug ingested.

3. Administer acetylcysteine (Acetadote IV).

4. Administer activated charcoal.

Empty boxes for additional answers or rationales.

4. When developing the plan of care for a toddler who has taken an acetaminophen overdose, which of the following should the nurse expect to include as part of the initial treatment?

- 1. Frequent blood level determinations.
- 2. Gastric lavage.
- 3. Tracheostomy.
- 4. Electrocardiogram.

5. While assessing a preschooler brought by her parents to the emergency department after ingestion of kerosene, the nurse should be alert for which of the following?

- 1. Uremia.
- 2. Hepatitis.
- 3. Carditis.
- 4. Pneumonitis.

### The Client with Lead Poisoning

6. Which of the following statements by the mother of an 18-month-old child should indicate to the nurse that the child needs laboratory testing for lead levels?

- 1. "My child does not always wash after playing outside."
- 2. "My child drinks 2 cups of milk every day."
- 3. "My child has more temper tantrums than other kids."
- 4. "My child is smaller than other kids of the same age."

7. In an initial screening for lead poisoning a 2-year-old child is found to have a lead level of 12 mcg/dL. The nurse should:

- 1. Arrange a follow-up appointment in 6 months.
- 2. Obtain a consultation for chelation therapy.
- 3. Educate parents on ways to reduce lead in the environment.
- 4. Assure the parents this is a normal lead level.

8. When teaching the mother of a toddler diagnosed with lead poisoning, which of the following should the nurse include as the **most** serious complication if the condition goes untreated?

- 1. Cirrhosis of the liver.
- 2. Stunted growth rate.
- 3. Neurologic deficits.
- 4. Heart failure.

9. Which of the following is the nurse's **best** response to a mother who asks about the outcome for her child with lead poisoning?

- 1. "Many children suffer brain damage from lead poisoning."
- 2. "Many of its effects require the child to receive special schooling."
- 3. "Most children with lead poisoning experience problems with the law."
- 4. "Most effects of lead poisoning are reversible if diagnosed early."

### The Client with Celiac Disease

10. Which of the following statements by a mother about her child would suggest to the nurse that the child may have celiac disease and should be referred to a health care provider?

- 1. "His urine is so dark in color."
- 2. "His stools are large and smelly."
- 3. "His belly is so small."
- 4. "He is so short."

11. During assessment of a child with celiac disease, the nurse should **most** likely note which of the following physical findings?

- 1. Enlarged liver.
- 2. Protuberant abdomen.
- 3. Tender inguinal lymph nodes.
- 4. Periorbital edema.

12. After teaching the mother of a child with celiac disease about dietary management, which of the following statements by the mother indicates successful teaching?

- 1. "I will feed my child foods that contain wheat products."
- 2. "I will be sure to give my child lots of milk."
- 3. "I will plan to feed my child foods that contain rice."
- 4. "I will be sure my child gets oatmeal every day."

13. After teaching the parents of a child with celiac disease about diet, which of the following, if stated by the parents to be avoided, indicates effective teaching? Select all that apply.

- 1. Chocolate candy.
- 2. Hot dogs.
- 3. Bologna on rye sandwich.
- 4. Corn tortillas.
- 5. White rice.

14. Which of the following foods would be appropriate for a 12-month-old child with celiac disease?

- 1. Cheerios.
- 2. Pancakes.
- 3. Rice Chex.
- 4. Waffles.

15. The mother of a child with celiac disease asks, "How long must he stay on this diet?" Which response by the nurse is **best**?

- 1. "Until the jejunal biopsy is normal."
- 2. "Until his stools appear normal."
- 3. "For the next 6 months."
- 4. "For the rest of his life."

### The Client with Phenylketonuria

**16.** When preparing to obtain a neonatal screening test for phenylketonuria (PKU), the neonate must have received which of the following to ensure reliable results?

- 1. A feeding of an iron-rich formula.
- 2. Nothing by mouth for 4 hours before the test.
- 3. Initial formula or breast milk at least 24 hours before the test.
- 4. A feeding of glucose water.

**17.** When developing the plan of care for a child diagnosed with phenylketonuria (PKU), the nurse should establish which of the following goals?

- 1. Meeting the child's nutritional needs for optimal growth.
- 2. Ensuring that the special diet is started at age 3 weeks.
- 3. Maintaining serum phenylalanine level higher than 12 mg/100 mL.
- 4. Maintaining serum phenylalanine level lower than 2 mg/100 mL.

**18.** When taking a diet history from the mother of a 7-year-old child with phenylketonuria, a report of an intake of which of the following foods should cause the nurse to gather additional information?

- 1. Cola.
- 2. Carrots.
- 3. Orange juice.
- 4. Bananas.

**19.** Which foods would the nurse teach the parents of a child with phenylketonuria (PKU) to avoid? Select all that apply.

- 1. Hamburger.
- 2. Hot dog.
- 3. Ice cream.
- 4. Juice.
- 5. Cereal.

**20.** When teaching the mother of a child diagnosed with phenylketonuria (PKU) about its transmission, the nurse should use knowledge of which of the following as the basis for the discussion?

- 1. Chromosome translocation.
- 2. Chromosome deletion.
- 3. Autosomal recessive gene.
- 4. X-linked recessive gene.

**21.** A newborn diagnosed with phenylketonuria (PKU) is placed on a milk substitute, Lofenalac. The mother asks the nurse how long her infant will be taking this. Which of the following responses would be **most** appropriate?

- 1. "Until the infant is taking solid foods well."
- 2. "Until the child has stopped growing."
- 3. "Until the phenylalanine level remains below normal for 6 months."
- 4. "Probably for a long time, but it's not definitely known."

**22.** Even though several teaching sessions have been documented in the client's health record, the mother asks the nurse again what caused her child's phenylketonuria (PKU). Which of the following statements would **best** reflect the nurse's interpretation of why the mother keeps asking for information that she has already received?

- 1. Because the child's condition is chronic, parents commonly want very detailed explanations about the causes of and treatments for their child's disease.
- 2. Parents of a chronically ill child commonly require a long time to work through the grieving process for their child's disease.
- 3. Parents commonly test health workers' knowledge about the causes of and treatments for their child's disease.
- 4. Parents commonly deal with their guilt about possibly causing their child's disease by asking challenging questions.

### The Client with Colic

**23.** When performing the nursing history, which of the following would be **most** important for the nurse to obtain from the mother of an infant with suspected colic?

- 1. The type of formula the infant is taking.
- 2. The infant's crying pattern.
- 3. The infant's sleep position.
- 4. The position of the infant during burping.

**24.** The parents of a child with colic are asked to describe the infant's bowel movements. Which of the following descriptions should the nurse expect?

- 1. Soft, yellow stools.
- 2. Frequent watery stools.
- 3. Ribbon-like stools.
- 4. Foul-smelling stools.

**25.** The mother tells the nurse that the diagnosis of colic upsets her because she knows her infant will continue to have colicky pain. Which of the following responses by the nurse would be **most** appropriate?

- 1. "I know that your baby's crying upsets you, but she needs your undivided attention for the next few months."
- 2. "It can be difficult to listen to your baby cry so loud and so long, so try to make sure that you get some free time."
- 3. "It's must be distressing to see your baby in pain, but at least she doesn't have an intestinal obstruction."
- 4. "The next 3 months will be a difficult time for you, but your baby will outgrow the colic by this time."

**26.** The nurse judges that the mother has understood the teaching about care of an infant with colic when the nurse observes the mother doing which of the following?

- 1. Holding the infant prone while feeding.
- 2. Holding the infant in her lap to burp.
- 3. Placing the infant prone after the feeding.
- 4. Burping the infant during and after the feeding.

### The Client with Obesity

**27.** An 8-year-old has a body mass index (BMI) for age at the 90<sup>th</sup> percentile, but has no other risk factors. The nurse should:

- 1. Refer the family to a dietician.
- 2. Recommend the child be reweighed in one year.
- 3. Refer the child to a physician specializing in pediatric weight loss.
- 4. Recommend the child participate in a commercial diet program.

**28.** A mother brings her 7-month-old infant to the well-baby clinic for a checkup. She is concerned that the infant is overweight. She feeds the infant formula that has 20 calories per ounce whenever the infant is hungry. The nurse should instruct the mother to:

- 1. Give the infant 2% milk formula and add vitamins.
- 2. Use skim milk because it is high in protein and lower in calories.
- 3. Decrease the amount of formula feedings to 16 oz daily, and supplement with juice and water.
- 4. Continue with the formula, keep a 3-day record of the infant's intake, and bring the infant back to the clinic for further evaluation.

**29.** Which of the following methods should the nurse use to provide the **most** accurate assessment of an adolescent's status regarding obesity?

- 1. A food intake diary for 1 week.
- 2. Body mass index.
- 3. A 4-hour dietary history.
- 4. Skinfold thickness measurements.

**30.** When counseling an obese adolescent, the nurse should advise the client that which complication is the **most** common?

- 1. Lifelong obesity.
- 2. Gastrointestinal problems.
- 3. Orthopedic problems.
- 4. Psychosocial problems.

**31.** When developing a teaching plan for the mother of an infant about introducing solid foods into the diet, which of the following measures should the nurse expect to include in the plan to help prevent obesity?

- 1. Decreasing the amount of formula or breast milk intake as solid food intake increases.
- 2. Introducing the infant to the taste of vegetables by mixing them with formula or breast milk.
- 3. Mixing cereal and fruit in a bottle when offering solid food for the first few times.
- 4. Using a large-bowled spoon for feeding solid foods during the first several months.

**32.** A pregnant mother who has brought her toddler to the clinic for a check-up asks the nurse how she can keep her next baby from becoming obese. The mother plans to bottle-feed her next child. Which information should the nurse include in the teaching plan to help the mother avoid over-nourishing her infant?

- 1. Recognizing clues indicating that a baby is full.
- 2. Establishing a regular feeding schedule.
- 3. Supplementing feedings with sterile water.
- 4. Adding more water than directed when preparing formula.

### The Client with Food Sensitivity

**33.** During a school party a child with a known food allergy complains of an itchy throat, wheezing, and not feeling "quite right." The nurse should do the following in what order from first to last?

1. Administer the child's epinephrine (Epipen).

2. Assess vital signs.

3. Position to facilitate breathing.

4. Send someone to activate the Emergency Management Systems (EMS)

5. Notify the parents.

**34.** After teaching the parents of a child with lactose intolerance about the disorder, the nurse determines that the teaching was effective when the mother describe the condition?

- 1. "The lack of an enzyme to break down lactose."
- 2. "An allergy to lactose found in milk."
- 3. "Inability to digest proteins completely."
- 4. "Inability to digest fats completely."

**35.** After teaching the mother of a 2-year-old child with lactose intolerance about which dairy products to include in the child's diet, which of the following if stated by the mother indicates effective teaching?

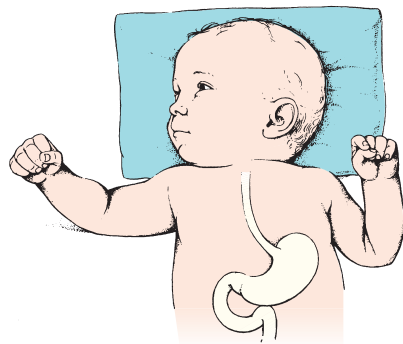
- 1. Ice cream.
- 2. Creamed soups.
- 3. Pudding.
- 4. Cheese.

**36.** The breast-feeding mother of a 1-month-old diagnosed with cow's milk sensitivity asks the nurse what she should do about feeding her infant. Which of the following recommendations would be **most** appropriate?

- 1. Continue to breast-feed but eliminate all milk products from your own diet.
- 2. Discontinue breast-feeding and start using a predigested formula.
- 3. Limit breast-feeding to once per day and begin feeding an iron-fortified formula.
- 4. Change to a soy-based formula exclusively and begin solid foods.

### The Client with Failure to Thrive

**37.** The nurse is inserting a nasogastric tube in an infant to administer feedings. In the figure below, indicate the location for the correct placement of the distal end of the tube.



**38.** The nurse formulates the nursing diagnosis *Imbalanced Nutrition: Less than body requirements* related to negative feeding patterns for a 5-month old infant diagnosed with failure to thrive. To meet the short-term outcomes of the infant's plan of care, the nurse should expect to do which of the following?

- 1. Instruct the parents in proper feeding techniques.
- 2. Give infant formula that has 24 calories/ounce.
- 3. Provide consistent staff to care for the infant.
- 4. Allow the infant to sit in a high chair during feedings.

**39.** The health care team determines that the family of an infant with failure to thrive who is to be discharged will need follow-up care. Which of the following would be the **most** effective method of follow-up?

- 1. Daily phone calls from the hospital nurse.
- 2. Enrollment in community parenting classes.
- 3. Twice-weekly clinic appointments.
- 4. Weekly visits by a community health nurse.

### Managing Care Quality and Safety

**40.** When providing intermittent nasogastric feedings to an infant with failure to thrive which method is preferred to confirm tube placement before each feeding?

- 1. Obtain a chest X-ray.
- 2. Verify that the gastric PH is **less** than 5.5.
- 3. Auscultate the stomach while instilling an air bolus.
- 4. Compare the tube insertion length to a standardized chart.

**41.** When teaching a mother about measures to prevent lead poisoning in her children, which of the following preventive measures should the nurse include as the **most** effective?

- 1. Condemning of old housing developments.
- 2. Educating the public on common sources of lead.
- 3. Educating the public on the importance of good nutrition.
- 4. Keeping pregnant women out of old homes that are being remodeled.

**42.** A child with a nut allergy is admitted with a severe reaction for the third time in three months. The parent says, "I am having trouble with the food labels." The nurse should first:

- 1. Assess the parent's ability to read.
- 2. Refer the client to the dietician.
- 3. Notify the primary care provider.
- 4. Obtain a social service consult.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Toxic Substance Ingestion

**1. 2.** Drain cleaner almost always contains lye, which can burn the mouth, pharynx, and esophagus on ingestion. The nurse would be prepared to assist with a tracheostomy, which may be necessary because of swelling around the area of the larynx. An emetic is contraindicated because, as the substance burns on ingestion, so too would it burn when vomiting. Additionally, the mucosa becomes necrotic and vomiting could lead to perforations. Gastric lavage is contraindicated because the mucosa is burned from the ingestion of the caustic lye, causing necrosis. Gastric lavage also could lead to perforation of the necrotic mucosa. Insertion of an indwelling urinary (Foley) catheter would be indicated after the measures to remove the caustic substance have been started.

🔑 CN: Reduction of risk potential;  
CL: Apply

**2. 3.** As the burn from the lye ingestion heals, scar tissue develops and can lead to esophageal strictures, a common complication of lye ingestion. Tracheal stenosis would occur if the child had vomited and aspirated. Tracheal varices do not commonly occur after the ingestion of lye or other substances. Although very rare, esophageal diverticula may occur. Diverticula are commonly found in the colon of adults.

🔑 CN: Physiological adaptation;  
CL: Analyze

**3.**

2. Attempt to determine the exact time and amount of drug ingested.

4. Administer activated charcoal.

1. Draw acetaminophen serum levels.

3. Administer acetylcysteine (Acetadote IV).

The nurse should first attempt to determine exactly when and how much acetaminophen the parents think the child has taken. Determining the time of ingestion helps establish the immediate care and when lab values should be drawn. Gastric decontamination with activated charcoal is used within 4 hours of ingestion to bind the drug and help prevent toxic serum levels. Serum blood levels should be done after the gastric decontamination, but preferably not too soon after ingestion since levels drawn before 4 hours may not reflect maximum serum concentrations and will need to be repeated. The decision to administer acetylcysteine and prevent liver damage is based on serum levels.

🔑 CN: Pharmacological and parenteral therapies; CL: Synthesize

**4. 2.** Initial management of a child who has ingested a large amount of acetaminophen would include inducing vomiting or performing gastric lavage with or without activated charcoal to aid in the removal of the substance. Frequent blood level determinations may be obtained during the follow-up phase, but they are not done as part of the initial treatment. Tracheostomy is not typically part of the initial treatment for acetaminophen overdose. However, it may be necessary later if respiratory distress develops. Acetaminophen primarily affects the liver, not the heart. Therefore, an electrocardiogram would not be considered part of the initial treatment plan.

🔑 CN: Reduction of risk potential;  
CL: Apply

**5. 4.** Chemical pneumonitis is the most common complication of ingestion of hydrocarbons, such as in kerosene. The pneumonitis is caused by irritation from the hydrocarbons aspirated into the lungs. Uremia is the result of renal insufficiency, which causes nitrogenous waste products to build up in the blood rather than being excreted. Hepatitis is caused by a viral infection. Carditis in a preschooler may be the result of rheumatic fever.


🔑 CN: Physiological adaptation;  
CL: Analyze

### The Client with Lead Poisoning

**6. 1.** Eating with dirty hands, especially after playing outside, can lead to lead poisoning because lead is often present in soil surrounding homes. Also, children who eat lead-containing paint chips commonly develop lead poisoning. Drinking 2 cups of milk per day is less than that which is




recommended for this age group, so more nutritional information would need to be obtained. Temper tantrums are characteristic of 18-month-old children as they try to assert themselves. Determining whether the child is smaller than other children the same age requires measuring height and weight and plotting them on growth charts. In addition, inadequate growth could be a result of numerous causes, such as genetics, chronic illness, or chronic drug use (e.g., prednisone).

 CN: Physiological adaptation;  
CL: Evaluate


**7. 3.** Healthy People 2010 has set a goal of eliminating blood lead levels of greater than 10 mcg/dL in children age 1 to 5 years of age. The CDC recommends that the treatment for children with lead levels between 10 and 14 mcg/dL should include family lead education, follow-up testing, and a social service consultation if needed. Waiting 6 months for a follow-up screening is too long because the effects of lead are irreversible. Oral chelation therapy is not begun until levels approach 45 mcg/dL. There is no such thing as a “normal” lead level because there is no beneficial action in the body.

 CN: Safety and infection control;  
CL: Synthesize

**8. 3.** The most serious and irreversible consequence of lead poisoning is mental retardation due to neurologic changes. It can be expected if lead poisoning is long-standing and goes untreated. Lead poisoning also affects the hematologic and renal systems. Cirrhosis is the end stage of several chronic liver diseases, such as biliary atresia and hepatitis. Lead poisoning is not associated with stunted growth. Chronic illnesses, such as cystic fibrosis, cause slowing of the growth velocity. Heart failure is associated with congenital heart disease and rheumatic fever.


 CN: Physiological adaptation;  
CL: Apply

**9. 4.** Most of the pathologic effects of lead poisoning are reversible as long as the problem is diagnosed early. The most serious effects are those on the central nervous system (e.g., brain damage, mental retardation, behavior changes), not problems with the law. However, because of screening programs, many children with lead poisoning are diagnosed and treated early. As a result, little if any brain damage occurs that would require children to receive special schooling.


 CN: Physiological adaptation;  
CL: Synthesize

## The Client with Celiac Disease


**10. 2.** Celiac disease is a disorder involving intolerance to the protein gluten, which is found in wheat, rye, oats, and barley. The stools of a child with celiac disease are characteristically malodorous, pale, large (bulky), and soft (loose). Excessive flatus is common, and bouts of diarrhea may occur. Dark urine is commonly associated with concentrated urine, such as when a child has dehydration. The belly of a child with celiac disease, a malabsorption disorder, typically is protuberant. A small belly may be associated with a child who is thin. Short stature is not associated with this malabsorption disorder.

 CN: Physiological adaptation;  
CL: Analyze

**11. 2.** The intestines of a child with celiac disease fill with accumulated undigested food and flatus, causing the characteristic protuberant abdomen. Celiac disease is not usually associated with any liver dysfunction, including poor liver functioning leading to liver enlargement. Tender inguinal lymph nodes are often associated with an infection. Periorbital edema, swelling around the eyes, is associated with nephritis.

 CN: Physiological adaptation;  
CL: Analyze


**12. 3.** Damage to intestinal mucosa in celiac disease is caused by gliadin, a part of the protein found in wheat, rye, barley, and oats. Foods containing these grains must be eliminated entirely from the diet of children with celiac disease. Foods containing rice and corn are a good substitute. Although an adequate intake of milk is important for any child, children with celiac disease do not need an increased milk intake.

 CN: Physiological adaptation;  
CL: Evaluate


**13. 1, 2, 3.** Children with celiac disease should avoid foods containing the protein gluten, which is found in wheat, oats, rye, and barley grains. Children are allowed to eat foods containing rice or corn. Labels need to be read carefully since these glutes are used as fillers in many food items including many types of chocolate candy and hot dogs.

 CN: Reduction of risk potential;  
CL: Evaluate

**14. 3.** The child with celiac disease should not eat foods containing wheat, oats, rye, or barley. Foods containing rice, such as Rice Chex cereal, or corn are appropriate. Because Cheerios are made from oats, this cereal should be avoided. Pancakes and waffles are made from flour that typically is derived from wheat and therefore should be avoided.

 CN: Physiological adaptation;  
CL: Synthesize

**15. 4.** Most children with celiac disease have a lifelong sensitivity to gluten, which requires that they maintain some type of diet restriction for the rest of their lives.


 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Phenylketonuria

**16. 3.** PKU is an autosomal recessive disorder involving the absence of an enzyme needed to metabolize the essential amino acid, phenylalanine, to tyrosine. To ensure reliable results, the neonate must have ingested sufficient protein, such as breast milk or formula, for at least 24 hours. Testing the infant before that time, excessive vomiting, or poor intake can yield false-negative results. The infant does not need to fast 4 hours before the test. A loading dose of glucose water does not affect test values.

 CN: Reduction of risk potential;  
CL: Evaluate

**17. 1.** The goal of care is to prevent mental retardation by adjusting the diet to meet the infant's nutritional needs for optimal growth. The diet needs to be started as soon as the infant is diagnosed, ideally within a few days of birth. Serum phenylalanine level should be maintained between 3 and 7 mg/100 mL. Significant brain damage usually occurs if the serum phenylalanine level exceeds 10 to 15 mg/100 mL. If the level drops below 2 mg/100 mL, the body begins to catabolize its protein stores, causing growth retardation.

 CN: Physiological adaptation; CL: Create

**18. 1.** Foods with low phenylalanine levels include vegetables, fruits, and juices. Foods high in phenylalanine include meats and dairy products, which must be restricted or eliminated. Colas contain more phenylalanine than the fruits listed.

 CN: Physiological adaptation;  
CL: Analyze

**19. 1, 2, 3.** Children with PKU lack an enzyme to metabolize phenylalanine and convert it to tyrosine. Treatment is dietary management to control the amount of phenylalanine ingested. Foods with low phenylalanine levels include fruits, most vegetables, and cereals. High-protein foods have high levels of phenylalanine and include meats and dairy products.

 CN: Reduction of risk potential;  
CL: Create


**20. 3.** PKU is caused by an inborn error of metabolism. It is an autosomal recessive disorder that inhibits the conversion of phenylalanine to tyrosine. A form of Down syndrome, trisomy 21, is an example of a disorder caused by chromosomal translocation. Cri du chat is an example of a disorder caused by chromosomal deletion. Hemophilia A is an example of a disorder caused by an X-linked recessive gene.

 CN: Physiological adaptation; CL: Apply

**21. 4.** Although it is not known how long diet therapy must continue for children with PKU, many experts suggest continuing it indefinitely because of academic difficulties and lower intelligence quotients in older children who have stopped the restrictive diet. For women it is necessary to resume the diet before conception to lower the phenylalanine levels in the fetus and prevent complications.

 CN: Physiological adaptation;  
CL: Synthesize

**22. 2.** PKU is considered a chronic illness. Parents typically grieve about the loss of health in their child afflicted with a chronic disease. Many times, they repeat questions, as though trying to deny what is really happening. This type of behavior represents an attempt to integrate the experience and their feelings with their self-image as they pass through the grieving process. Asking for detailed explanations, testing the competence of health workers, and expressing impatience with health workers may explain the parents' behavior, but viewing the behavior as a part of the grieving process is the most plausible explanation.


 CN: Psychosocial adaptation;  
CL: Analyze

### The Client with Colic


**23. 2.** Information on the crying pattern of the infant is most helpful in confirming the diagnosis of colic. Typically the colic attack begins abruptly, with the infant crying loudly and continuously, possibly for hours. The attack may end when the child becomes exhausted. The child also may attain some relief after passing stool or flatus. Often, in an attempt to alleviate the infant's crying, parents try to feed the infant, resulting in overfeeding leading to discomfort and distention. Asking about the type of formula, sleep position, or position for burping will not provide sufficient information to confirm the diagnosis of colic. However, the nurse can obtain additional information after determining the nature of the crying pattern.

 CN: Physiological adaptation;  
CL: Analyze


**24. 1.** Infants with colic usually pass normal stools, typically soft and yellowish. Frequent watery stools might indicate diarrhea. Ribbon-like stools are suggestive of a narrowing of the colon or rectum. Foul-smelling stools by themselves are related to diet. When other symptoms such as large size and protuberant abdomen are present, malabsorption may be possible.

 CN: Physiological adaptation;  
CL: Analyze

**25. 2.** The nurse needs to provide the parents with support because of the infant's crying. The parents are stressed and need to be encouraged to get out of the house and arrange for some free time. Although infants need lots of attention and care for the first few months, they do not need the mother's undivided attention. Comparing colic with other problems is inappropriate. Parents have the right to be upset. Although colic usually disappears spontaneously by age 3 months, the nurse should not make any guarantees.

 CN: Psychosocial adaptation;  
CL: Synthesize

**26. 4.** Infants with colic should be burped frequently during and after the feeding. Much of the discomfort of colic appears to be associated with the presence of air in the stomach and intestines. Frequent burping helps to relieve the air. Infants with colic should be held fairly upright while being fed, to help air rise. The preferred position for burping the infant with colic is to hold the infant at the mother's shoulder so that the infant's abdomen lies on the shoulder. This position causes more pressure to be exerted on the infant's abdomen, leading to a more forceful burp. The child should be placed in an infant seat after feedings.

 CN: Physiological adaptation;  
CL: Evaluate

### The Client with Obesity

**27. 1.** Children ages 2 to 20 years of age with a BMI-for-age at the 90<sup>th</sup> percentile are considered at risk for being overweight. If no other risk factors are present, the family should receive dietary counseling to slow the child's weight gain until an appropriate height for weight is attained. Without intervention, the child may become overweight. A physician who specializes in pediatric weight loss should be considered when the child is overweight and has complicating factors. Commercial diet programs alone do not include the necessary monitoring for children, thus are rarely appropriate.

 CN: Management of care ; CL: Synthesize

**28. 4.** A 3-day diet history is the best way to accurately assess the child's intake. Children under age 1 year should not drink cow's milk because of the risk of allergy. Children over age 1 year should drink whole milk because skim milk and 2% milk do not contain all the essential fatty acids needed by young children. It is unknown at this time how much formula the child is actually taking, but an infant should not have more than 6 oz of juice per day and additional water is usually not necessary. If an infant is taking no more than 32 oz of formula per day and is eating some baby food and cereal, additional fluids and frequent feeding should not be necessary.

 CN: Health promotion and maintenance;  
CL: Synthesize

**29. 2.** The most accurate way to determine whether an adolescent has a problem with obesity is to calculate the body mass index (BMI). The BMI indicates a relationship between height and weight. Numbers obtained through calculation are then applied to a BMI table for interpretation. A food diary will provide information on what the adolescent is eating but does not provide information about obesity. A 4-hour diet history will not provide sufficient information about the client's typical eating patterns over time. Measuring skinfold thickness with skinfold calipers is a common method used to assess obesity. The skinfold thickness test, which determines the amount of subcutaneous fat, determines obesity more accurately than does a height and weight chart. However, it is not the most accurate method and is not routinely performed by nurses.

 CN: Health promotion and maintenance;  
CL: Analyze

**30. 1.** The most common complication of adolescent obesity is its persistence into adulthood. The incidence of gastrointestinal and orthopedic problems, such as Legg-Calvé-Perthes disease and genu valgum (knock knees), is greater for obese adolescents; however, they are not the most common complication. Although psychosocial problems do occur, they are not the most common complication.


 CN: Reduction of risk potential;  
CL: Apply

**31. 1.** Decreasing the amount of formula given as the infant begins to take solids helps prevent excess caloric intake. Because the infant is receiving calories from the solid foods, the formula no longer needs to provide the infant's total caloric requirements. Mixing vegetables with formula or breast milk does not allow the child to become accustomed to new textures or tastes. Solid foods should be given with a spoon, not in a bottle. Using a bottle

with food allows the infant to ingest more food than is needed. Also, the infant needs to learn to eat from a spoon. A small-bowled spoon is recommended for infants because infants have a tendency to push food out with the tongue. The small-bowled spoon helps in placing the food at the back of the infant's tongue when feeding.

 CN: Basic care and comfort; CL: Create

**32. 1.** Infants generally do not overeat unless they are urged to do so. Parents should watch for clues indicating that the infant is full—for example, stopping sucking and pushing the nipple out of the mouth. Bottle-feeding instead of breast-feeding is more likely to lead to excessive caloric intake. A demand schedule, rather than a regulated schedule, allows the infant to regulate intake according to individual needs. Normally, giving an infant a regular supplementation of water is unnecessary; the infant's sucking needs can be met by providing a pacifier. Adding more water to the formula than as directed decreases the caloric intake and also places the infant at risk for hyponatremia due to decreased sodium and increased water intake.

 CN: Basic care and comfort;  
CL: Synthesize

### The Client with Food Sensitivity

#### 33.

4. Send someone to activate the Emergency Management Systems (EMS)

1. Administer the child's epinephrine (Epipen).

3. Position to facilitate breathing.


2. Assess vital signs.

5. Notify the parents.


The child is exhibiting signs of anaphylaxis. The principles of emergency management involve activating EMS when an emergency is first realized. The nurse then follows the priorities of Airway, Breathing, Circulation (A, B, C). The epinephrine should then be given to reduce airway constriction. The child should be assisted into the most comfortable position to facilitate breathing, usually with the head elevated. Then nurse can take the child's vital signs to assess circulation. Lastly, the nurse should notify the family.

 CN: Physiological adaptation;  
CL: Synthesize


**34. 1.** Lactose intolerance is not an allergy. Rather, it is caused by the lack of the digestive enzyme lactase. This enzyme, found in the intestines, is necessary for the digestion of lactose, the primary carbohydrate in cow's milk. Protein and fat digestion are not affected.

 CN: Physiological adaptation;  
CL: Evaluate

**35. 4.** People who are lactose-intolerant usually are able to tolerate dairy products in which lactose has been fermented, such as yogurt, cheese, and buttermilk. Pudding, ice cream, and creamed soups contain lactose that has not been fermented.

 CN: Physiological adaptation;  
CL: Evaluate

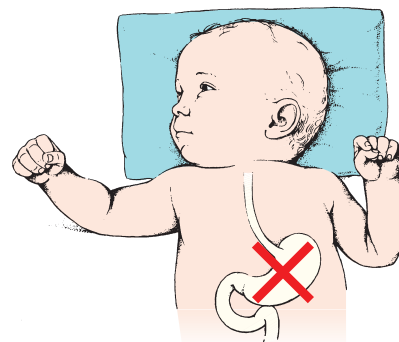
**36. 1.** Mothers of infants with a cow's milk allergy can continue to breast-feed if they eliminate cow's milk from their diet. It is important to encourage mothers to continue to breast-feed because breast milk is usually the least allergenic and most easily digested food for an infant. In addition, the infant is able to obtain protein through the mother's milk. If the mother stops breast-feeding, then a predigested protein hydrolysate formula would be the first choice. An iron-fortified formula is a cow's milk-based formula. A soy-based formula is not used because approximately 20% of infants with cow's milk sensitivity are also sensitive to soy. Solid foods are not introduced until the infant is 4 to 6 months of age.

 CN: Basic care and comfort;  
CL: Synthesize


### The Client with Failure to Thrive

**37.** The nasogastric tube should reside in the stomach. The site placement can be verified by inserting 3 to 5 mL of air in the tube and auscultating the infant's abdomen for the sound of air. The nurse should then aspirate the injected air and a small amount of stomach contents and then test the contents for acidity.


 CN: Safety and infection control;  
CL: Apply



**38. 3.** In the short-term care of this infant, it is important that the same person feed the infant at each meal and that this person be able to assess for negative feeding patterns and replace them with positive patterns. Once the infant is gaining weight and shows progress in the feeding patterns, the parents can be instructed in proper feeding techniques. This is a long-term outcome of nursing care. Because there is no organic reason for the failure to thrive, it should not be necessary to increase the formula calorie content from 20 to 24 calories/ounce. A 5-month-old infant is too young to be expected to sit in a high chair for feedings and should still be bottle-fed.

 CN: Physiological adaptation;  
CL: Synthesize

**39. 4.** The most effective follow-up care would occur in the home environment. The community health nurse can be supportive of the parents and will be able to observe parent-infant interactions in a natural environment. The community health nurse can evaluate the infant's progress in gaining weight, offer suggestions to the parents, and help the family solve problems as they arise.

 CN: Physiological adaptation;  
CL: Synthesize


### Managing Care Quality and Safety

**40. 2.** For children receiving intermittent gavage feedings the best method to verify the tube placement before each feeding is to aspirate a small amount of gastric contents to verify that the PH is acidic. A PH of 5.5 or less should indicate correct placement in most babies. Depending on the type of feeding tube used, an x-ray may be used to confirm the original tube placement, but use before every

feeding would expose the child to unnecessary radiation. Air boluses are misleading because placement in the esophagus or respiratory tract may make the same sound in small infants. Charts might be helpful in determining initial tube insertion length, but do not substitute for nursing assessments.

 CN: Reduction of risk potential;  
CL: Apply

**41. 2.** Public education about the sources of lead that could cause poisoning has been found to be the most effective measure to prevent lead poisoning. This includes recent efforts to alert the public to lead in certain types of window blinds. Condemning old housing developments has been ineffective because lead paint still exists in many other dwellings. Providing education about good nutrition, although important, is not an effective preventive measure. Pregnant women and children should not remain in an older home that is being remodeled because they may breathe in lead in the dust, but this is not the most effective preventive measure.

 CN: Safety and infection control;  
CL: Synthesize

**42. 1.** Three severe reactions in 3 months indicate a serious problem with adhering to the prevention plan. The nurse should first determine if the parent can actually read the label. The underlying problem may be that the parent is visually impaired or unable to read. The parent's reading level determines what additional support is needed. Referrals to social service or dietary may be indicated, but the nurse does not yet have enough information about the problem. The nurse would communicate with the primary care provider after assessing the situation to recommend referrals.

 CN: Management of care; CL: Synthesize

**TEST**  
**6**

## The Child with Health Problems of the Urinary System

- The Client with Cryptorchidism
- The Client with Hydrocele
- The Client with Hypospadias
- The Client with Urinary Tract Infection
- The Client with Glomerulonephritis
- The Client with Nephrotic Syndrome
- The Client with Acute or Chronic Renal Failure
- The Client with Wilms' Tumor
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Cryptorchidism

**1.** A father brings his 4-week-old son to the clinic for a checkup, stating that he believes his son's testicle is missing. Which of the following explanations would be **most** appropriate?

- 1. "Although the testes should have descended by now, it is not a cause for worry."
- 2. "The testes often do not descend until age 6 months, but let's check to see whether the testes are present."
- 3. "The testes are present in the scrotal sac at birth, but surgery can remedy the situation."
- 4. "Although the testes normally descend by 1 year of age, I can understand your concern."

**2.** While preparing to examine a 6-week-old infant's scrotal sac and testes for possible undescended testes, which of the following would be **most** important for the nurse to do?

- 1. Check the diaper for recent urination.
- 2. Give the infant a pacifier.
- 3. Ensure that the room is kept warm.
- 4. Tap lightly on the left inguinal ring.

**3.** While the nurse is examining the infant for presence of testes, the father paces around the room shaking his head. Which of the following would be the **most** appropriate response by the nurse?

- 1. "I'm sure everything will work out for the best, and he'll be fine."
- 2. "You seem upset; please tell me how you're feeling."
- 3. "Don't worry; his testes will probably descend on their own."
- 4. "Would you like to talk with a parent of a child who has the same problem?"

**4.** When assessing an infant with an undescended testis, the nurse should be alert for which of the following?

- 1. Abnormal lower extremity reflexes.
- 2. A history of frequent emesis.
- 3. A bulging in the inguinal area.
- 4. Poor weight gain.

**5.** When explaining the plan of care to the parents of an infant with an undescended testis, the nurse should tell the parents about which of the following as a nonsurgical treatment method?

- 1. A trial of human chorionic gonadotrophic hormone.
- 2. A trial of adrenocorticotrophic hormone.
- 3. Frequent stimulation of the cremasteric reflex.
- 4. Use of several warm baths each day.

**6.** When developing the preoperative teaching plan for a 14-month-old child with an undescended testis who is scheduled to have surgery, which of the following methods is appropriate?

- 1. Telling the child that his penis and scrotum will be "fixed."
- 2. Explaining to the parents how the defect will be corrected.
- 3. Telling the child that he will not see any incisions after surgery.
- 4. Using an anatomically correct doll to show the child what will be "fixed."

7. An adolescent with a history of surgical repair for an undescended testis comes to the clinic for a sports physical. Anticipatory guidance for the parents and adolescent should focus on which of the following as **most** important?

- 1. The adolescent's sterility.
- 2. The adolescent's future plans.
- 3. Technique for monthly testicular self-examinations.
- 4. Need for a lot of psychological support.

### The Client with Hydrocele

8. When explaining to the parents of a child with a hydrocele about the possible cause of the condition, the nurse bases this explanation on the interpretation that a hydrocele is **most** likely the result of which condition?

- 1. Blockage in the inguinal canal that allows fluid to accumulate in epididymis and ductus deferens.
- 2. Failure of the upper part of the processus vaginalis to atrophy, allowing accumulation of fluid in the testicle and the peritoneal cavity.
- 3. A patent processus vaginalis that results in the collection of fluid along the spermatic cord or tunica vaginalis of the testicle.
- 4. An obliterated processus vaginalis that allows fluid to accumulate in the scrotal sac.

9. During a clinic visit, the mother of an infant with hydrocele states that the infant's scrotum is smaller now than when he was born. After teaching the mother about the infant's condition, which of the following statements by the mother indicates that the teaching has been effective?

- 1. "I guess keeping his bottom up has helped."
- 2. "Massaging his groin area is working."
- 3. "It seems like the fluid is being reabsorbed."
- 4. "Keeping him quiet and in an infant seat has helped."

10. Shortly after an infant is returned to his room following hydrocele repair, the infant's mother tells the nurse that the child's scrotum looks swollen and bruised. Which of the following responses by the nurse would be **most** appropriate?

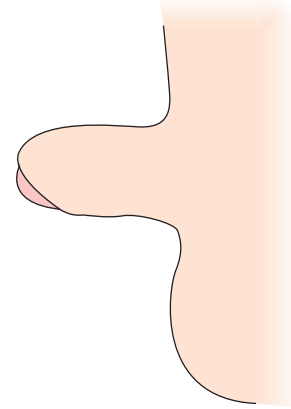
- 1. "Let me see if the doctor has ordered aspirin for him. If he did, I'll get it right away."
- 2. "Why don't you wait in his room? Then you can ask me any questions when I get there."
- 3. "What you are describing is unusual after this type of surgery. I'll let the doctor know."
- 4. "This is normal after this type of surgery. Let's look at it together just to be sure."

### The Client with Hypospadias

11. The parents of a neonate with hypospadias and chordee wish to have him circumcised. Which of the following explanations should the nurse incorporate into the discussion with the parents concerning the recommendation to delay circumcision?

- 1. The associated chordee is difficult to remove during circumcision.
- 2. The foreskin is used to repair the deformity surgically.
- 3. The meatus can become stenosed, leading to urinary obstruction.
- 4. The infant is too small to have a circumcision.

12. The nurse is caring for an infant with hypospadias. Identify the area where the nurse would assess for this condition.



13. A 1-year-old child is scheduled for surgery to correct hypospadias and chordee. The nurse explains to the parents that this is the preferred time for surgical repair based on which of the following?

- 1. At this age, the child will experience less pain.
- 2. The child is too young to have developed castration anxiety.
- 3. The child will not remember the surgical experience.
- 4. The repair is easier to perform after the child is toilet trained.

14. A 6-month-old child is discharged with a urinary stent after a procedure to repair a hypospadias. The nurse should tell the parents to:

- 1. Avoid tub baths until the stent is removed.
- 2. Measure output in the urinary bag.
- 3. Avoid drinking fruit juice.
- 4. Clean the tip of the penis 3 times a day with soap and water.

**15.** After teaching the parents about the urethral catheter placed after surgical repair of their son's hypospadias, the nurse determines that the teaching was successful when the mother states that the catheter in her child's penis accomplishes which of the following?

- 1. Decreases pain at the surgical site.
- 2. Keeps the new urethra from closing.
- 3. Measures his urine correctly.
- 4. Prevents bladder spasms.

**16.** While assessing the penis of a child who has had surgery for repair of a hypospadias, the nurse observes the appearance of the penis. The nurse should report which aspect to the surgeon?

- 1. Swollen.
- 2. Dusky blue at the tip.
- 3. Somewhat misshapen.
- 4. Pink.

**17.** When developing the teaching plan for the parents of a 12-month-old infant with hypospadias and chordee repair, which of the following should the nurse expect to include as **most** important?

- 1. Assisting the child to become familiar with his dressings so he will leave them alone.
- 2. Encouraging the child to ambulate as soon as possible by using a favorite push toy.
- 3. Forcing fluids to at least 2,500 mL/day by offering his favorite juices.
- 4. Preventing the child from disrupting the catheters by using soft restraints.

**18.** The physician orders a urinalysis for a child who has undergone surgical repair of a hypospadias. Which of the following results should the nurse report to the physician?

- 1. Urine specific gravity of 1.017.
- 2. Ten red blood cells per high-powered field.
- 3. Twenty-five white blood cells per high-powered field.
- 4. Urine pH of 6.0.

### The Client with Urinary Tract Infection

**19.** The health care provider has ordered a sterile urine specimen on a 3-year-old boy with a history of recurrent urinary tract infections. The family is upset because the last time the child was catheterized the procedure was very painful and traumatic. The nurse should tell the family:

- 1. "I will request an order for a sedative to help him relax."
- 2. "I can't do anything to reduce the pain, but you can hold him during the procedure."
- 3. "I will get an order for a lidocaine-based lubricant to make the procedure more comfortable."
- 4. "I can apply a topical anesthetic 20 minutes before placing the catheter."

**20.** The parents of a child on sulfamethoxazole and trimethoprim (Bactrim) for a urinary tract infection report that the child has a red, blistery rash.

The nurse should tell the parents to:

- 1. Apply lotion to the affected areas.
- 2. Discontinue the medicine and come for immediate further evaluation.
- 3. Use sunblock while on the medication.
- 4. Increase the child's fluid intake.

**21.** A recent history of which of the following should alert the nurse to gather additional information about the possibility of a urinary tract infection in a 2-year-old child who is exhibiting fever and fussiness?

- 1. Abdominal pain.
- 2. Swollen lymph glands.
- 3. Skin rash.
- 4. Back pain.

**22.** A father of a child with a urinary tract infection calls the clinic and explains, "My wife and I are concerned because our child refuses to obey us concerning the preventions you told us about. Our child refuses to take the medication unless we buy a present. We don't want to use discipline because of the illness, but we're worried about the behavior."

Which response by the nurse is **best**?

- 1. "I sympathize with your difficulties, but just ignore the behavior for now."
- 2. "I understand it's hard to discipline a child who is ill, but things need to be kept as normal as possible."
- 3. "I understand that things are difficult for you right now, but your child is ill and deserves special treatment."
- 4. "I understand your concern, but this type of behavior happens all the time; your child will get over it when feeling better."

**23.** A nurse is teaching the parents of a child diagnosed with a urinary tract infection secondary to vesicoureteral reflux. How should the nurse explain how the reflux contributes to the infection?

- 1. "It prevents complete emptying of the bladder."
- 2. "It causes urine backflow into the kidney."
- 3. "It results in painful bladder spasms."
- 4. "It causes painful urination."

### The Client with Glomerulonephritis

**24.** A 15-year-old has been diagnosed with acute glomerulonephritis and has been in the hospital for 1 day. Which of the following findings requires immediate action?

- 1. Large amount of generalized edema.
- 2. Urine specific gravity of 1.030.
- 3. Large amount of albumin in the urine.
- 4. 24-hour output of 1,500 mL.



**25.** Which of the following meals would be **most** appropriate for a 15-year-old with glomerulonephritis with severe hypertension?

- 1. Egg noodles, hamburger, canned peas, milk.
- 2. Baked ham, baked potato, pear, canned carrots, milk.
- 3. Baked chicken, rice, beans, orange juice.
- 4. Hot dog on a bun, corn chips, pickle, cookie, milk.

**26.** A 10-year-old with glomerulonephritis reports a headache and blurred vision. The nurse should immediately:

- 1. Put the client to bed.
- 2. Obtain the child's blood pressure.
- 3. Notify the physician.
- 4. Administer acetaminophen (Tylenol).

**27.** Which of the following questions should the nurse ask **first** when obtaining a history from the mother of a 10-year-old child with a fever, complaints of not feeling well, and swelling around the eyes?

- 1. "Has the child had a sore throat recently?"
- 2. "Is the child playing with friends as usual?"
- 3. "Does the child urinate as much as usual?"
- 4. "Is the urine pale in color?"

**28.** A school-age client admitted to the hospital because of decreased urine output and periorbital edema is diagnosed with acute poststreptococcal glomerulonephritis. Which of the following actions should receive the **highest** priority?

- 1. Assessing vital signs every 4 hours.
- 2. Monitoring intake and output every 12 hours.
- 3. Obtaining daily weight measurements.
- 4. Obtaining serum electrolyte levels daily.

**29.** When developing the plan of care for a school-age child with acute poststreptococcal glomerulonephritis who has a fluid restriction of 1,000 mL/day, which of the following fluids should the nurse consider as **most** appropriate for the client's condition and effective for preventing excessive thirst?

- 1. Diet cola.
- 2. Ice chips.
- 3. Lemonade.
- 4. Tap water.

**30.** During hospitalization, a 10-year-old child with acute poststreptococcal glomerulonephritis and oliguria asks for food from home. After teaching the mother and child about diet, the nurse determines that the teaching had been effective when the mother brings in which food?

- 1. Pizza and cola.
- 2. Hamburger and fries.
- 3. Ice cream sundae.
- 4. Strawberries and kiwi.

**31.** The nurse is planning interventions for the nursing diagnosis *Deficient diversional activity* for a school-age child. Which of the following activities should the nurse expect to include?

- 1. Playing a card game with someone the same age.
- 2. Putting together a puzzle with mother.
- 3. Playing video games with a 4-year-old.
- 4. Watching a movie with a younger brother.

**32.** A 10-year-old child hospitalized with acute poststreptococcal glomerulonephritis during the acute stage has elevated blood pressure and low urine output for 14 hours. The nurse should next:

- 1. Assess the child's neurologic status.
- 2. Encourage the child to drink more water.
- 3. Advise the child to eat a low-sodium breakfast.
- 4. Help the client to ambulate in the hallway.

**33.** When developing the discharge plan for a school-age child diagnosed with acute poststreptococcal glomerulonephritis, which instruction should the nurse plan to discuss?

- 1. Restricting dietary protein.
- 2. Monitoring pulse rate and rhythm.
- 3. Preventing respiratory infections.
- 4. Restricting foods high in potassium.

**34.** An adolescent with a history of losing weight and fatigue is admitted to the hospital with a diagnosis of stage I chronic renal failure. The chart shows:

Intake and Output	
Day 1: Intake 1850 mL	Output 1550 mL
Day 2: Intake 2200 mL	Output 1150 mL

Based on these findings, the nurse should:

- 1. Continue monitoring intake and output.
- 2. Notify the physician.
- 3. Restrict the client's fluids.
- 4. Increase the client's fluids.

## The Client with Nephrotic Syndrome

**35.** A child with nephrosis is taking prednisone. The nurse should teach the caregivers to report which of the following adverse effects? Select all that apply.

- 1. Increased urinary output.
- 2. Hematemesis.
- 3. Respiratory infection.
- 4. Bleeding gums.
- 5. Vision problems.

**36.** The nurse is caring for a 5-year-old boy who is taking prednisolone for nephrotic syndrome. The child is at the 75<sup>th</sup> percentile for height and has a blood pressure of 114/73. The nurse compares the reading to the below blood pressure levels for boys age and height percentiles.

Age	Systolic BP Reading								Diastolic BP Reading							
	←Percentile for Height→								←Percentile for height→							
Percentile	5 <sup>th</sup>	10 <sup>th</sup>	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>	95 <sup>th</sup>	98 <sup>th</sup>	5 <sup>th</sup>	10 <sup>th</sup>	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>	95 <sup>th</sup>	
50th	90	91	93	95	96	98	98	98	50	51	52	53	54	55	55	
90th	104	105	106	108	110	111	112	112	65	66	67	68	69	69	70	
95th	108	109	110	112	114	115	116	116	69	70	71	72	73	74	74	
99th	115	116	118	120	121	123	123	77	78	79	80	81	81	82	82	

The nurse determines that the blood pressure represents a change and notifies the primary care provider of the assessment of:

- 1. Hypotension.
- 2. Prehypertension.
- 3. Hypertension.
- 4. Hypertension stage II.

**37.** Which of the following statements by the mother of a toddler diagnosed with nephrotic syndrome indicates that the mother has understood the nurse's teaching about this disease?

- 1. "My child really likes chips and bologna. I guess we'll have to find something else."
- 2. "We'll have to encourage lots of liquids. Did you say about 4 liters every day?"
- 3. "We worry about the surgery. Do you think we should do direct donation of blood?"
- 4. "We understand the need for antibiotics. I just wish the antibiotics could be given by mouth."

**38.** A toddler diagnosed with nephrotic syndrome has a nursing diagnosis of *Excess fluid volume* related to fluid accumulation in the tissues. Which measure should the nurse anticipate including in the child's plan of care?

- 1. Limiting visitors to 2 to 3 hours a day.
- 2. Maintaining strict bed rest.
- 3. Testing urine specific gravity every shift.
- 4. Weighing the child before breakfast.

**39.** The mother of a toddler with nephrotic syndrome asks the nurse what can be done about the child's swollen eyes. Which measure should the nurse suggest?

- 1. Applying cool compresses to the child's eyes.
- 2. Elevating the head of the child's bed.
- 3. Applying eye drops every 8 hours.
- 4. Limiting the child's television watching.

**40.** The nurse determines that interventions for decreasing fluid retention have been effective when the child with nephrotic syndrome demonstrates evidence of which of the following?

- 1. Decreased abdominal girth.
- 2. Increased caloric intake.
- 3. Increased respiratory rate.
- 4. Decreased heart rate.

**41.** The toddler with nephrotic syndrome exhibits generalized edema. Which of the following measures should the nurse institute for this child with a nursing diagnosis of *Impaired skin integrity* related to edema?

- 1. Ambulate every shift while awake.
- 2. Apply lotion on opposing skin surfaces.
- 3. Apply powder to skinfolds.
- 4. Separate opposing skin surfaces with soft cloth.

**42.** A child with nephrosis is placed on prednisone. The dose is 2 mg/kg/day to be administered twice a day. The child weighs 25 lb. How many milligrams will the child receive at each dose?

\_\_\_\_\_ mg.

**43.** The toddler with nephrotic syndrome responds to treatment and is ready to go home. When helping the family plan for home care, which of the following instructions should the nurse include in the teaching?

- 1. Administer pain medication as needed.
- 2. Keep the child away from others with an infection.
- 3. Notify the physician if there is an increase in the child's urine output.
- 4. Administer acetaminophen (Tylenol) daily.

### The Client with Acute or Chronic Renal Failure

**44.** The nurse is planning care with the parents of a child who requires continuous peritoneal dialysis. Which finding should be discussed with the physician?

- 1. The family lives a long distance from the medical facility.
- 2. The child attends a large public school.
- 3. The child reports having a previous surgery for a ruptured appendix.
- 4. The family feels the child cannot self-regulate to wake at night and change bags.

**45.** While performing daily peritoneal dialysis and catheter exit site care with the mother of a child with chronic renal failure, which of the following would be an important step to emphasize to the mother?

- 1. Applying an occlusive dressing after cleaning the site.
- 2. Changing the dressing when the peritoneal space is dry.
- 3. Examining the site for signs of infection while cleaning the area.
- 4. Pulling on the catheter to hold taut while cleaning the skin.

**46.** When developing the discharge teaching plan for a child with chronic renal failure and the family, the nurse should emphasize restriction of which of the following nutrients?

- 1. Ascorbic acid.
- 2. Calcium.
- 3. Magnesium.
- 4. Phosphorus.

**47.** After emphasizing to an adolescent with renal failure the importance of maintaining a positive self-concept, which of the following behaviors by the adolescent should the nurse identify as an indicator that the plan is working?

- 1. Reports of headaches, abdominal pain, and nausea.
- 2. Insistence on making diet choices even if the foods chosen are restricted.
- 3. Verbalization of plans to quit all after-school activities when returning home.
- 4. Demonstration of desire to do the dressing changes and take care of the medications.

**48.** Which of the following diet plans would be appropriate for the nurse to discuss with the family of a child with acute renal failure?

- 1. High carbohydrate and protein.
- 2. High fat and carbohydrate.
- 3. Low fat and protein.
- 4. Low in carbohydrate and fat.

**49.** An adolescent with chronic renal failure is scheduled to go home with a peritoneal dialysis catheter in place. When developing the discharge teaching plan for the client and family focusing on psychosocial needs, which of the following areas should be a top priority to include?

- 1. Advantages of limiting social activities and contacts for the first few months.
- 2. Not disclosing information about the peritoneal dialysis to people outside the family.
- 3. Possible effect on body image of the presence of an abdominal catheter.
- 4. Importance of relying on parents to do the dialysis and dressing changes.

**50.** During a home visit, the public health nurse assesses the peritoneal catheter exit site of a child with chronic renal failure. Which of the following findings should lead the nurse to formulate the nursing diagnosis *Risk for infection*?

- 1. Dialysate leakage.
- 2. Granulation tissue.
- 3. Increased time for drainage.
- 4. Tissue swelling.

**51.** After teaching the mother of a young child with a peritoneal catheter about the signs and symptoms of peritonitis, the nurse determines that the mother has understood the teaching when she identifies which of the following as an important sign?

- 1. Cloudy dialysate drainage return.
- 2. Distended abdomen.
- 3. Shortness of breath.
- 4. Weight gain of 3 lb in 2 days.

**52.** The nurse assesses the child with chronic renal failure who is receiving peritoneal dialysis for edema. Which finding is expected for this child?

- 1. Absence of pulmonary crackles.
- 2. Increased dialysate outflow.
- 3. Normal blood pressure.
- 4. Pallor.

**53.** The mother of a child with chronic renal failure who is receiving peritoneal dialysis at home asks the nurse what she can do if both inflow and drain times are increased. Which of the following instructions would be **most** appropriate for the nurse to include when responding to the mother?

- 1. Assess the child for constipation.
- 2. Decrease the amount of dialysate infused for each dwell.
- 3. Incorporate the increased inflow and drain times into the dialysis schedule.
- 4. Monitor the child for shoulder pain during inflow and drain times.

**54.** The nurse judges that the mother understands the diet restrictions for her child with chronic renal failure who is receiving peritoneal dialysis when she reports providing a diet involving which of the following?

- 1. Sodium and water restrictions.
- 2. High protein and carbohydrates.
- 3. High potassium and iron.
- 4. Protein and phosphorus restrictions.

## The Client with Wilms' Tumor

**55.** A 3-year-old child receiving chemotherapy after surgery for a Wilms' tumor has developed neutropenia. The parent is trying to encourage the child to eat by bringing extra foods to the room. Which food would not be appropriate for this child?

- 1. Fudge.
- 2. French fries.
- 3. Fresh strawberries.
- 4. A milk shake.

**56.** When assessing a 2-year-old child with Wilms' tumor, the nurse should avoid?

- 1. Measuring the child's chest circumference.
- 2. Palpating the child's abdomen.
- 3. Placing the child in an upright position.
- 4. Measuring the child's occipitofrontal circumference.

**57.** Which statement by the mother of a child with Wilms' tumor tells the nurse that the mother understands what *stage II tumor* means?

- 1. "The tumor has extended beyond the kidney but was completely removed."
- 2. "Although the tumor was in the kidney, it has spread to the lung, liver, and bone."
- 3. "The tumor has extended outside the kidney to the lungs and the liver."
- 4. "The tumor was solely located in the kidney but it was totally removed."

**58.** A child diagnosed with Wilms' tumor undergoes successful surgery for removal of the diseased kidney. When the child returns to the room, the nurse should place the child in which position?

- 1. Modified Trendelenburg.
- 2. Sims'.
- 3. Semi-Fowler's.
- 4. Supine.

**59.** After a child undergoes nephrectomy for a Wilms' tumor, the nurse should assess the child postoperatively for which early sign of a complication?

- 1. Increased abdominal distention.
- 2. Elevated blood pressure.
- 3. Increased respiratory rate.
- 4. Increased urine output.

**60.** When developing the discharge plan for a child who had a nephrectomy for a Wilms' tumor, the nurse identifies outcomes to prevent damage to the child's remaining kidney and accomplish which of the following?

- 1. Minimize pain.
- 2. Prevent dependent edema.
- 3. Prevent urinary tract infection.
- 4. Minimize sodium intake.

## Managing Care Quality and Safety

**61.** The nurse reads the new medications orders for a 4-year-old child with nephrotic syndrome on the chart below:

Orders
D/C prednisolone 40 mg PO Daily Prednisolone 30 mg PO QOD

The nurse should:

- 1. Discontinue the prednisolone 40 mg and give the 30 mg dose today.
- 2. Check the medication record first to see when the last dose of prednisolone was given.
- 3. Start the 30 mg dose tomorrow.
- 4. Contact the prescriber for clarification.

**62.** The charge nurse finds the mother of a child with a chronic bladder condition requiring clean intermittent catheterization (CIC) visibly upset. The mother states, "That other nurse said parents are not allowed to perform CIC in the hospital because of increased infection risk." The charge nurse should tell the parent:

- 1. "Your child is exposed to additional bacterial in the hospital that makes CIC unsafe."
- 2. "You can catheterize your child as long as you use sterile technique."
- 3. "You can use CIC on your child. I will talk with your nurse to clarify the policy."
- 4. "I can tell you are having a conflict with this nurse. I will switch assignments."

**63.** The parent of an 18-year-old with chronic renal disease states, "My son has so many problems. I'm really worried that he will not get the right care if he gets sick at college." The nurse should tell the parent:

- 1. "I can have his records sent to the school's health center."
- 2. "Make sure your son always carries his nephrologist's phone number."
- 3. "Your son can make an e-health history to facilitate his care if he gets sick away from home."
- 4. "Your son is going to need to learn to manage his own disease."

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Cryptorchidism

**1. 4.** Normally the testes descend by 1 year of age; failure to do so may indicate a problem with patency or a hormonal imbalance. By age 4 weeks, descent may not have occurred. However, telling the father that lack of descent is not a cause for worry is inappropriate and uncaring. Additionally, a statement such as this may be false reassurance. By acknowledging the father's concern, the nurse indicates acceptance of his feelings. If the testes have not descended, then they will not be palpable in the scrotal sac. Surgery is not discussed until after a full assessment is completed.

🔑 CN: Health promotion and maintenance;  
CL: Synthesize

**2. 3.** A cold environment can cause the testes to retract. Cold and touch stimulate the cremasteric reflex, which causes a normal retraction of the testes toward the body. Therefore, the nurse should warm the hands and make sure that the environment also is warm. Checking the diaper for urination provides information about the infant's voiding and urinary function, not information about the testes. Giving the infant a pacifier may help to calm the infant and possibly make the examination easier, but the concern here is with the temperature of the environment. Tapping on the inguinal ring would not be helpful in assessing the infant.

🔑 CN: Health promotion and maintenance;  
CL: Synthesize

**3. 2.** The nurse needs more information about the father's perceptions and feelings before providing any information or taking action. Determining the exact nature of the father's concern rather than making an assumption about it is essential. Therefore, the nurse should identify what is observed and ask the father how he is feeling. Telling the father that everything will be fine or not to worry is inappropriate and provides false reassurance. It also devalues the father's concern. Later on it may be appropriate for the father to talk to a parent of a child with the same problem for support.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**4. 3.** When an anomaly is found in one system, such as the genitourinary system, that system requires a more focused assessment to reveal other conditions that also may be occurring. A bulging in the inguinal area may suggest an inguinal hernia. Also, hydrocele or an upper urinary tract anomaly may occur on the same side as the undescended testis. A neuromuscular problem, not a genitourinary problem such as undescended testes, would most likely be the cause of abnormal lower extremity reflexes. A history of frequent emesis may be caused by pyloric stenosis or viral gastroenteritis. Poor weight gain might suggest a metabolic or feeding problem.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**5. 1.** A trial of human chorionic gonadotrophin may be given to stimulate descent of the affected testis. A trial of adrenocorticotrophic hormone will not cause the testis to descend. The cremasteric reflex results in the testis being drawn up, the opposite of the intended effect. Application of warmth, such as warm baths, although soothing and relaxing for the infant, would have little or no effect on stimulating the testis to descend.

🔑 CN: Pharmacological and parenteral therapies; CL: Apply

**6. 2.** Preoperative teaching would be directed at the parents, because the child is too young to understand the teaching. Telling the child that his penis and scrotum will be "fixed," telling the child he will not see incisions after surgery, and using a doll to illustrate the surgery are appropriate interventions for a preschool-age child.

🔑 CN: Psychosocial adaptation;  
CL: Create

**7. 3.** Because the incidence of testicular cancer is increased in adulthood among children who have had undescended testes, it is extremely important to teach the adolescent how to perform the testicular self-examination monthly. The undescended testicle is removed to reduce the risk of cancer in that testicle. Removal of a testis would not necessarily make the adolescent sterile because the other testicle remains. Although discussing the adolescent's future plans is important, it is not the priority at this time. Because the adolescent has been dealing with the situation for a long time, the need for a sports physical at this time should not be a cause of emotional distress requiring a lot of psychological support.


🔑 CN: Health promotion and maintenance;  
CL: Synthesize

### The Client with Hydrocele


**8. 3.** A hydrocele is a collection of fluid in the tunica vaginalis of the testicle or along the spermatic cord that results from a patent processus vaginalis. Failure of the upper part of the processus vaginalis to atrophy allows the accumulation of fluid in the testicle and peritoneal cavity, causing an inguinal hernia.

 CN: Physiological adaptation; CL: Apply

**9. 3.** A hydrocele is a collection of fluid in the tunica vaginalis of the testicle or along the spermatic cord that results from a patent processus vaginalis. Because scrotal size is decreasing, the fluid is being absorbed. Elevation of the infant's bottom, massage, or keeping the infant quiet or in an infant seat would have no effect in promoting fluid reabsorption in hydrocele.

 CN: Physiological adaptation;  
CL: Evaluate

**10. 4.** Some swelling and bruising are normal post-operatively. By assessing the area with the mother, the nurse is conveying acceptance of the mother's concern. In addition, the nurse needs to inspect the area to determine if what the mother is describing is accurate. Doing so also provides an opportunity for teaching. Aspirin is not usually prescribed for children because of the link between aspirin and Reye's syndrome. Acetaminophen is commonly administered for fever or pain relief. Asking the mother to wait in the child's room ignores the mother's concerns. There is no need to notify the doctor at this time.

 CN: Psychosocial adaptation;  
CL: Synthesize

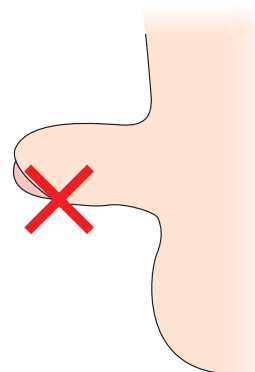
### The Client with Hypospadias

**11. 2.** The condition in which the urethral opening is on the ventral side of the penis or below the glans penis is referred to as *hypospadias*. *Chordee* refers to a ventral curvature of the penis that results from a fibrous band of tissue that has replaced normal tissue. Circumcision is delayed because the foreskin, which is removed with a circumcision, often is used to reconstruct the urethra. The chordee is corrected when the hypospadias is repaired. Circumcision is performed at the same time. Urethral meatal stenosis, which can occur in circumcised infants, results from meatal ulceration, possibly leading to urinary obstruction. It is not associated with hypospadias or circumcision. The infant is not too small to have a circumcision, which is commonly performed on the first or second day of life.

 CN: Reduction of risk potential;  
CL: Apply

**12.** In hypospadias, the urethral opening is on the ventral side of the penis.


 CN: Physiological adaptation; CL: Apply



**13. 2.** The preferred time for surgery is between the ages of 6 and 18 months, before the child develops castration and body image anxiety. Children learn early on about society's emphasis on the importance of genitals. Pain is different for each child and is not related to the preferred time for repair of the hypospadias or chordee. Although the child will probably not remember the experience, this is not the basis for having the surgery at this age. If the condition is not repaired, the child will have difficulty with toilet training because urine is not eliminated through the tip of the penis.

 CN: Physiological adaptation; CL: Apply


**14. 1.** The parents should keep the penis as dry as possible until the stent is removed. Soaking in a tub bath is not recommended. Children this age typically go home voiding directly into a diaper. Infants may be started on juice at 6 months of age. Parents are advised to keep their child well hydrated after a hypospadias repair. Therefore, there is no reason to avoid juice. Cleaning the tip of the penis 3 times a day may cause unnecessary irritation.

 CN: Safety and infection control;  
CL: Synthesize


**15. 2.** The main purpose of the urethral catheter is to maintain patency of the reconstructed urethra. The catheter prevents the new tissue inside the urethra from healing on itself. However, the urethral catheter can cause bladder spasms. Recently, stents have been used instead of catheters. The urethral catheter will have no effect on the child's pain level. In fact, because bladder spasms are associated with its use, the child's complaints of pain may actually increase. Urine output can be measured through the suprapubic catheter because it provides an alternative route for urinary elimination, thus keeping the bladder empty and pressure-free.

 CN: Reduction of risk potential;  
CL: Evaluate

**16. 2.** A dusky blue color at the tip of the penis may indicate a problem with circulation, and the nurse should notify the surgeon. Following surgery, it is normal for the penis to be swollen and pink. The penis may be misshapen and is unlikely to look normal even after reconstruction.

 CN: Physiological adaptation;  
CL: Analyze

**17. 4.** The most important consideration for a successful outcome of this surgery is maintenance of the catheters or stents. A 12-month-old infant likes to explore his environment but must be prevented from manipulating his dressings or catheters through the use of soft restraints. Allowing the infant to become familiar with the dressings will not prevent him from pulling at them. After surgery the child is allowed limited activity, possibly with sitting in the parent's lap. A 12-month-old infant may or may not be walking. If he is, most likely he will be clumsy and possibly injure himself. Although increasing fluids is important, 2,500 mL/day is an excessive amount for a 12-month-old. Fluid requirements would be 115 mL/kg.


 CN: Physiological adaptation;  
CL: Create

**18. 3.** A normal white blood cell count in a urinalysis is 1 to 2 cells/mL. A white blood cell count of 25 per high-powered field indicates a urinary tract infection. A urine specific gravity of 1.017 is within the normal range of 1.002 to 1.030. After urologic surgery, it is not unusual for a small number of red blood cells to appear in the urine. The child's urine pH is within the normal range of 4.6 to 8.


 CN: Reduction of risk potential;  
CL: Analyze

### The Client with Urinary Tract Infection


**19. 3.** 2% lidocaine lubricants have been found to significantly reduce the pain of urinary catheter insertion in children. If the unit does not have a standing protocol to use the lubricant, the nurse should request an order. A sedative would carry with it additional risks that could be avoided with the use of other methods to reduce pain. The parents should be encouraged to hold the child in addition to other pain relief methods. Frequent urination would make the use of topical anesthetics that must be left in place for a period of time impractical.

 CN: Basic care and comfort;  
CL: Synthesize

**20. 2.** Sulfonamides have been associated with severe adverse reactions. A blistering rash may be a sign of Stevens-Johnson syndrome, a severe allergic reaction that manifests as skin lesions. This reaction is life threatening and requires immediate attention. Lotion should not be applied to skin with blisters. Bactrim may cause photosensitivity, but this usually appears as a mild red rash, not blisters. Increasing the child's fluid intake may help the urinary tract infection, but does not address the rash.

 CN: Pharmacological and parenteral therapies;  
CL: Synthesize

**21. 1.** Abdominal pain frequently accompanies urinary tract infection in children 2 years of age and older. Other associated signs and symptoms include decreased appetite, vomiting, fever, and irritability. The presence of swollen lymph glands (lymphadenopathy) is unrelated to urinary tract infections. Lymphadenopathy is associated with a systemic infection or possibly cancer. Skin rash is associated with exposure to allergens or irritants (e.g., poison ivy or harsh soaps); prolonged contact with urine (e.g., diaper dermatitis); or illnesses such as measles, rheumatic fever, or juvenile rheumatoid arthritis. Flank or back pain is associated with urinary tract infection in children older than 2 years of age and in adults.

 CN: Physiological adaptation;  
CL: Analyze

**22. 2.** To ensure appropriate psychosocial development, a child needs to have normal patterns maintained as much as possible during illness. It is tempting to give ill children special treatment and to relax discipline. However, family routines and discipline should be kept as normal as possible. The child needs to know the limits to ensure feelings of security. When they are ill, children commonly attempt to stretch the rules and limits. If this occurs, returning to the previous well-behavior patterns will take time.


 CN: Health promotion and maintenance;  
CL: Synthesize

**23. 1.** The reason that urinary tract infections are a problem in children with vesicoureteral reflux is that urine flows back up the ureter, past the incompetent valve, and back into the bladder after the child has finished voiding. This incomplete emptying of the bladder results in stasis of urine, providing a good medium for bacterial growth and subsequent infection. Vesicoureteral reflux does not cause bladder spasms or painful urination. However, the child may experience painful urination with a urinary tract infection.

 CN: Physiological adaptation;  
CL: Apply

## The Client with Glomerulonephritis


**24. 2.** An adolescent with acute glomerulonephritis has a high urine specific gravity related to oliguria caused by inflammation of the glomeruli. The client will have periorbital edema, but not the generalized edema that occurs in nephrotic syndrome. In glomerulonephritis, there is some albumin in the urine, but there are large amounts of red blood cells, giving the urine a brown color. The urine in glomerulonephritis is scanty, averaging about 400 mL in 24 hours, which leads to fluid volume excess and hypertension.

 CN: Physiological adaptation;  
CL: Synthesize

**25. 3.** The best selection of food would include no added salt or salty food. Because sodium cannot be excreted due to the oliguria and to avoid increasing the hypertension, a low-salt diet is recommended. Most canned foods have sodium added as a preservative. Hamburger, ham, hot dogs, canned peas, canned carrots, corn chips, pickles, and milk are high in sodium.


 CN: Health promotion and maintenance;  
CL: Synthesize

**26. 2.** Hypertension occurs with acute glomerulonephritis. The symptoms of headache and blurred vision may indicate an elevated blood pressure. Hypertension in acute glomerulonephritis occurs due to the inability of the kidneys to remove fluid and sodium; the fluid is reabsorbed, causing fluid volume excess. The nurse must verify that these symptoms are due to hypertension. Calling the physician before confirming the cause of the symptoms would not assist the physician in his treatment. Putting the client to bed may help treat an elevated blood pressure, but first the nurse must establish that high blood pressure is the cause of the symptoms. Administering Tylenol for high blood pressure is not recommended.


 CN: Physiological adaptation;  
CL: Synthesize

**27. 3.** Most likely, the nurse suspects that the child is exhibiting signs and symptoms of glomerulonephritis, such as periorbital edema and fever. Other signs and symptoms include loss of appetite, dark-colored urine, pallor, headaches, and abdominal pain. To confirm this suspicion, the nurse would ask about the child's urinary elimination patterns. Typically the child with glomerulonephritis experiences a decrease in urine output. Asking about any recent sore throat would provide additional information to confirm the suspicion of glomerulonephritis, because the most common type is acute poststreptococcal glomerulonephritis, which

follows a strep throat by 10 to 14 days. Frequently, the children have only mild cold symptoms and do not realize they have a streptococcal infection. Asking whether the child plays with friends as usual is important and gives the nurse information about how the child feels in general. However, this is a general question that would be appropriate to ask later on in the history. Although asking the mother about the color of the child's urine is important, the nurse needs to determine whether there is any change in the child's urinary output first.

 CN: Physiological adaptation;  
CL: Analyze


**28. 3.** The child with acute poststreptococcal glomerulonephritis experiences a problem with renal function that ultimately affects fluid balance. Because weight is the best indicator of fluid balance, obtaining daily weights would be the highest priority.

 CN: Physiological adaptation;  
CL: Analyze

**29. 2.** The most appropriate and effective choice would be ice chips, because they help moisten the mouth and lips while keeping fluid intake low. However, ice chips must still be counted as intake with the fluid restriction. Sweet beverages, such as diet cola or lemonade, commonly increase thirst. Tap water effectively relieves thirst but does not help keep fluid intake low.

 CN: Physiological adaptation;  
CL: Synthesize

**30. 4.** The best choice would be fruits such as strawberries and kiwi because they are low in sodium and potassium. Typically, diet is related to the stage and severity of the disease. In children with uncomplicated disease, a regular diet is offered but sodium is usually restricted. In children with hypertension and edema, moderate restriction of sodium is instituted. Pizza and cola, hamburgers and fries, and ice cream are high in sodium and should be avoided. Children with oliguria usually also have potassium restricted. Therefore, foods such as bananas and oranges would be avoided.

 CN: Physiological adaptation;  
CL: Evaluate

**31. 1.** Generally, school-age children enjoy activities with their peers first, then family members, and lastly younger children. School-age children like to be busy but also to accomplish something. This helps to meet their task of industry versus inferiority, feeling good about what they are able to accomplish.


 CN: Health promotion and maintenance;  
CL: Create



**32. 1.** The nurse should assess the child's neurologic status, because hypertensive encephalopathy is a major potential complication of the acute phase of glomerulonephritis. Seizure precautions also should be instituted. Hypertensive encephalopathy can result in transient loss of vision, hemiparesis, disorientation, and grand mal seizures. Encouraging the child to drink more water is inappropriate because the child has had a low urine output for 14 hours. Typically, in this situation, fluids would be restricted. Although a low-sodium diet is encouraged, it is not the priority action at this time. Initially, bed rest, not ambulation, is advocated during the acute phase of glomerulonephritis.

 CN: Reduction of risk potential;  
CL: Synthesize

**33. 3.** Children recovering from glomerulonephritis need to avoid exposure to all types of infections. Glomerulonephritis is caused by group A beta-hemolytic streptococcus, a common cause of sore throat. As the child recovers, he or she may be susceptible to a recurrence if exposed to the organism again. During convalescence from glomerulonephritis, fluid and dietary restrictions are no longer indicated because the kidneys are now functioning normally. There is no need for the parents to assess the child's vital signs.

 CN: Physiological adaptation;  
CL: Synthesize

**34. 2.** The nurse would expect a person with a normal GFR to have approximately equal inputs and outputs. Chronic renal failure has five stages. In stage I the glomerular filtration rate (GFR) is approximately  $\geq 90$  mL/minute/1.73 m<sup>2</sup>. In stage II the GFR decreases to approximately 60 to 89 mL/minute/1.73 m<sup>2</sup>. The decreased urine output may indicate worsening disease and should be reported. Assessing the client's intake and output is still important, but notifying the provider is the priority. Fluids are restricted based on decreased sodium. Clients are encouraged to drink to thirst. Therefore, there is not enough information to suggest increasing or restricting fluids.

 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Nephrotic Syndrome


**35. 2, 3.** Adverse effects of steroid therapy include edema of the face and trunk, increased susceptibility to infection, gastric and intestinal mucosal bleeding, sodium and water retention, and hypertension. Urinary output is decreased due to the retention of sodium. Bleeding gums do not result from steroids. Steroid therapy does not cause vision problems.

 CN: Pharmacological and parenteral therapies; CL: Create


**36. 3.** The National Institute of Health has established blood pressure standards for gender, age, and height. Reading at or above the 95<sup>th</sup> percentile are considered indicative of hypertension. Here, both the systolic and diastolic readings are at the 95<sup>th</sup> percentile for a boy who is at the 75<sup>th</sup> percentile for height. This blood pressure may be a side effect of the medication or part of the disease process and needs to be reported. The charts do not define hypotension. Readings below the 90<sup>th</sup> percentile are considered normal. Blood pressures at the 90<sup>th</sup> percentile, but below the 95<sup>th</sup> are considered prehypertension. Blood pressures at the 99<sup>th</sup> percentile are considered stage II hypertension and are most likely to need antihypertensive medications.

 CN: Reduction of risk potential;  
CL: Analyze


**37. 1.** Children with nephrotic syndrome usually require sodium restriction. Because potato chips and bologna are high in sodium, the mother's statement about finding something else reflects understanding of this need. Although fluid intake is not restricted in children with nephrotic syndrome, 4 L is an excessive amount for a toddler. The typical fluid requirement for a toddler is 115 mL/kg. Surgical intervention and antibiotic therapy are not parts of the treatment plan for nephrotic syndrome.

 CN: Physiological adaptation;  
CL: Evaluate

**38. 4.** The best indicator of fluid balance is weight. Therefore, daily weight measurements help determine fluid losses and gains. Although limiting visitors to 2 to 3 hours per day or maintaining strict bed rest would help to ensure that the child gets adequate rest, this is unrelated to the child's fluid balance. In nephrotic syndrome, urine is tested for protein, not specific gravity.


 CN: Physiological adaptation;  
CL: Synthesize

**39. 2.** The child's swollen eyes are caused by fluid accumulation. Elevating the head of the bed allows gravity to increase the downward flow of fluids in the body, away from the face. Applying cool compresses or eye drops, or limiting television, may be comforting but will not relieve the swelling.


 CN: Physiological adaptation;  
CL: Synthesize

**40. 1.** Fluid accumulates in the abdomen and interstitial spaces owing to hydrostatic pressure changes. Increased abdominal fluid is evidenced by an increase in abdominal girth. Therefore, decreased abdominal girth is a sign of reduced fluid in the third spaces and tissues. When fluid accumulates in the abdomen and interstitial spaces, the child does not feel hungry and does not eat well. Although

increased caloric intake may indicate decreased intestinal edema, it is not the best and most accurate indicator of fluid retention. Increased respiratory rate may be an indication of increasing fluid in the abdomen (ascites) causing pressure on the diaphragm. Heart rate usually stays in the normal range even with excessive fluid volume.

 CN: Physiological adaptation;  
CL: Evaluate

**41. 4.** Placing soft cloth between opposing skin surfaces absorbs moisture and keeps the area dry, thus preventing any further breakdown. The child with nephrotic syndrome and severe edema is usually maintained on bed rest. Therefore, ambulation is not appropriate. Applying lotion or powder to edematous surfaces that touch increases moisture and can lead to maceration, causing further breakdown.

 CN: Basic care and comfort;  
CL: Synthesize

**42. 11.3 mg**

$$25 \text{ lb} \times 2.2 = 11.3 \text{ kg}$$

$$11.3 \text{ kg} \times 2 \text{ mg} = 22.7 \text{ mg/day}$$

$$22.7 \text{ mg} \times 2 = 11.3 \text{ mg per dose}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**43. 2.** A child recovering from nephrotic syndrome should be protected from infection. Therefore, the nurse would teach the parents to keep the child away from others with an infection. Because pain is not associated with this disorder, pain medication typically is not needed. The physician should be notified if urine output decreases, not increases. In children recovering from nephrotic syndrome, there is no reason to administer acetaminophen daily.


 CN: Reduction of risk potential;  
CL: Synthesize

### The Client with Acute or Chronic Renal Failure

**44. 3.** A client who has had a ruptured appendix may have peritoneal scarring that may alter the effectiveness of treatment. Living a long distance from a medical facility is typically a reason to select peritoneal dialysis. Attending a large school is not a problem, but the school nurse needs to be included as part of the health care team. Typically the treatment schedule can be planned to allow for uninterrupted sleep at night.

 CN: Management of care; CL: Create

**45. 3.** Until it heals, the catheter exit site is particularly vulnerable to invasion by pathogenic organisms. Therefore, the site must be monitored for signs of infection. An occlusive dressing is not needed because there is no danger of air being sucked in or out of the peritoneal space. Furthermore, the catheter used is designed with a cuff, so that the skin grows around the catheter, sealing off the area. Site care may be done at any time, but the child may experience abdominal discomfort if the peritoneal space is dry during site care. Holding the catheter taut or pulling on it may cause irritation of the skin at the exit site, which could lead to infection.

 CN: Safety and infection control;  
CL: Synthesize

**46. 4.** With minimal or absent kidney function, the serum phosphate level rises, and the ionized calcium level falls in response. This causes increased secretion of parathyroid hormone, which releases calcium from the bones. Therefore, the intake of foods high in phosphorus is restricted. Because renal failure results in decreased erythropoietin production, an increase in ascorbic acid intake is needed. Because magnesium is minimally affected by renal failure, its intake need not be restricted.

 CN: Physiological adaptation; CL: Apply

**47. 4.** Demonstration of desire to do the dressing changes and manage medications implies compliance with the medical regimen and acceptance of the condition, thereby indicating a positive self-image. Diffuse somatic symptoms could indicate anxiety or problems with coping, with a negative effect on self-concept. Insistence on choosing restricted foods implies that the adolescent has not accepted the diagnosis and is noncompliant, possibly indicating a negative self-concept. Social withdrawal from activities may indicate depression, possibly negatively affecting the self-concept.

 CN: Physiological adaptation;  
CL: Evaluate

**48. 2.** The child with acute renal failure needs extra calories to reduce tissue catabolism, metabolic acidosis, and uremia. Using a high-fat and carbohydrate diet helps to supply the necessary extra calories. If the child is able to tolerate oral foods, concentrated food sources that are high in carbohydrate and fat but low in protein, potassium, and sodium may be provided.


 CN: Physiological adaptation; CL: Apply

**49. 3.** For an adolescent, body image is a major concern. The presence of an abdominal catheter can greatly affect the client's body image. The adolescent needs opportunities to discuss feelings about altered body image due to the catheter. Adolescents need to be with their peers and to maintain social activities


and contacts in order to meet the developmental tasks for this age group. The adolescent client may choose to confide in friends for both psychological health and physical safety. Because peers are most important to adolescents, they will confide in their peers before confiding in family members. Another major developmental need of the adolescent is achieving independence. Relying on the parents would interfere with the adolescent's ability to do so.

 CN: Psychosocial adaptation; CL: Create


**50. 4.** Tissue swelling, pain, redness, and exudate indicate infection. Dialysate leakage is associated with improper catheter function, incomplete healing at the insertion site, or excessive instillation of dialysate. Granulation tissue indicates healing around the exit site, not infection. Increased time for drainage may indicate that the tube is kinked, suggesting an obstruction.

 CN: Reduction of risk potential;  
CL: Analyze

**51. 1.** Normally, dialysate drainage return should be clear. With peritonitis, large numbers of bacteria, white blood cells, and fibrin cause the dialysate to appear cloudy. Abdominal distention is unrelated to peritonitis. However, it might suggest an obstruction. Weight gain and shortness of breath are associated with fluid excess, not infection.

 CN: Physiological adaptation;  
CL: Evaluate


**52. 4.** With edema, pallor can occur owing to hemodilution as intestinal fluid moves to the vascular space. The child would exhibit pulmonary crackles secondary to pulmonary congestion and edema. Dialysate outflow would decrease, not increase, as the body attempts to conserve fluid. The child's blood pressure would be increased because of excessive fluid volume.

 CN: Physiological adaptation;  
CL: Analyze

**53. 1.** Accumulation of hard stool in the bowel can cause the distended intestine to block the holes of the catheter. Consequently, the dialysate cannot flow freely through the catheter. Decreasing the dialysate infusion may make the dialysis less effective. Altering fluid, electrolyte, and waste product removal can cause fluid and electrolyte imbalance and increased levels of blood urea nitrogen and creatinine. Incorporating the increased times into the dialysis may make the dialysis less effective because fewer cycles can be scheduled. Shoulder pain, which may occur occasionally, can be caused by air in the peritoneal space and diaphragmatic irritation. However, it is unrelated to inflow and drain times.

 CN: Physiological adaptation;  
CL: Synthesize

**54. 4.** Regulation of the diet is the most effective means, besides dialysis, for reducing renal excretion. Dietary phosphorus is restricted, which reduces the protein load on the kidneys. Clients are also given substances to bind phosphorus in the intestines to prevent absorption. Limited protein in the diet should include foods high in essential amino acids. Foods high in fat and carbohydrate are used to increase caloric intake. Sodium and water may not be restricted because of the continual loss of sodium and water through the dialysate. Iron-rich foods are commonly high in protein.


 CN: Physiological adaptation;  
CL: Evaluate

### The Client with Wilms' Tumor


**55. 3.** When a client receiving chemotherapy develops neutropenia, eating uncooked fruits and vegetables may pose a health risk due to possible bacterial contamination. All other foods are either cooked or pasteurized and would not produce a health risk.

 CN: Safety and infection control;  
CL: Apply

**56. 2.** The abdomen of the child with Wilms' tumor should not be palpated because of the danger of disseminating tumor cells. Techniques such as measuring the occipitofrontal circumference (which is done in children younger than 18 months of age because the anterior fontanel closes between 12 to 18 months of age), upright positioning, and measuring chest circumference are not necessarily contraindicated; however, the child with Wilms' tumor should always be handled gently and carefully.

 CN: Physiological adaptation;  
CL: Analyze

**57. 1.** A stage II tumor is one that extends beyond the kidney but is completely resected. The tumor staging is verified during surgery to maximize treatment protocols. The following criteria for staging are commonly used: *stage I*, tumor is limited to the kidney and completely resected; *stage II*, tumor extends beyond the kidney but is completely resected; *stage III*, residual nonhematogenous tumor is confined to the abdomen; *stage IV*, hematogenous metastasis occurs, with deposits beyond stage III (lung, bone and brain, liver); *stage V*, bilateral renal involvement is present at diagnosis.

 CN: Physiological adaptation;  
CL: Evaluate

**58. 3.** The child who has undergone abdominal surgery is usually placed in a semi-Fowler's position to facilitate draining of abdominal contents

and promote pulmonary expansion. The modified Trendelenburg position is used for clients in shock. The Sims' position is likely to be uncomfortable for this child because of the large trans-abdominal incision. The supine position, without the head elevated, puts the child at increased risk for aspiration.

 CN: Reduction of risk potential;  
CL: Synthesize

**59. 1.** Children who have undergone abdominal surgery are at risk for intestinal obstruction from a dynamic ileus. Indications of intestinal obstruction include abdominal distention, decreased or absent bowel sounds, and vomiting. Later signs of intestinal obstruction include tachycardia, fever, hypotension, increased respirations, shock, and decreased urinary output.

 CN: Reduction of risk potential;  
CL: Analyze

**60. 3.** Because the child has only one kidney, measures should be recommended to prevent urinary tract infection and injury to the remaining kidney. Severe pain and dependent edema are not associated with surgery for Wilms' tumor. Dietary sodium is not restricted because function in the remaining kidney is not impaired.

 CN: Reduction of risk potential;  
CL: Create

### Managing Care Quality and Safety

**61. 4.** There are many problems with this medication order. The abbreviation QOD is on the Joint Commission's "do not use list." The abbreviation D/C may also be interpreted as "discontinue" or "discharge." The prescriber should have specifically stated when to start the lower dose because the

nurse could reason beginning the medication that day, the next, or even the day after that. The only safe thing to do is call for clarification.

 CN: Safety and infection control;  
CL: Synthesize

**62. 3.** The charge nurse should assure the parent that it is okay to use CIC and discuss the conversation with the nurse. It is possible that the nurse was unaware of current research findings or unit policies. The charge nurse should also determine if the parent has the supplies and space to clean the catheters. If not, the procedure may need to be modified to use a new catheter each time, but the insertion principles would not change. Parents are frequently taught how to do CIC while a child is in the hospital. Therefore, the rationale that it now becomes unsafe, or that sterile technique is needed, is faulty. Switching nurses will not solve the underlying problem.

 CN: Management of care; CL: Synthesize

**63. 3.** The U.S. Department of Health and Human Services has an Internet-based family health history tool that can make sharing a client's health history easier. This is particularly helpful because it can be accessed by the client from a variety of locations. Access to a well-constructed e-history will facilitate care if the adolescent becomes ill while at college. Because the client is 18, legally the nurse cannot transfer the records to the school without permission. Also, the adolescent may need to seek treatment in facilities other than the health center. Instructing the adolescent to always carry the nephrologist's phone number is not bad advice, but compliance may vary and there is no guarantee the provider will be available in all instances. Telling the parent that the son must learn to manage his own disease does not address the parent's concern.

 CN: Management of care; CL: Synthesize

# TEST 7

## The Child with Neurologic Health Problems

- The Client with Myelomeningocele
- The Client with Hydrocephalus
- The Client with Down Syndrome
- The Client with a Seizure Disorder
- The Client with Meningitis
- The Client with Near-Drowning
- The Client with Guillain-Barré Syndrome (Infectious Polyneuritis)
- The Client with a Head Injury
- The Client with a Brain Tumor
- The Client with a Spinal Cord Injury
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Myelomeningocele

1. Parents bring a 10-month-old boy born with myelomeningocele and hydrocephalus with a ventriculoperitoneal shunt to the emergency department. His symptoms include vomiting, poor feeding, lethargy, and irritability. What interventions by the nurse are appropriate? Select all that apply.

- 1. Weigh the child.
- 2. Listen to bowel sounds.
- 3. Palpate the anterior fontanel.
- 4. Obtain vital signs.
- 5. Assess pitch and quality of the child's cry.

2. When positioning a neonate with an unrepaired myelomeningocele, which of the following positions is **most** appropriate?

- 1. Supine with the hips at 90-degree flexion.
- 2. Right side-lying position with the knees flexed.
- 3. Prone with hips in abduction.
- 4. Supine in semi-Fowler's position with chest and abdomen elevated.

3. The nurse is teaching the parents of a child with myelomeningocele how to prevent urinary tract infections. What should the care plan include for this child? Select all that apply.

- 1. Provide meticulous skin care.
- 2. Use the Crede's maneuver to empty the bladder.
- 3. Encourage frequent emptying of the bladder.
- 4. Assure adequate fluid intake.
- 5. Use tight-fitting diapers around the meatus.

4. The nurse reports to the physician signs of increased intracranial pressure in an infant with a myelomeningocele who has which of the following?

- 1. Minimal lower extremity movement.
- 2. A high-pitched cry.
- 3. Overflow voiding only.
- 4. A fontanel that bulges with crying.

5. When developing the plan of care for an infant diagnosed with myelomeningocele and the parents who have just been informed of the infant's diagnosis, which action should the nurse include as the **priority** when the parents visit the infant for the first time?

- 1. Emphasizing the infant's normal and positive features.
- 2. Encouraging the parents to discuss their fears and concerns.
- 3. Reinforcing the doctor's explanation of the defect.
- 4. Having the parents feed their infant.

6. The mother of an infant with myelomeningocele asks if her baby is likely to have any other defects. The nurse responds based on the understanding that myelomeningocele is commonly associated with which disorder?

- 1. Excessive cerebrospinal fluid within the cranial cavity.
- 2. Abnormally small head.
- 3. Congenital absence of the cranial vault.
- 4. Overriding of the cranial sutures.

**7.** The parents of an infant with myelomeningocele ask the nurse about their child's future mental ability. What is the nurse's **best** response?

- 1. "About one-third are mentally retarded, but it's too early to tell about your child."
- 2. "About two-thirds are significantly retarded, and you'll know soon if this will occur."
- 3. "Your child will probably be of normal intelligence since he demonstrates signs of it now."
- 4. "You'll need to talk with the doctor about that, but you can ask later."

**8.** After placing an infant with myelomeningocele in an isolette shortly after birth, which indicator should the nurse use as the **best** way to determine the effectiveness of this intervention?

- 1. The partial pressure of arterial oxygen remains between 94 and 100 mm Hg.
- 2. The axillary temperature remains between 97° and 98° F (36.1° and 36.7° C).
- 3. The bilirubin level remains stable.
- 4. Weight increases by about 1 oz (28.35 g) per day.

**9.** Prior to surgery, a nurse is positioning a neonate with a myelomeningocele. The nurse should position the neonate in which of the following ways? Select all that apply.

- 1. Place the neonate in a prone position.
- 2. Keep a diaper over the sac.
- 3. Allow the neonate's feet to hang over the mattress edge.
- 4. Use a foam pad to maintain hip adduction.
- 5. Use a soft pad over the mattress.

**10.** After surgical repair of a myelomeningocele, which position should the nurse use to prevent musculoskeletal deformity in the infant?

- 1. Placing the feet in flexion.
- 2. Allowing the hips to be abducted.
- 3. Maintaining knees in the neutral position.
- 4. Placing the legs in adduction.

**11.** When caring for an infant who has undergone surgical repair of a myelomeningocele, which of the following should the nurse report to the surgeon?

- 1. Seizures and vomiting.
- 2. Frontal bossing and sunset eyes.
- 3. Increased head circumference and bulging fontanel.
- 4. Irritability and shrill cry.

**12.** When developing the discharge plan for the parents of an infant who has undergone a myelomeningocele repair, what information is **most** important for the nurse to include?

- 1. A list of available hospital services.
- 2. Schedule for daily home health care.
- 3. Chaplain referral for psychological support.
- 4. Daily care required by the infant.

**13.** Which of the following statements by the mother of an infant with a repaired upper lumbar myelomeningocele indicates that she understands the nurse's teaching at the time of discharge?

- 1. "I can apply a heating pad to his lower back."
- 2. "I'll be sure to keep him away from other children."
- 3. "I will call the doctor if his urine has a funny smell."
- 4. "I will prop him on pillows to keep him from rolling over."

**14.** A preschooler with a history of repaired lumbar myelomeningocele is in the emergency department with wheezing and skin rash. Which of the following questions should the nurse ask the mother **first**?

- 1. "Is your child taking any medications?"
- 2. "Who brought your child to the emergency department?"
- 3. "Is your child allergic to bananas or milk products?"
- 4. "What are you doing to treat your child's skin rash?"

### The Client with Hydrocephalus

**15.** Before placement of a ventriculoperitoneal shunt for hydrocephalus, an infant is irritable, lethargic, and difficult to feed. To maintain the infant's nutritional status, which of the following actions would be **most** appropriate?

- 1. Feeding the infant just before doing any procedures.
- 2. Giving the infant small, frequent feedings.
- 3. Feeding the infant in a horizontal position.
- 4. Scheduling the feedings for every 6 hours.

**16.** A 4-year-old child with hydrocephalus is scheduled to have a ventroperitoneal shunt in the right side of the head. When developing the child's postoperative plan of care, the nurse should place the preschooler in which of the following positions immediately after surgery?

- 1. On the right side, with the foot of the bed elevated.
- 2. On the left side, with the head of the bed elevated.
- 3. Prone, with the head of the bed elevated.
- 4. Supine, with the head of the bed flat.

**17.** Which action should the nurse take when providing postoperative nursing care to a child after insertion of a ventriculoperitoneal shunt?

- 1. Administer narcotics for pain control.
- 2. Check the urine for glucose and protein.
- 3. Monitoring for increased temperature.
- 4. Test cerebrospinal fluid leakage for protein.

**18.** A nurse evaluates discharge teaching as successful when the parents of a school-age child with a ventriculoperitoneal shunt insertion identify which sign as signaling a blocked shunt?

- 1. Decreased urine output with stable intake.
- 2. Tense fontanel and increased head circumference.
- 3. Elevated temperature and reddened incisional site.
- 4. Irritability and increasing difficulty with eating.

### The Client with Down Syndrome

**19.** A 7-year-old has been diagnosed as mentally retarded. Which of the parents' expectations for their child is realistic? Select all that apply.

- 1. Difficulty learning.
- 2. An IQ below 70.
- 3. Deficits in adaptive behavior.
- 4. Normal intellectual capacity.
- 5. Behavioral problems.

**20.** A nurse is assessing a child who is mildly mentally retarded. The best indication of how a mentally retarded child is progressing can be obtained by observing him:

- 1. At school with his teacher.
- 2. At home with his family.
- 3. In the clinic with his mother.
- 4. Playing soccer with his friends.

**21.** After talking with the parents of a child with Down syndrome, the nurse should help the parents establish which goal?

- 1. Encouraging self-care skills in the child.
- 2. Teaching the child something new each day.
- 3. Encouraging more lenient behavior limits for the child.
- 4. Achieving age-appropriate social skills.

**22.** The nurse discusses with the parents how best to raise the IQ of their child with Down syndrome. Which of the following would be **most** appropriate?

- 1. Serving hearty, nutritious meals.
- 2. Giving vasodilator medications as prescribed.
- 3. Letting the child play with more able children.
- 4. Providing stimulating, nonthreatening life experiences.

**23.** When developing a teaching plan for the parents of a child with Down syndrome, the nurse focuses on activities to increase which of the following for the parents?

- 1. Affection for their child.
- 2. Responsibility for their child's welfare.
- 3. Understanding of their child's disability.
- 4. Confidence in their ability to care for their child.

**24.** The nurse mentions that a group meeting for mothers of mentally retarded children is to be held soon. "Not retarded!" the child's mother angrily blazes, "Exceptional." When responding to this outburst, which of the following replies by the nurse would be **most** appropriate?

- 1. "'Retarded' is the commonly used and accepted term."
- 2. "I'm sorry if I offended you by my thoughtless remark."
- 3. "No matter what it's called, the condition is still the same, isn't it?"
- 4. "I'd like to hear more of your thoughts and feelings on that."

### The Client with a Seizure Disorder

**25.** A child with a known seizure disorder is hospitalized for an appendectomy. While assisting the child back from the restroom, the child begins tonic-clonic movements. The nurse should take which actions in order of priority from first to last?

1. Note the time.

2. Clear the area of potentially harmful objects and pad the head.

3. Ease the child to the floor.

4. Roll the child to the side.

**26.** What should be part of the nurse's teaching plan for a child with epilepsy being discharged on a regimen of diphenylhydantoin (Dilantin)?

- 1. Drinking plenty of fluids.
- 2. Brushing teeth after each meal.
- 3. Having someone be with the child during waking hours.
- 4. Reporting signs of infection.

**27.** After teaching a group of school teachers about seizures, the teachers role-play a scenario involving a child experiencing a generalized tonic-clonic seizure. Which of the following actions, when performed **first**, indicates that the nurse's teaching has been successful?

- 1. Asking the other children what happened before the seizure.
- 2. Moving the child to the nurse's office for privacy.
- 3. Removing any nearby objects that could harm the child.
- 4. Placing a padded tongue blade between the child's teeth.

**28.** A nurse is developing a plan of care with the parents of a 6-year-old girl diagnosed with a seizure disorder. To promote growth and development, the nurse should instruct the parents that:

- 1. The child will need activity limitation and will be unable to perform as well as her peers.
- 2. There is potential for a learning disability and the child may need tutoring to reach her grade level.
- 3. The child will likely have normal intelligence and be able to attend regular school.
- 4. There will be problems associated with social stigma and parents should consider home schooling.

**29.** The parents of a child with occasional generalized seizures want to send the child to summer camp. The parents contact the nurse for advice on planning for the camping experience. Which of the following activities should the nurse and family decide the child should avoid?

- 1. Rock climbing.
- 2. Hiking.
- 3. Swimming.
- 4. Tennis.

**30.** Which of the following statements obtained from the nursing history of a toddler should alert the nurse to suspect that the child has had a febrile seizure?

- 1. The child has had a low-grade fever for several weeks.
- 2. The family history is negative for convulsions.
- 3. The seizure resulted in respiratory arrest.
- 4. The seizure occurred when the child had a respiratory infection.

**31.** After teaching the parents of a child with febrile seizures about methods to lower temperature other than using medication, which of the following statements indicates successful teaching?

- 1. "We'll add extra blankets when he complains of being cold."
- 2. "We'll wrap him in a blanket if he starts shivering."
- 3. "We'll make the bath water cold enough to make him shiver."
- 4. "We'll use a solution of half alcohol and half water when sponging him."

**32.** An adolescent girl with a seizure disorder controlled with phenytoin (Dilantin) and carbamazepine (Tegretol) asks the nurse about getting married and having children. Which of the following responses by the nurse would be **most** appropriate?

- 1. "You probably shouldn't consider having children until your seizures are cured."
- 2. "Your children won't necessarily have an increased risk of seizure disorder."
- 3. "When you decide to have children, talk to the doctor about changing your medication."
- 4. "Women who have seizure disorders commonly have a difficult time conceiving."

**33.** When teaching an adolescent with a seizure disorder who is receiving valproic acid (Depakene), which sign or symptom should the nurse instruct the client to report to the health care provider?

- 1. Three episodes of diarrhea.
- 2. Loss of appetite.
- 3. Jaundice.
- 4. Sore throat.

### The Client with Meningitis

**34.** The parents of an 18-year-old preparing to enter college ask if their daughter should have the meningococcal (MCV4) vaccine. The nurse should tell the parents:

- 1. "It is only necessary to have the vaccine if your daughter will be living in a dormitory."
- 2. "Yes, we recommend the vaccine, but it needs to be given as a series of three injections."
- 3. "Let's review your records. The vaccine may have already been given a few years ago."
- 4. "We highly recommend this vaccine, but we will need to do a pregnancy screening first."

**35.** During the acute stage of meningitis, a 3-year-old child is restless and irritable. Which of the following would be **most** appropriate to institute?

- 1. Limiting conversation with the child.
- 2. Keeping extraneous noise to a minimum.
- 3. Allowing the child to play in the bathtub.
- 4. Performing treatments quickly.

**36.** Which sign should lead the nurse to suspect that a child with meningitis has developed disseminated intravascular coagulation?

- 1. Hemorrhagic skin rash.
- 2. Edema.
- 3. Cyanosis.
- 4. Dyspnea on exertion.



**37.** When interviewing the parents of a 2-year-old child, a history of which of the following illnesses should lead the nurse to suspect pneumococcal meningitis?

- 1. Bladder infection.
- 2. Middle ear infection.
- 3. Fractured clavicle.
- 4. Septic arthritis.

**38.** A preschooler with pneumococci meningitis is receiving intravenous antibiotic therapy. When discontinuing the intravenous therapy, the nurse allows the child to apply a dressing to the area where the needle is removed. The nurse's rationale for doing so is based on the interpretation that a child in this age-group has a need to accomplish which of the following?

- 1. Trust those caring for her.
- 2. Find diversional activities.
- 3. Protect the image of an intact body.
- 4. Relieve the anxiety of separation from home.

**39.** A child with meningitis is to receive 1,000 mL of dextrose 5% in normal saline over 12 hours. At what rate in milliliters per hour should the nurse set the pump? Round your answer to the nearest whole number.

\_\_\_\_\_ mL/hour.

**40.** A hospitalized preschooler with meningitis who is to be discharged becomes angry when the discharge is delayed. Which of the following play activities would be **most** appropriate at this time?

- 1. Reading the child a story.
- 2. Painting with watercolors.
- 3. Pounding on a pegboard.
- 4. Stacking a tower of blocks.

### The Client with Near-Drowning

**41.** The nurse is admitting a toddler with the diagnosis of near-drowning in a neighbor's heated swimming pool to the emergency department. The nurse should assess the child for:

- 1. Hypothermia.
- 2. Hypoxia.
- 3. Fluid aspiration.
- 4. Cutaneous capillary paralysis.

**42.** The nurse is caring for a lethargic 4-year-old who is a victim of a near-drowning accident. The nurse should first:

- 1. Administer oxygen.
- 2. Institute rewarming.
- 3. Prepare for intubation.
- 4. Start an intravenous infusion.

**43.** The parents of a child tell the nurse that they feel guilty because their child almost drowned. Which of the following remarks by the nurse would be **most** appropriate?

- 1. "I can understand why you feel guilty, but these things happen."
- 2. "Tell me a little bit more about your feelings of guilt."
- 3. "You should not have taken your eyes off of your child."
- 4. "You really shouldn't feel guilty; you're lucky because your child will be all right."

### The Client with Guillain-Barré Syndrome (Infectious Polyneuritis)

**44.** Which of the following assessments would be **most** important for the nurse to make initially in a school-age child being seen in the clinic who has a sore throat, muscle tenderness, arms feeling weak, and generally is not feeling well?

- 1. Difficulty swallowing.
- 2. Diet intake for the last 24 hours.
- 3. Exposure to illnesses.
- 4. Difficulty urinating.

**45.** Which of the following actions should be the **priority** when caring for a school-age child admitted to the pediatric unit with the diagnosis of Guillain-Barré syndrome?

- 1. Assessing the child's ability to follow simple commands.
- 2. Evaluating the child's bilateral muscle strength.
- 3. Making a game of the range-of-motion exercises.
- 4. Providing the child with a diversional activity.

**46.** The nurse asks a school-age child with Guillain-Barré syndrome to cough and also assesses the child's speech for decreased volume and clarity. The underlying rationale for these assessments is to determine which of the following?

- 1. Inflammation of the larynx and epiglottis.
- 2. Increased intracranial pressure.
- 3. Involvement of facial and cranial nerves.
- 4. Regression to an earlier developmental phase.

**47.** Assessment of a school-age child with Guillain-Barré syndrome reveals absent gag and cough reflexes. Which of the following nursing diagnoses should receive the **highest** priority during the acute phase?

- 1. *Risk for infection* due to altered immune system.
- 2. *Ineffective breathing pattern* related to neuromuscular impairment.
- 3. *Impaired swallowing* related to neuromuscular impairment.
- 4. *Total urinary incontinence* related to fluid losses.

**48.** A 9-year-old child with Guillain-Barré syndrome requires mechanical ventilation. Which action should the nurse take?

- 1. Maintain the child in a supine position to prevent unnecessary nerve stimulation.
- 2. Transfer the child to a bedside chair three times a day to prevent postural hypotension.
- 3. Engage the child in vigorous passive range-of-motion exercises to prevent loss of muscle function.
- 4. Turn the child slowly and gently from side to side to prevent respiratory complications.

**49.** The mother brings her child to the clinic after discharge from the hospital for Guillain-Barré syndrome. Which of the following statements by the mother indicates that she is following the discharge plan?

- 1. “She and her sister argue all day.”
- 2. “I have to bribe her to get her to do her exercises.”
- 3. “I take her to the pool where she can exercise with other children.”
- 4. “She’s missed a few of her therapy sessions because she often sleeps.”

### The Client with a Head Injury

**50.** The nurse is inserting a nasogastric (NG) tube in a child admitted with head trauma. The nurse should explain to the parents that the NG tube will be used for what purpose?

- 1. Administer medications.
- 2. Decompress the stomach.
- 3. Obtain gastric specimens for analysis.
- 4. Provide adequate nutrition.

**51.** A nasogastric tube is ordered to be inserted for a child with severe head trauma. Diagnostic testing reveals that the child has a basilar skull fracture. What should the nurse do next?

- 1. Ask for the order to be changed to oral gastric tube.
- 2. Attempt to place the tube into the duodenum.
- 3. Test the gastric aspirate for blood.
- 4. Use extra lubrication when inserting the nasogastric tube.

**52.** The parents of a child with a serious head injury ask the nurse if the child is going to be all right. Which of the following responses by the nurse would be **most** appropriate?

- 1. “Children usually don’t do very well after head injuries like this.”
- 2. “Children usually recover rapidly from head injuries.”
- 3. “It’s hard to tell this early, but we’ll keep you informed of the progress.”
- 4. “That’s something you’ll have to talk to the doctor about.”

**53.** A parent of a child with a moderate head injury asks the nurse, “How will you know if my child is getting worse?” The nurse should tell the parents that best indicator of the child’s brain function is:

- 1. The vital signs.
- 2. Level of consciousness.
- 3. Reactions of the pupils.
- 4. Motor strength.

**54.** When developing the plan of care for a child who is unconscious after a serious head injury, in which of the following positions should the nurse expect to place the child?

- 1. Prone with hips and knees slightly elevated.
- 2. Lying on the side, with the head of the bed elevated.
- 3. Lying on the back, in the Trendelenburg position.
- 4. In the semi-Fowler’s position, with arms at the side.

**55.** The physician has ordered intravenous mannitol (Osmitrol) for a child with a head injury. The **best** indicator that the drug has been effective is:

- 1. Increased urine output.
- 2. Improved level of consciousness.
- 3. Decreased intracranial pressure.
- 4. Decreased edema.

### The Client with a Brain Tumor

**56.** A child with a brain tumor is less responsive to verbal commands than he was when the nurse assessed the client the previous hour. The nurse should next:

- 1. Raise the head of the bed.
- 2. Notify the physician.
- 3. Administer an analgesic.
- 4. Obtain an oximeter reading.

**57.** A 12-year-old child has had a traumatic head injury from playing in a football game. He is admitted to the emergency department and transferred to the pediatric intensive care unit. He has an I.V. of dextrose 5% in water at a “keep-open” rate and nasal oxygen at 2 L/minute. The nurse is assessing the child at the beginning of the shift (11:00 p.m.) and reviews the Glasgow Coma Scale flow sheet below. The nurse notes that the child responds to pain, is making incomprehensible sounds, and has abnormal flexion of the limbs. What should the nurse do **first**?

### Flow Sheet

#### Glasgow Coma Scale

Test	Score	Client's response
<b>Eye Opening</b>		
Spontaneously	4	Opens eyes spontaneously
To Speech	3	Opens eyes to verbal command
To Pain	2	Opens eyes to painful stimulus
None	1	Doesn't open eyes in response to stimulus
<b>Motor Response</b>		
Obeys	6	Reacts to verbal command
Localizes	5	Identifies localized pain
Withdraws	4	Flexes and withdraws from painful stimulus
Abnormal Flexion	3	Assumes a decorticate position
Abnormal Extension	2	Assumes a decerebrate position
None	1	No response; lies flaccid
<b>Verbal Response</b>		
Oriented	5	Is oriented and converses
Confused	4	Is disoriented and confused
Inappropriate Words	3	Replies randomly with incorrect words
Incomprehensible	2	Moans or screams
None	1	No response
<b>Date</b>	<b>Time</b>	<b>Progress Notes</b>
11/13/07	05:00 pm	GCS = 13
11/13/07	06:00 pm	GCS = 12
11/13/07	07:00 pm	GCS = 13
11/13/07	08:00 pm	GCS = 11
11/13/07	09:00 pm	GCS = 10
11/13/07	10:00 pm	GCS = 9

- 1. Notify the physician.
- 2. Lower the head of the bed.
- 3. Increase the rate of nasal oxygen.
- 4. Increase the rate of the I.V. infusion.

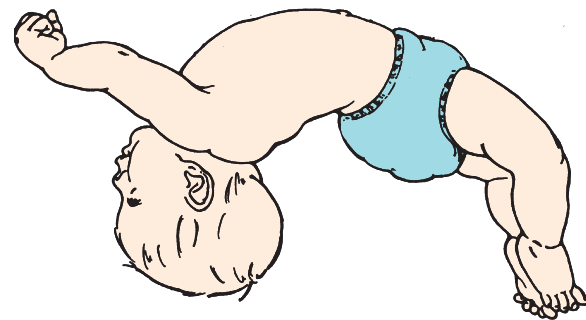
**58.** A 13-year-old child has seen the school nurse several times with headache, vomiting, and difficulty walking. When calling the adolescent's mother about these symptoms, what should the nurse suggest the mother do **first**?

- 1. Schedule an appointment with the eye doctor.
- 2. Begin psychological counseling for her adolescent.
- 3. Make an appointment with the adolescent's physician.
- 4. Meet with the adolescent's teachers to determine academic progress.

**59.** A school-age child is admitted to the hospital with the diagnosis of probable infratentorial brain tumor. During the child's admission to the pediatric unit, which action should the nurse anticipate taking **first**?

- 1. Eliminating the child's anxiety.
- 2. Implementing seizure precautions.
- 3. Introducing the child to other clients of the same age.
- 4. Preparing the child and parents for diagnostic procedures.

**60.** The nurse is giving care to an infant with a brain tumor. The nurse observes the infant arch the back (see figure). The nurse should:



- 1. Notify the physician
- 2. Stroke the back to release the arching
- 3. Pad the side rails of the crib
- 4. Place the child prone

**61.** The nurse is assessing a child diagnosed with a brain tumor. Which of the following signs and symptoms should the nurse expect the child to demonstrate? Select all that apply.

- 1. Head tilt.
- 2. Vomiting.
- 3. Polydipsia.
- 4. Lethargy.
- 5. Increased appetite.
- 6. Increased pulse.

**62.** After a child undergoes a craniotomy for an infratentorial brain tumor, the nurse should place the child in which of the following positions to prevent undue strain on the sutures?

- 1. Prone.
- 2. Semi-Fowler's.
- 3. Side-lying.
- 4. Trendelenburg.

**63.** A child who was intubated after a craniotomy now shows signs of decreased level of consciousness. The physician orders manual hyper-ventilation to keep the  $\text{Paco}_2$  between 25 and 29 mm Hg and the  $\text{Pao}_2$  between 80 and 100 mm Hg. The nurse interprets this order based on the understanding that this action will accomplish which of the following?

- 1. Decrease intracranial pressure.
- 2. Ensure a patent airway.
- 3. Lower the arousal level.
- 4. Produce hypoxia.

**64.** Which action should the nurse do **first** when noting clear drainage on the child's dressing and bed linen after a craniotomy for a brain tumor?

- 1. Change the dressing.
- 2. Elevate the head of the bed.
- 3. Test the fluid for glucose.
- 4. Notify the physician.

**65.** An 8-year-old child does well after infratentorial tumor removal and is transferred back to the pediatric unit. Although she had been told about having her head shaved for surgery, she is very upset. After exploring the child's feelings, which action should the nurse take?

- 1. Ask the child if she'd like to wear a hat.
- 2. Reassure the child that her hair will grow back.
- 3. Explain to the child's parents that her reaction is normal.
- 4. Suggest that the parents buy the child a wig as a surprise.

**66.** Which of the following statements made by the mother of a school-age child who has had a craniotomy for a brain tumor would warrant further exploration by the nurse?

- 1. "After this, I'll never let her out of my sight again."
- 2. "I hope that she'll be able to go back to school soon."
- 3. "I wonder how long it will be before she can ride her bike."
- 4. "Her best friend is eager to see her; I hope she won't be upset."

## The Client with a Spinal Cord Injury

**67.** A nurse who witnesses an accident involving an adolescent riding a motorcycle, hitting a tree, and being thrown 30 feet into a field stops to help. The adolescent reports that he is now unable to move his legs. While waiting for the emergency medical service to arrive, what should the nurse do?

- 1. Flex the adolescent's knees to relieve stress on his back.
- 2. Leave the adolescent as he is, staying close by.
- 3. Remove the adolescent's helmet as soon as possible.
- 4. Assess the adolescent for abdominal trauma.

**68.** An adolescent sustains a T3 spinal cord injury. After insertion of an intravenous line, a nasogastric tube, and an indwelling urinary (Foley) catheter, the adolescent is admitted to the intensive care unit. What should the nurse do **next** when assessment reveals that the adolescent's feet and legs are cool to the touch?

- 1. Cover the adolescent's legs with blankets.
- 2. Report this finding to the physician immediately.
- 3. Reposition the adolescent's legs.
- 4. Lay the adolescent flat to aid circulation.

**69.** During assessment of an adolescent who has sustained a recent thoracic spinal injury, the nurse auscultates the adolescent's abdomen. The nurse explains to the parents that this is necessary because clients with spinal cord injury often develop which of the following?

- 1. Abdominal cramping.
- 2. Hyperactive bowel sounds.
- 3. Paralytic ileus.
- 4. Profuse diarrhea.

**70.** Which of the following findings should lead the nurse to decide that spinal shock was resolving in the adolescent with a spinal cord injury?

- 1. Atonic urinary bladder.
- 2. Flaccid paralysis.
- 3. Hyperactive reflexes.
- 4. Widened pulse pressure.

**71.** A school-age boy with a spinal cord injury is moved to the rehabilitation unit. The nurse notes that the child tends to refuse to cooperate in care and to be hostile. The nurse interprets this behavior as indicative of which of the following?

- 1. A stage of grief reaction.
- 2. A phase of rebellion.
- 3. A reaction to sensory overload.
- 4. A response to too much attention.

**72.** Two months after an adolescent's thoracic spinal cord injury, he complains of a pounding headache. The nurse notes that the client's arms and face are flushed and he is diaphoretic. What should the nurse do next?

- 1. Check the patency of the urinary catheter.
- 2. Lower the adolescent's head below his knees.
- 3. Place the adolescent flat on his back.
- 4. Prepare to administer epinephrine subcutaneously.

### Managing Care Quality and Safety

**73.** The nurse is admitting a child who has been diagnosed with bacterial meningitis to the pediatric unit. The nurse should implement which type of isolation?

- 1. Standard precautions.
- 2. Contact precautions.
- 3. Airborne precautions.
- 4. Droplet precautions.

**74.** The nurse manager on a pediatric floor is reviewing national sentinel event alerts and preparing recommendations for the unit. Which strategy would help reduce pediatric medication errors? Select all that apply.

- 1. Eliminate the pediatric satellite pharmacy.
- 2. Increase the steps in the medication administration procedure.
- 3. Utilize only oral syringes to administer oral medication.
- 4. Limit the size of I.V. fluid bags that can be hung on small children.
- 5. Reduce the available concentrations or dose strengths of high alert medications to the minimum.


**75.** The physician orders carbamazepine extended release (Tegretol-XR) for a client with a cerebral palsy who also has a seizure disorder. The client has a gastrostomy feeding tube, and carbamazepine is on the hospital's "no crush" list. In order to administer the medication, the nurse should:

- 1. Cut the medication into four pieces that can be placed in the feeding tube.
- 2. Dissolve the medication in 30 mL's of juice.
- 3. Ask the pharmacist for an oral suspension.
- 4. Contact the primary care provider to change the order.

**76.** When making rounds on the pediatric neurology unit, the nurse manager notes that when giving I.V. medications many of the staff nurses are disconnecting the flush syringe first and then clamping the intermittent infusion device. The nurse is concerned that the nurses do not understand the benefits of positive pressure technique and turbulence flow flush in preventing clots. After discussing the problem with the staff educator which intervention would be the **most** effective way to improve the nursing practice?

- 1. Create a poster presentation on the topic with a required post test.
- 2. Send a group email discussing the importance of clamping the device first.
- 3. Ask each nurse if they are aware that their practice is not current.
- 4. Post an evidence-based article on the unit.

## Answers, Rationales, and Test Taking Strategies


The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Myelomeningocele

**1, 2, 3, 4, 5.** Common shunt complications are obstruction, infection, and disconnection of the tubing. The signs presented by the child indicate increased intracranial pressure from a shunt malformation, which could be caused by an infection, such as peritonitis or meningitis. By listening to bowel sounds, the nurse will note if peritonitis might be a possibility. Palpating the fontanel would indicate increased intracranial pressure if it were bulging and taut. Obtaining vital signs would assess for signs of infection, such as elevated temperature or, possibly, Cushing's triad (elevated blood pressure, slow pulse, and depressed respirations). A high-pitched cry is a sign of increased intracranial pressure. Weighing the child at this time would not be a priority, nor would it add to identifying the cause of the signs and symptoms.

 CN: Physiological adaptation;  
CL: Synthesize


**2. 3.** Before surgery, the infant is kept flat in the prone position to decrease tension on the sac. This allows for optimal positioning of the hips, knees, and feet because orthopedic problems are common. The supine position is unacceptable because it causes pressure on the defect. Flexing the knees when side lying will increase tension on the sac, as will placing the infant in semi-Fowler's position, even though the chest and abdomen are elevated.

 CN: Physiological adaptation;  
CL: Synthesize

**3. 2, 3, 4.** Prevention of urinary tract infections includes adequate fluid intake, urine acidification, frequent emptying of the bladder including the use of the Crede's maneuver if needed. While the nurse should keep the skin clean and dry, this will not prevent urinary tract infections. Keeping urine close to the meatus with a tight-fitting diaper would increase the risk for infection.


 CN: Reduction of risk potential;  
CL: Create

**4. 2.** A Chiari malformation obstructs the flow of cerebral spinal fluid resulting in hydrocephalus. This is a common problem in infants with myelomeningocele and will require surgical intervention with a shunt. A high-pitched cry is one sign of increased intracranial pressure that may indicate the presence of a Chiari malformation and requires further evaluation. Minimal movement of the lower extremities is an expected finding associated with spinal cord damage. Overflow voiding comes from a neurogenic bladder, not increased intracranial pressure. It is normal for the fontanel to bulge with crying.

 CN: Physiological adaptation;  
CL: Analyze

**5. 1.** The parents should see the neonate as soon as possible, because the longer they must wait to see the neonate, the more anxiety they will feel. Because the parents are acutely aware of the deficit, the nurse should emphasize the neonate's normal and positive features during the visit. All parents, but especially those with a child who has a disability or defect, need to hear positive comments and comments that reflect how the infant is normal. Although the parents need to discuss their fears and concerns, the priority on the first visit is to emphasize the neonate's normal and positive features. Reinforcing the doctor's explanation of the defect may be necessary later. Reinforcing the explanation at this initial visit emphasizes the defect, not the child. The parents should spend time with or care for the neonate after birth because parent-infant contact is necessary for attachment. The parents cannot feed the neonate before the defect is repaired because the repair typically occurs within 24 hours. The infant will be prone in an isolette or warmed

and watched closely. However, the parents can fondle and stroke the neonate.

 CN: Psychosocial adaptation;  
CL: Synthesize


**6. 1.** Excessive cerebrospinal fluid in the cranial cavity, called *hydrocephalus*, is the most common anomaly associated with myelomeningocele. Microencephaly, an abnormally small head, is associated with maternal exposure to rubella or cytomegalovirus. Anencephaly, a congenital absence of the cranial vault, is a different type of neural tube defect. Overriding of the sutures, possibly a normal finding after a vaginal delivery, is not associated with myelomeningocele.

 CN: Physiological adaptation; CL: Apply

**7. 1.** Approximately one-third of infants diagnosed with myelomeningocele are mentally retarded, but the degree of retardation is variable and it is difficult to predict intellectual functioning in neonates. The parents are asking for an answer now and should not be told to talk with the physician later.

 CN: Physiological adaptation;  
CL: Synthesize

**8. 2.** The nurse places the neonate with myelomeningocele in an isolette shortly after birth to help to maintain the infant's temperature. Because of the defect, the neonate cannot be bundled in blankets. Therefore, it may be difficult to prevent cold stress. The isolette can be maintained at higher than room temperature, helping to maintain the temperature of a neonate who cannot be dressed or bundled. Body temperature readings, not arterial oxygen levels, are the best indicator. Typically, an infant loses 5% to 10% of body weight before beginning to regain the weight.

 CN: Reduction of risk potential;  
CL: Analyze


**9. 1, 3, 5.** Prior to surgery, the neonate with a myelomeningocele should be placed in a prone position. The feet can hang over the edge of the mattress to prevent foot deformities. The neonate should rest on a soft surface to reduce pressure on the skin; the nurse can use a fleece pad or foam over the mattress. The meningeal sac should not be covered. The hips should be maintained in abduction using a diaper roll or small pillow.

 CN: Basic care and comfort;  
CL: Synthesize

**10. 2.** Because of the potential for hip dislocation, the neonate's legs should be slightly abducted, hips maintained in slight to moderate abduction, and feet maintained in a neutral position. The infant's knees are flexed to help maintain the hips in abduction.

 CN: Reduction of risk potential;  
CL: Synthesize


**11. 3.** In a neonate with open cranial sutures, increasing head circumference is the predominant and earliest sign of increased intracranial pressure and the nurse should report this to the surgeon. Bulging fontanels also are seen. However, some neonates may exhibit bulging fontanels without head enlargement. Seizures and vomiting are associated with hydrocephalus, but most often these are seen in an older child with closed cranial sutures. Shortly after increasing head circumference and bulging fontanels occur, other signs and symptoms, such as frontal bossing or enlargement with depressed eyes and the sunset sign (sclera visible above the iris), may develop. Although irritability is an early sign, a brief, shrill cry is a later sign of increasing intracranial pressure associated with the development of hydrocephalus.

 CN: Physiological adaptation;  
CL: Analyze

**12. 4.** The most important aspect of the discharge plan is to ensure that the parents understand what the daily care of their infant involves and to provide teaching related to carrying out this daily care. In addition to the routine care required by the infant, care also may include physical therapy to the lower extremities. Providing a list of available hospital services may be helpful to the parents, but it is not the most important aspect to include in the discharge plan. Usually, home health care is not needed because the parents are able to care for their child. A referral for counseling is initiated whenever the need arises, not just at discharge.

 CN: Reduction of risk potential;  
CL: Synthesize

**13. 3.** Children with a myelomeningocele are prone to urinary tract infections (UTI) and foul smelling urine is one symptom of a UTI. Because of the level of defect, the child may be insensitive to pressure or heat. Using a heating pad may lead to thermal injury because the child may not be able to sense if the pad is too hot. Keeping the child away from other children is unnecessary and can retard social development. Using pillows as props increases the risk of sudden infant death syndrome.

 CN: Safety and infection control;  
CL: Evaluate


**14. 3.** Children with myelomeningocele are at high risk for development of latex allergy because of repeated exposure to latex products during surgery and bladder catheterizations. Cross-reactions to food items such as bananas, kiwi, milk products, chestnuts, and avocados also occur. These allergic reactions vary in severity ranging from mild (such as sneezing) to severe anaphylaxis. While the child could have allergies to medications that caused the wheezing, the latex and food allergies are more

common. Asking about the skin rash is not a priority when a child is wheezing. Who brought the child to the emergency department is irrelevant at this time.


 CN: Reduction of risk potential;  
CL: Analyze

## The Client with Hydrocephalus

**15. 2.** An infant with hydrocephalus is difficult to feed because of poor sucking, lethargy, and vomiting, which are associated with increased intracranial pressure. Small, frequent feedings given at times when the infant is relaxed and calm are tolerated best. Feeding an infant before any procedure is inappropriate because the stress of the procedure may lead to vomiting. Ideally, the infant should be held in a slightly vertical position when feeding to prevent backflow of formula into the eustachian tubes and subsequent development of ear infections. Most infants are fed on demand every 3 to 4 hours.

 CN: Basic care and comfort;  
CL: Synthesize

**16. 4.** For at least the first 24 hours after insertion of a ventriculoperitoneal shunt, the child is positioned supine with the head of the bed flat to prevent too rapid a decrease in cerebrospinal fluid pressure. Although elevating the head increases cerebrospinal fluid drainage and reduces intracranial pressure, a rapid reduction in the size of the ventricles can cause subdural hematoma. Positioning on the operative or right side is avoided because it places pressure on the shunt valve, possibly blocking desired drainage of the cerebrospinal fluid. Elevating the foot of the bed could increase intracranial pressure. With continued increased intracranial pressure, the child would be positioned with the head of the bed elevated to allow gravity to aid drainage. The child should be kept off the nonoperative side (side opposite the shunt), or the left side, to help prevent rapid decompression leading to a cerebral hematoma.

 CN: Reduction of risk potential;  
CL: Synthesize

**17. 3.** Monitoring the temperature allows the nurse to assess for infection, the most common and most hazardous postoperative complication after ventriculoperitoneal shunt placement. Typically, pain after insertion of a ventriculoperitoneal shunt is mild, requiring the use of mild analgesics. Usually narcotics are not administered because they alter the level of consciousness, making assessment of cerebral function difficult. Neither proteinuria nor glycosuria is associated with shunt placement. Cerebrospinal fluid leakage commonly occurs with head injury. It is not usually associated with shunt placement.

 CN: Reduction of risk potential;  
CL: Synthesize

**18. 4.** In a school-age child, irritability, lethargy, vomiting, difficulty with eating, and decreased level of consciousness are signs of increased intracranial pressure caused by a blocked shunt. Decreased urine output with stable fluid intake indicates fluid loss from a source other than the kidneys. A tense fontanel and increased head circumference would be signs of a blocked shunt in an infant. Elevated temperature and redness around incisions might suggest an infection.

 CN: Reduction of risk potential;  
CL: Evaluate

### The Client with Down Syndrome

**19. 1, 2, 3.** The definition of mental retardation includes deficits in intellectual functioning and behavior. The child's IQ will be 70 or less and he will have difficult learning. The client cannot adapt to situations in a manner consistent with children with higher IQs. The client does not have a normal intellectual capacity to learn and develop from his experiences. The client may have behavioral problems but these are not considered a result of mental retardation.

 CN: Health promotion and maintenance;  
CL: Evaluate

**20. 1.** Watching the child relate to his teacher and school work is the best indication of how he is progressing. School involves interacting with a person who is not a relative and in a situation that is not totally familiar. Observing the client in situations with family and friends shows social relationships but does not indicate how the child is learning new intellectual skills.

 CN: Health promotion and maintenance;  
CL: Evaluate

**21. 1.** The goal in working with mentally retarded children is to train them to be as independent as possible, focusing on developmental skills. The child may not be capable of learning something new every day but needs to repeat what has been taught previously. Rather than encouraging more lenient behavior limits, the parents need to be strict and consistent when setting limits for the child. Most children with Down syndrome are unable to achieve age-appropriate social skills due to their mental retardation. Rather, they are taught socially appropriate behaviors.

 CN: Health promotion and maintenance;  
CL: Synthesize

**22. 4.** Nonthreatening experiences that are stimulating and interesting to the child have been observed to help raise IQ. Practices such as serving


nutritious meals or letting the child play with more able children have not been supported by research as beneficial in increasing intelligence. Vasodilator medications act to increase oxygenation to the tissues, including the brain. However, these medications do not increase the child's IQ.

 CN: Health promotion and maintenance;  
CL: Synthesize

**23. 4.** When teaching the parents of a child with Down syndrome, activities should focus on increasing the parents' confidence in their ability to care for the child. The parents must continue to work daily with their child. Most parents feel affection and a sense of responsibility for their child regardless of the child's limitations. Parents usually understand the child's disability on the cognitive level but have difficulty accepting it on the emotional level. As the parents' confidence in their caring abilities increases, their understanding of the child's disability also increases on all levels.

 CN: Psychosocial adaptation; CL: Create

**24. 4.** When responding to a mother who becomes angry when someone calls her child mentally retarded instead of exceptional, the nurse should give the mother a chance to explore her feelings on the subject. Because the mother obviously has difficulty with the term "retarded," stressing the use of this term would cause further angry feelings. Apologizing, trying to use logic, and defending the comment are not effective ways to handle the situation because the mother's feelings need to be addressed.

 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with a Seizure Disorder

#### 25.

1. Note the time.

3. Ease the child to the floor.

2. Clear the area of potentially harmful objects and pad the head.

4. Roll the child to the side.


The nurse should very quickly check the time the seizure begins to be able to determine its length. Seizure duration will determine the need for immediate additional interventions. Anyone who is standing or sitting needs to be lowered to the floor to prevent a fall injury. The next step is to prevent potential




bodily harm by removing any item in the immediate area that might present a danger and pad the head. Finally, the child should be rolled to the side, if possible, to protect the airway.

 CN: Reduction of risk potential;  
CL: Synthesize

**26. 2.** Diphenylhydantoin (Dilantin) can cause gingival hyperplasia. Children taking Dilantin should brush their teeth after every meal and at bedtime, and visit their dentist on a regular basis. Drinking plenty of fluids is not required while taking Dilantin. A child on Dilantin does not need to be observed during waking hours because the seizures should be under control. Infections do not occur with an increased incidence in clients receiving Dilantin.

 CN: Pharmacological and parenteral therapies; CL: Create


**27. 3.** During a generalized tonic-clonic seizure, the first priority is to keep the child safe and protect the child by removing any nearby objects that could cause injury. Although obtaining information about events surrounding the seizure is important, this information can be obtained later, once the child's safety is ensured. During a seizure, the child should not be moved. Although providing privacy is important, the child's safety is the priority. During a seizure, nothing should be forced into the client's mouth because this can cause severe damage to the teeth and mouth.

 CN: Physiological adaptation;  
CL: Evaluate


**28. 3.** Most children who develop seizures after infancy are intellectually normal. A child with a seizure disorder needs the same experiences and opportunities to develop intellectual, emotional, and social abilities as any other child. Activity limitation is not needed. Learning disabilities are not associated with seizures. The child is able to attend public school, and social stigma is a rarity.

 CN: Health promotion and maintenance;  
CL: Create


**29. 1.** A child who has generalized seizures should not participate in activities that are potentially hazardous. Even if accompanied by a responsible adult, the child could be seriously injured if a seizure were to occur during rock climbing. Someone also should accompany the child during activities in the water. At summer camp, hiking and swimming would occur most commonly as group activities, so someone should be with the child. Tennis would be considered an appropriate, nonhazardous activity for a child with generalized seizures.

 CN: Safety and infection control;  
CL: Synthesize


**30. 4.** Most febrile seizures occur in the presence of an upper respiratory infection, otitis media, or tonsillitis. Febrile seizures typically occur during a temperature rise rather than after prolonged fever. There appears to be increased susceptibility to febrile seizures within families. Infrequently, febrile seizures may lead to respiratory arrest.

 CN: Physiological adaptation;  
CL: Analyze


**31. 2.** Shivering, the body's defense against rapid temperature decrease, results in an increase in body temperature. Therefore the parents need to take measures to stop the shivering (and the resulting increase in body temperature) by increasing the room temperature or the temperature of the child's immediate environment (such as with blankets) until the shivering stops. Then, attempts are made to lower the temperature more slowly. Shivering does not necessarily correlate with being cold. Alcohol, a toxic substance, can be absorbed through the skin. Its use is to be avoided.

 CN: Physiological adaptation;  
CL: Evaluate

**32. 3.** Phenytoin sodium (Dilantin) is a known teratogenic agent, causing numerous fetal problems. Therefore the adolescent should be advised to talk to the doctor about changing the medication. Additionally, anticonvulsant requirements usually increase during pregnancy. Seizures can be controlled but cannot be cured. There is a familial tendency for seizure disorders. Seizure disorders and infertility are not related.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**33. 3.** A toxic effect of valproic acid (Depakene) is liver toxicity, which may manifest with jaundice and abdominal pain. If jaundice occurs, the client needs to notify the health care provider as soon as possible. Diarrhea and sore throat are not common side effects of this drug. Increased appetite is common with this drug.

 CN: Pharmacological and parenteral therapies; CL: Analyze


## The Client with Meningitis

**34. 3.** The current recommendation is that the MCV4 vaccine be given at the earliest opportunity after the age of 11. Therefore, it is quite possible that the client received the vaccine at a previous visit and did not remember. On a college campus, students living in dormitories are at highest risk, but because it is difficult to target that group colleges may elect to require proof of vaccination for


all incoming students. Other risk factors should also be considered, such as if the student plans to travel abroad. The vaccination is typically given as a single injection, but sometimes a second dose is recommended based on risk factors. The MCV4 is not a live vaccine. It may be given during pregnancy if the client is at risk.

 CN: Health promotion and maintenance;  
CL: Synthesize


**35. 2.** A child in the acute stage of meningitis is irritable and hypersensitive to loud noise and light. Therefore, extraneous noise should be minimized and bright lights avoided as much as possible. There is no need to limit conversations with the child. However, the nurse should speak in a calm, gentle, reassuring voice. The child needs gentle and calm bathing. Because of the acuteness of the infection, sponge baths would be more appropriate than tub baths. Although treatments need to be completed as quickly as possible to prevent overstressing the child, they should be performed carefully and at a pace that avoids sudden movements to prevent startling the child and subsequently increasing intracranial pressure.

 CN: Basic care and comfort;  
CL: Synthesize


**36. 1.** Disseminated intravascular coagulation is characterized by skin petechiae and a purpuric skin rash caused by spontaneous bleeding into the tissues. An abnormal coagulation phenomenon causes the condition. Heparin therapy is often used to interrupt the clotting process. Edema would suggest a fluid volume excess. Cyanosis would indicate decreased tissue oxygenation. Dyspnea on exertion would suggest respiratory problems, such as pulmonary edema.

 CN: Physiological adaptation;  
CL: Analyze

**37. 2.** Organisms that cause bacterial meningitis, such as pneumococci or meningococci, are commonly spread in the body by vascular dissemination from a middle ear infection. The meningitis may also be a direct extension from the paranasal and mastoid sinuses. The causative organism is a pneumococcus. A chronically draining ear is also frequently found. Bladder infections commonly are caused by *Escherichia coli*, unrelated to the development of pneumococcal meningitis. Pneumococcal meningitis is unrelated to a fractured clavicle or to septic arthritis, which is commonly caused by *Staphylococcus aureus*, group A streptococci, or *Haemophilus influenzae*.

 CN: Physiological adaptation;  
CL: Analyze

**38. 3.** Preschool-age children worry about having an intact body and become fearful of any threat to body integrity. Allowing the child to participate in required care helps protect her image of an intact body. Development of trust is the task typically associated with infancy. Additionally, allowing the child to apply a dressing over the intravenous insertion site is unrelated to the development of trust. Finding diversional activities is not a priority need for a child in this age group. Separation anxiety is more common in toddlers than in preschoolers.

 CN: Health promotion and maintenance;  
CL: Apply

### 39. 83 mL/hour

$$1,000 \text{ mL} \div 12 \text{ hours} = 83 \text{ mL/hour}$$


 CN: Pharmacological and parenteral therapies; CL: Apply

**40. 3.** The child is angry and needs a positive outlet for expression of feelings. An emotionally tense child with pent-up hostilities needs a physical activity that will release energy and frustration. Pounding on a pegboard offers this opportunity. Listening to a story does not allow the child to express emotions. It also places the child in a passive role and does not allow the child to deal with feelings in a healthy and positive way. Activities such as painting and stacking a tower of blocks require concentration and fine movements, which could add to frustration. However, if the child then knocks the tower over, doing so may help to dispel some of the anger.

 CN: Health promotion and maintenance;  
CL: Synthesize


## The Client with Near-Drowning

**41. 2.** Hypoxia is the primary problem because it results in brain cell damage. Irreversible brain damage occurs after 4 to 6 minutes of submersion. Hypothermia occurs rapidly in infants and children because of their large body surface area. Hypothermia is more of a problem when the child is in cold water. Although fluid aspiration occurs in most drownings and results in atelectasis and pulmonary edema, further aggravating hypoxia, hypoxia is the primary problem. Cutaneous capillary paralysis is not a problem.


 CN: Physiological adaptation;  
CL: Analyze

**42. 1.** Near-drowning victims typically suffer hypoxia and mixed acidosis. The priority is to restore oxygenation and prevent further hypoxia. Here, the client has blunted sensorium, but is not unconscious; therefore, delivery of supplemental

oxygen with a mask is appropriate. Warming protocols and fluid resuscitation will most likely be needed to help correct acidosis, but these interventions are secondary to oxygen administration. Intubation is required if the child is comatose, shows signs of airway compromise, or does not respond adequately to more conservative therapies.

 CN: Physiological adaptation;  
CL: Synthesize

**43. 2.** Guilt is a common parental response. The parents need to be allowed to express their feelings openly in a nonthreatening, nonjudgmental atmosphere. Telling the parents that these things happen does not allow them to verbalize their feelings. Telling the parents that they should not have taken their eyes off the child blames them, possibly further contributing to their guilt. Telling the parents that they shouldn't feel guilty denies the parents' feelings of guilt and is inappropriate. Telling the parents that they are lucky that the child will be okay does not remove the feelings of guilt.

 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Guillain-Barré Syndrome (Infectious Polyneuritis)

**44. 1.** Most children with sore throat have some difficulty swallowing, so it is important for the nurse to determine the extent of difficulty to aid in determining what action is necessary. Typically a sore throat precedes the paralysis of this disorder. Muscle tenderness is an initial symptom. Distal muscle weakness follows proximal muscle weakness, ultimately progressing to paralysis. Diet history and difficulty urinating will not contribute to assessment of the cause of a sore throat or difficulty swallowing. After determining the extent of difficulty swallowing, the nurse can obtain information about exposure to illness.

 CN: Health promotion and maintenance;  
CL: Analyze


**45. 2.** With Guillain-Barré syndrome, progressive ascending paralysis occurs. Therefore, the nurse should assess the child's muscle strength bilaterally to determine the extent of involvement and progression of the illness. Assessing the child's ability to follow simple commands evaluates brain function. Range-of-motion exercises are an important part of treatment, but they are not a priority initially. Although the child may need diversional activities later, they also are not an initial priority.

 CN: Physiological adaptation;  
CL: Synthesize


**46. 3.** In a child with Guillain-Barré syndrome, decreased volume and clarity of speech and decreased ability to cough voluntarily indicate ascending progression of neural inflammation, specifically affecting the cranial nerves. Inflammation of the larynx and epiglottis is manifested by hoarseness, stridor, and dyspnea. A child with laryngeal inflammation still retains the ability to cough. Irritability, behavior changes, headache, and vomiting are common signs of increased intracranial pressure in a school-age child. Regression would be manifested by being more dependent and less able to care for self.

 CN: Physiological adaptation; CL: Apply

**47. 2.** *Ineffective breathing pattern* caused by the ascending paralysis of the disorder interferes with the child's ability to maintain an adequate oxygen supply. Therefore, this nursing diagnosis takes precedence. Additionally, as the neurologic impairment progresses, it will probably have an effect on the child's ability to maintain respirations. *Risk for infection* related to an altered immune system is not involved with Guillain-Barré syndrome. Although impaired swallowing and incontinence may occur with the ascending paralysis of this disorder, oxygenation is the priority.


 CN: Physiological adaptation;  
CL: Analyze

**48. 4.** Even in the absence of respiratory problems or distress, the child must be turned frequently to help prevent the cardiopulmonary complications associated with immobility, such as atelectasis and pneumonia. Maintaining the child in a supine position is unnecessary. Doing so does not prevent unnecessary nerve stimulation. In addition, maintaining a supine position may lead to stasis of secretions, placing the child at risk for pneumonia. Transferring the child to a chair will not prevent postural hypotension. However, doing so will increase vascular tone and help prevent respiratory and skin complications. During the acute disease phase, vigorous physiotherapy is contraindicated because the child may experience muscle pain and be hypersensitive to touch. Careful and gentle handling is essential.

 CN: Physiological adaptation;  
CL: Synthesize

**49. 3.** Developmentally appropriate activities and therapeutic play should be used as rehabilitation modalities. Taking the child to the pool to exercise with other children indicates that the child is participating in exercise as well as engaging with other children, thus fostering development. Arguing with the sister does not address the discharge plan. Inappropriate rewards or threats should not be used

to coerce a child into compliance. Although the mother is attempting to comply with the discharge plan, bribery is an inappropriate technique to foster compliance. Missing therapy sessions delays recovery. The parents need to help set the child's schedule to ensure that she gets adequate rest to be able to follow her treatment plan.


 CN: Physiological adaptation;  
CL: Evaluate

### The Client with a Head Injury


**50. 2.** For the child with serious head trauma, a nasogastric tube is inserted initially to decompress the stomach and to prevent vomiting and aspiration. Medications would be administered intravenously in the initial period. The tube will not be used to obtain gastric specimens. Nutrition is not a priority initially. Later on, the tube may be used to administer feedings.

 CN: Reduction of risk potential;  
CL: Apply

**51. 1.** Because a basilar skull fracture can involve the frontal and ethmoid bones, inserting a nasogastric tube carries the risk of introducing the tube into the cranial cavity through the fracture. An oral gastric tube is preferred for a client with a basilar skull fracture. The tube would not be placed into the duodenum. Gastric aspirate is not routinely tested for blood unless there is an indication to suggest bleeding, such as a falling hemoglobin or visible blood in the drainage.

 CN: Reduction of risk potential;  
CL: Synthesize

**52. 3.** As a rule, children demonstrate more rapid and more complete recovery from coma than do adults. However, it is extremely difficult to predict a specific outcome. Reassuring the parents that they will be kept informed helps open lines of communication and establish trust. Telling the parents that children do not do well would be extremely negative, destroying any hope that the parents might have. Telling the parents that children recover rapidly may give the parents false hopes. Telling the parents to talk to the doctor ignores the parents' concerns and interferes with trust-building.


 CN: Physiological adaptation;  
CL: Synthesize

**53. 2.** The level of consciousness (LOC) is the best indicator of brain function. If the child's condition deteriorates, the nurse would notice changes in LOC before any other changes and should notify the physician that these changes are occurring. Changes


in vital signs and pupils typically follow changes in LOC. Motor strength is primarily assessed as a voluntary function. With changes in levels of consciousness there may be motor changes.

 CN: Physiological adaptation; CL: Apply

**54. 2.** The unconscious child is positioned to prevent aspiration of saliva and minimize intracranial pressure. The head of the bed should be elevated, and the child should be in either the semi-prone or the side-lying position. Lying prone with hips and knees slightly elevated increases intracranial pressure, as does lying on the back in the Trendelenburg position. The semi-Fowler's position with arms at the side is not the best choice.


 CN: Physiological adaptation;  
CL: Synthesize

**55. 3.** Mannitol is an osmotic diuretic used to reduce intracranial pressure. The use of the drug is controversial and should be reserved to cases which do not respond to other treatments or when brain herniation is likely. Children this sick should be on intracranial pressure (ICP) monitoring. The best indicator that the drug has produced the desired results is a reduction in the ICP. Improved levels of consciousness should follow reduced ICP. While the drug will cause increased urine output, that measurement in and of itself does not indicate successful treatment. Because the drug is being used for head injuries, not to improve urine output in acute renal failure, the child may not have visible edema.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

### The Client with a Brain Tumor


**56. 2.** A decreasing level of consciousness, decerebrate positioning, or Cushing's triad (elevated systolic blood pressure, decreased pulse, and decreased respiratory rate) indicates that there is pressure on the brain stem and the client could require intubation and cardiac resuscitation unless the physician can order a medication or surgical procedure to reduce the intracranial pressure. Raising the head of the bed could offer some reduction in the intracranial pressure by increasing venous blood return from the head, but it is not the priority at this time. An analgesic administered at this time would mask the sign of decreasing level of consciousness and hinder assessment. An oximeter would measure the oxygen level in the blood, but not necessarily in the brain.

 CN: Physiological adaptation;  
CL: Synthesize


**57. 1.** This client is experiencing neurological changes consistent with increasing intracranial pressure (ICP). The nurse should first notify the physician. The physician may intubate the child to ensure a patent airway. The nurse should not lower the head of the bed as this will cause increased ICP. The nurse should ensure an adequate fluid balance. The physician will likely order hypertonic saline to draw fluid from the brain.

 CN: Management of care; CL: Synthesize

**58. 3.** A child who has symptoms of vomiting, headaches, and problems walking needs to be evaluated by a health care provider to determine the cause. Unexplained headaches and vomiting along with complaints of difficulty walking (e.g., ataxia) may suggest a brain tumor. Evaluation by an eye doctor would be appropriate once a complete medical evaluation has been accomplished. Psychological counseling may be indicated for this adolescent, but only after medical evaluation to determine that she is physically healthy. Meeting with the child's teachers would be appropriate after medical evaluation.

 CN: Physiological adaptation;  
CL: Synthesize

**59. 4.** When a brain tumor is suspected, the child and parents are likely to be very apprehensive and anxious. It is unrealistic to expect to eliminate their fears; rather, the nurse's goal is to decrease them. Preparing both the child and family during hospitalization can help them cope with some of their fears. Although the nurse may be able to decrease some of the child's anxiety, it would be impossible to eliminate it. Children with infratentorial tumors seldom have seizures, so seizure precautions are not indicated. Although introducing the child to other children is a positive action, this action would be more appropriate once the nurse has decreased some of the child's and parents' anxiety by preparing them.

 CN: Psychosocial adaptation;  
CL: Synthesize

**60. 1.** The infant has opisthotonos, an indication of brain stem herniation; the nurse should notify the physician immediately and have resuscitation equipment ready. Stroking the back will not relieve the herniation or release the arching. Although the infant may also have a seizure, and padded side rails will prevent injury, the first action is to notify the physician. Placing the child in a prone position will not relieve the herniation or release the arching.


 CN: Management of care; CL: Synthesize

**61. 1, 2, 4.** Head tilt, vomiting, and lethargy are classic signs assessed in a child with a brain tumor. Clinical manifestations are the result of location and size of the tumor. Polydipsia is rare with a brain

tumor. It is more often a sign of diabetes insipidus following a closed head injury. Increased appetite occurs during a growth spurt and is not necessarily a sign of a brain tumor. Increased pulse is a nonspecific sign and can occur with many illnesses, cardiac anomalies, fever, or exercise.

 CN: Physiological adaptation;  
CL: Analyze

**62. 3.** After surgery for an infratentorial tumor, the child is usually positioned flat on either side, with the head and neck in midline and the body slightly extended. Pillows against the back, not the head, help maintain position. Such a position helps avoid pressure on the operative site. Placing the child in a prone or semi-Fowler's position will cause pressure on the operative site. The Trendelenburg position is usually contraindicated because keeping the head below the level of the heart increases intracranial pressure as well as the risk of hemorrhage.

 CN: Physiological adaptation;  
CL: Synthesize

**63. 1.** Hypercapnia, hypoxia, and acidosis are potent cerebral vasodilating mechanisms that can cause increased intracranial pressure. Lowering the carbon dioxide level and increasing the oxygen level through hyperventilation is the most effective short-term method of reducing intracranial pressure. Although ensuring a patent airway is important, this is not accomplished by manual hyperventilation. Manual hyperventilation does not lower the arousal level; in fact, the arousal level may increase. Manual hyperventilation is used to reduce hypoxia, not produce it.


 CN: Reduction of risk potential;  
CL: Evaluate

**64. 3.** Glucose in this clear, colorless fluid indicates the presence of cerebrospinal fluid. Excessive fluid leakage should be reported to the physician. The nurse should not change the dressing of a postoperative craniotomy client unless instructed to do so by the surgeon. Ordinarily, the head of the bed would not be elevated because this would put pressure on the sutures. The nurse should notify the physician after testing the fluid for glucose.


 CN: Reduction of risk potential;  
CL: Synthesize

**65. 1.** It is not uncommon for a child to be concerned about a change in appearance when the entire head or only part of the head has been shaved. The child should be encouraged to participate in decisions about her care when possible. Asking her if she would like to wear a hat is one way to encourage this participation. Reassuring the child that her hair will grow back does not address the

immediate change in appearance, and it ignores the child's current feelings. Explaining that this type of reaction is normal does not address the child's feelings. The child needs to be able to express feelings and be involved in care as much as possible. Buying the child a wig as a surprise does not address the child's feelings and does not allow her to participate in decision making. Rather, the parents should ask the child if she would like a wig and then work with the child to determine what kind of wig she would like.

 CN: Psychosocial adaptation;  
CL: Synthesize

**66. 1.** Parents of a child who has undergone neurosurgery can easily become overprotective. Yet the parents must foster independence in the convalescing child. It is important for the child to resume age-appropriate activities, and parents play an important role in encouraging this. Statements about going back to school would be expected. Parents want the child to return to normal activities after a serious illness or injury as a sign that the child is doing well.


 CN: Psychosocial adaptation;  
CL: Evaluate

### The Client with a Spinal Cord Injury

**67. 2.** The adolescent's signs and symptoms suggest a spinal cord injury. A client with suspected spinal cord injury should not be moved until the spine has been immobilized. Removing the helmet could further aggravate a spinal cord injury. The nurse could assess for abdominal trauma, but only if it can be done without moving the adolescent.


 CN: Reduction of risk potential;  
CL: Synthesize

**68. 1.** In spinal cord injury, temperature regulation is lost below T3. Body temperature must be maintained by adjusting room temperature or bed linens, such as covering the client's legs with blankets. Coolness of the extremities is an expected finding. Therefore, it is not necessary to notify the physician immediately. Repositioning the client's legs does not alleviate the temperature regulation problem and could be harmful, considering the client's diagnosis. Moving the legs before the spine is stabilized could lead to further cord damage. Laying the client flat will not increase the warmth to the legs and feet.


 CN: Physiological adaptation;  
CL: Synthesize

**69. 3.** A thoracic spinal cord injury involves the muscles of the lower extremities, bladder, and rectum. Paralytic ileus often occurs as a result of


decreased gastrointestinal muscle innervation. The nurse evaluates this by auscultating the abdomen. Because the client has a thoracic spinal cord injury, the client may not feel abdominal cramping. Additionally, auscultation would provide no evidence of cramping. Hyperactive bowel sounds would be evidenced with increased peristalsis; peristalsis would probably be diminished with this injury. Profuse diarrhea, resulting from increased peristalsis, would not be an expected finding. Diarrhea would be more commonly associated with a gastrointestinal infection.

 CN: Physiological adaptation;  
CL: Analyze


**70. 3.** Spinal shock causes a loss of reflex activity below the level of the injury, resulting in bladder atony and flaccid paralysis. When the reflex arc returns, it tends to be overactive, resulting in spasticity. The reflexes and bladder becomes hypertonic during this phase of spinal shock resolution; sensation does not return. A widened pulse pressure is not associated with resolution of spinal shock.

 CN: Physiological adaptation;  
CL: Evaluate

**71. 1.** After a catastrophic injury, individuals commonly experience grief. Initially, the person experiences denial, the most common response. With gradual awareness of the situation, anger commonly occurs. The child is demonstrating anger, not rebellion, as he gradually becomes aware of his situation. Rebellion is the child's way to maintain autonomy and individuality. It is a reaction to rigid rules. Examples include refusing to follow a treatment protocol when the child had no input and running away. Sensory overload would cause the child to be irritable and tired and to have difficulty sleeping. Too much attention usually would lead to irritability, difficulty sleeping, and mood swings.


 CN: Psychosocial adaptation;  
CL: Analyze

**72. 1.** The adolescent is exhibiting signs of autonomic dysreflexia, a generalized sympathetic response usually caused by bladder or bowel distention. Immediate treatment involves eliminating the cause. Because bladder distention is a common cause of this problem, the nurse should immediately determine the patency of the indwelling (Foley) catheter. Lowering the head below the knees would increase the blood pressure and is contraindicated because of the spinal cord injury. Lying flat will not decrease blood pressure. Epinephrine is contraindicated because it elevates blood pressure and therefore can exacerbate the problem.

 CN: Physiological adaptation;  
CL: Synthesize


## Managing Care Quality and Safety

**73. 4.** Bacterial meningitis is caused by one of three organisms, *Haemophilus influenzae* type b, *Neisseria meningitidis*, or *Streptococcus pneumoniae*. All three organisms may be transmitted through contact with respiratory droplets. These droplets are heavy and typically fall within 3 feet of the client. Droplet precautions require, in addition to standard precautions, that health care providers wear masks when coming into close contact with the client. Standard precautions, previously referred to as universal precautions, are general measures used for all clients. Contact precautions are used when direct or indirect contact with the client causes disease transmission. Gowns and gloves are needed but not masks. Airborne precautions differ from droplet in that the particles are smaller and may stay suspended in the air for longer periods of time. These clients require negative pressure rooms and all health care workers must wear respirators.


 CN: Safety and infection control;  
CL: Apply

**74. 3, 4, 5.** Using only oral syringes to administer oral medications reduces the chance that the medication will be given intravenously. The use of smart pumps alone is not enough to prevent I.V. fluid administration. An additional measure pediatric floors can institute to prevent accidental fluid overload is to use smaller I.V. fluid bags, such as 250 mL. Whenever a medication comes in multiple concentrations and doses, there is risk of administering the wrong dose. The use of pediatric satellite pharmacies with pediatric pharmacists greatly

increases the safety of medication administration. Any time steps are added to the medication administration process there is one more place where an error might occur.

 CN: Safety and infection control;  
CL: Synthesize

**75. 4.** The coating on an extended release medication helps assure slow absorption of the medication. If the nurse crushes the medication, the medication may enter the client's system too quickly and result in toxic levels. The only appropriate action is to contact the prescriber and ask that the order be changed. Cutting the medication or trying to dissolve a whole tablet would have similar results as crushing it. Carbamazepine comes as an oral suspension, but it is not extended release. Therefore, an order would be needed to address dosing if switching to this form.

 CN: Safety and infection control;  
CL: Synthesize

**76. 1.** A poster presentation is an eye-catching way to disseminate information that can be used to educate nurses on all shifts. The addition of the post test will verify that the poster information has been received. Because of the large volume of emails the typical employee receives, information sent this way may be overlooked. If several nurses are observed not using the most current practice, it is quite possible many more do not understand it. Thus, a larger scale plan is needed. Posting an article will not alone assure that the information is read.

 CN: Reduction of risk potential;  
CL: Create

TEST  
8

## The Child with Musculoskeletal Health Problems

- The Client with Torticollis, Legg-Calvé-Perthes Disease and Musculoskeletal Dysfunction
- The Client with Cerebral Palsy
- The Client with Duchenne Muscular Dystrophy
- The Client with Developmental Dysplasia of the Hip
- The Client with Congenital Clubfoot
- The Client with Juvenile Idiopathic Arthritis
- The Client with a Fracture
- The Client with Osteomyelitis
- The Client with Scoliosis
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Torticollis, Legg-Calvé-Perthes Disease and Musculoskeletal Dysfunction

1. In planning the discharge for a newborn diagnosed with torticollis (wry neck), the nurse should:

- 1. Teach the parent the side effects of botulinum toxin (BOTOX).
- 2. Coordinate outpatient physical therapy.
- 3. Verify the date for corrective surgery.
- 4. Demonstrate the use of positioning wedges for sleep.

2. A child who limps and has pain has been found to have Legg-Calvé-Perthes disease. What should the nurse expect to include in the child's plan of care?

- 1. Initiation of pain control measures, especially at night when acute.
- 2. Promotion of ambulation despite child's discomfort in the affected hip.
- 3. Prevention of flexion in the affected hip and knee.
- 4. Avoidance of weight bearing on the head of the affected femur.

3. When planning home care for the child with Legg-Calvé-Perthes disease, what should be the **primary** focus for family teaching?

- 1. Need for intake of protein-rich foods.
- 2. Gentle stretching exercises for both legs.
- 3. Management of the corrective appliance.
- 4. Relaxation techniques for pain control.

4. At the 2 week well-child visit a parent states, "My baby seems to keep his head tilted to the right." The nurse should further assess the:

- 1. Fontanel.
- 2. Cervical vertebrae.
- 3. Trapezius muscle.
- 4. Sternocleidomastoid muscle.

5. An adolescent tells the nurse that the area below his knee has been hurting for several weeks. The nurse should obtain history information about participation in which of the following?

- 1. Soccer.
- 2. Golf.
- 3. Diving.
- 4. Swimming.

6. An adolescent is on the football team and practices in the morning and afternoon before school starts for the year. The temperature on the field has been high. The school nurse has been called to the practice field because the adolescent is now reporting that he has muscle cramps, nausea, and dizziness. Which of the following actions should the school nurse do **first**?

- 1. Administer cold water with ice cubes.
- 2. Take the adolescent's temperature.
- 3. Have the adolescent go to the swimming pool.
- 4. Move the adolescent to a cool environment.



## The Client with Cerebral Palsy

**7.** During a developmental screening, the nurse finds that a 3-year-old child with cerebral palsy has arrested social and language development. The nurse tells the family:

- 1. "This is a sign the cerebral palsy is progressing."
- 2. "Your child has reached his maximum language abilities."
- 3. "I need to refer you for more developmental testing."
- 4. "We need to modify your therapy plan."

**8.** A child with spastic cerebral palsy is to begin botulinum toxin type A (Botox) injections. Which treatment goals should the health care team set for the child related to Botox? Select all that apply.

- 1. Improved nutritional status.
- 2. Decreased pain from spasticity.
- 3. Improved motor function.
- 4. Enhanced self-esteem.
- 5. Reduced caregiver strain and improved self-care.
- 6. Decreased speech impediments.

**9.** The nurse judges that the mother understands the term cerebral palsy when she describes it as a term applied to impaired movement resulting from which of the following?

- 1. Injury to the cerebrum caused by viral infection.
- 2. Malformed blood vessels in the ventricles caused by inheritance.
- 3. Nonprogressive brain damage caused by injury.
- 4. Inflammatory brain disease caused by metabolic imbalances.

**10.** When assessing the development of a 15-month-old child with cerebral palsy, which of the following milestones should the nurse expect a toddler of this age to have achieved?

- 1. Walking up steps.
- 2. Using a spoon.
- 3. Copying a circle.
- 4. Putting a block in cup.

**11.** The parent of a child with spastic cerebral palsy and a communication disorder tells the nurse, "He seems so restless. I think he is in pain." The nurse should:

- 1. Assess the child for pain using the Faces, Legs, Activity, Cry, Consolability (FLACC) scale.
- 2. Assess the child using the pediatric FACES scale.
- 3. Administer the pain medication which is ordered to be given as needed and assess the response.
- 4. Notify the primary care provider of the change in behavior.

**12.** The mother asks the nurse whether her child with hemiparesis due to spastic cerebral palsy will be able to walk normally because he can pull himself to a standing position. Which of the following responses by the nurse would be **most** appropriate?

- 1. "Ask the doctor what he thinks at your next appointment."
- 2. "Maybe, maybe not. How old were you when you first walked?"
- 3. "It's difficult to predict, but his ability to bear weight is a positive factor."
- 4. "If he really wants to walk, and works hard, he probably will eventually."

**13.** The nurse assesses the family's ability to cope with the child's cerebral palsy. Which action should alert the nurse to the possibility of their inability to cope with the disease?

- 1. Limiting interaction with extended family and friends.
- 2. Learning measures to meet the child's physical needs.
- 3. Requesting teaching about cerebral palsy in general.
- 4. Not seeking financial help to pay for medical bills.

## The Client with Duchenne's Muscular Dystrophy

**14.** The mother of a child with Duchenne's muscular dystrophy asks about the chance that her next child will have the disease. The nurse responds based on the understanding of which of the following?

- 1. Sons have a 50% chance of being affected.
- 2. Daughters have a 1 in 4 chance of being carriers.
- 3. Each child has a 1 in 4 chance of developing the disease.
- 4. Each child has a 50% chance of being a carrier.

**15.** A nurse is making an initial visit to a family with a 3-year-old child with early Duchenne's muscular dystrophy. Which of the following findings is expected when assessing this child?

- 1. Contractures of the large joints.
- 2. Enlarged calf muscles.
- 3. Difficulty riding a tricycle.
- 4. Small, weak muscles.

**16.** The nurse observes as a child with Duchenne's muscular dystrophy attempts to rise from a sitting position on the floor. After attaining a kneeling position, the child "walks" his hands up his legs to stand. The nurse documents this as which of the following?

- 1. Galeazzi's sign.
- 2. Goodell's sign.
- 3. Goodenough's sign.
- 4. Gower's sign.

**17.** When developing the plan of care for a child with early Duchenne’s muscular dystrophy, which of the following nursing goals is the priority?

- 1. Encouraging early wheelchair use.
- 2. Fostering social interactions.
- 3. Maintaining function of unaffected muscles.
- 4. Prevent circulatory impairment.

**18.** When interacting with the mother of a child who has Duchenne’s muscular dystrophy, the nurse observes behavior indicating that the mother may feel guilty about her child’s condition. The nurse interprets this behavior as guilt stemming from which of the following?

- 1. The terminal nature of the disease.
- 2. The dependent behavior of the child.
- 3. The genetic mode of transmission.
- 4. The sudden onset of the disease.

**19.** The nurse teaches the mother of a young child with Duchenne’s muscular dystrophy about the disease and its management. Which of the following statements by the mother indicates successful teaching?

- 1. “My son will probably be unable to walk independently by the time he is 9 to 11 years old.”
- 2. “Muscle relaxants are effective for some children; I hope they can help my son.”
- 3. “When my son is a little older, he can have surgery to improve his ability to walk.”
- 4. “I need to help my son be as active as possible to prevent progression of the disease.”

### The Client with Developmental Dysplasia of the Hip

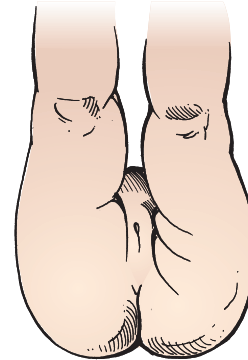
**20.** The nurse is examining an infant for hip placement and has abducted her flexed legs. The nurse should **next**:

- 1. Rotate the hips.
- 2. Extend the legs.
- 3. Listen for a “click.”
- 4. Palpate the hips for a mass.

**21.** A 16-month-old child is seen in the clinic for a checkup for the first time. The nurse notices that the toddler limps when walking. Which of the following would be appropriate to use when assessing this toddler for developmental dysplasia of the hip?

- 1. Ortolani’s maneuver.
- 2. Barlow’s maneuver.
- 3. Adam’s position.
- 4. Trendelenburg’s sign.

**22.** The nurse is assessing the infant shown in the figure. On observing the client from this angle, the nurse should document that this infant has which of the following?



- 1. Ortolani’s “click.”
- 2. Limited abduction.
- 3. Galeazzi’s sign.
- 4. Asymmetric gluteal folds.

**23.** The nurse teaches the parents of an infant with developmental dysplasia of the hip how to handle their child in a Pavlik harness. Which of the following is **most** appropriate?

- 1. Fitting the diaper under the straps.
- 2. Leaving the harness off while the infant sleeps.
- 3. Checking for skin redness under straps every other day.
- 4. Putting powder on the skin under the straps every day.

**24.** When developing the teaching plan for parents using the Pavlik harness with their child, what should be the nurse’s **initial** step?

- 1. Assessing the parents’ current coping strategies.
- 2. Determining the parents’ knowledge about the device.
- 3. Providing the parents with written instructions.
- 4. Giving the parents a list of community resources.

**25.** When teaching the family of an older infant who has had a hip spica cast applied for developmental dysplasia of the hip, which information should the nurse include when describing the abduction stabilizer bar?

- 1. It can be adjusted to a position of comfort.
- 2. It is used to lift the child.
- 3. It adds strength to the cast.
- 4. It is necessary to turn the child.

**26.** The mother asks the nurse about using a car seat for her toddler who is in a hip spica cast. The nurse should tell the mother:

- 1. "You can use a seat belt because of the spica cast."
- 2. "You will need a specially designed car seat for your toddler."
- 3. "You can still use the car seat you already have."
- 4. "You'll need to get a special release from the police so that a car seat won't be needed."

### The Client with Congenital Clubfoot

**27.** The nurse is discharging a baby with clubfoot who has had a cast applied. The nurse should provide additional teaching to the parents if they state:

- 1. "I should call if I see changes in the color of the toes under the cast."
- 2. "I should use a pillow to elevate my child's foot as he sleeps."
- 3. "My baby will need a series of casts to fix her foot."
- 4. "Having a cast should not prevent me from holding my baby."

**28.** The parents of a neonate born with congenital clubfoot express feelings of helplessness and guilt, exhibiting anxiety about how the neonate will be treated. Which of the following actions by the nurse would be **most** appropriate initially?

- 1. Ask them to share these concerns with the physician.
- 2. Arrange a meeting with other parents whose infants have had successful clubfoot treatment.
- 3. Discuss the problem with the parents and the current feelings that they are experiencing.
- 4. Suggest that they make an appointment to talk things over with a counselor.

**29.** After teaching the parents of an infant with clubfoot requiring application of a plaster cast how to care for the cast, which of the following statements would indicate that the parents have understood the teaching?

- 1. "If the cast becomes soiled, we'll clean it with soap and water."
- 2. "We'll elevate the leg with the cast on pillows, so the leg is above heart level."
- 3. "We will check the color and temperature of the toes of the casted leg frequently."
- 4. "The petals on the edge of the cast can be removed after the first 24 hours."

### The Client with Juvenile Idiopathic Arthritis

**30.** The father of a preschool-age child with a tentative diagnosis of juvenile idiopathic arthritis (JIA) asks about a test to definitively diagnose JIA. The nurse's response is based on knowledge of which of the following?

- 1. The latex fixation test is diagnostic.
- 2. An increased erythrocyte sedimentation rate is diagnostic.
- 3. A positive synovial fluid culture is diagnostic.
- 4. No specific laboratory test is diagnostic.

**31.** The parents of a child just diagnosed with juvenile idiopathic arthritis (JIA) tell the nurse that the diagnosis frightens them because they know nothing about the prognosis. What should the nurse include when teaching the parents about the disease?

- 1. Half of affected children recover without joint deformity.
- 2. Many affected children go into long remissions but have severe deformities.
- 3. The disease usually progresses to crippling rheumatoid arthritis.
- 4. Most affected children recover completely within a few years.

**32.** The mother of a 4-year-old child with juvenile idiopathic arthritis (JIA) is worried that her child will have to stop attending preschool because of the illness. Which of the following responses by the nurse would be **most** appropriate?

- 1. "It may be difficult for your child to attend school because of the side effects of the medications he will be prescribed."
- 2. "Your child should be encouraged to attend school, but he'll need extra time to work out early morning stiffness."
- 3. "You should keep your child at home from school whenever he experiences discomfort or pain in his joints."
- 4. "Your child will probably need to wear splints and braces so that his joints will be supported properly."

**33.** A preschool-age child with juvenile idiopathic arthritis (JIA) has become withdrawn, and the mother asks the nurse what she should do. Which of the following suggestions by the nurse would be **most** appropriate?

- 1. Introduce the child to other children her age who also have JIA.
- 2. Tell the mother to spend extra time with the child and less time with her other children.
- 3. Recommend that the mother send the child to see a counselor for therapy.
- 4. Encourage the mother to be supportive and understanding of the child.

**34.** Nonsteroidal anti-inflammatory drugs are the first choice in treating a child with juvenile idiopathic arthritis. Which adverse effects should the nurse include in the teaching plan for the parents? Select all that apply.

- 1. Weight gain.
- 2. Abdominal pain.
- 3. Blood in the stool.
- 4. Folic acid deficiency.
- 5. Reduced blood clotting ability.

**35.** What should the nurse include when developing the teaching plan for the parents of a child with juvenile idiopathic arthritis who is being treated with naproxen (Naprosyn)?

- 1. Anti-inflammatory effect will occur in approximately 8 weeks.
- 2. Within 24 hours, the child will have anti-inflammatory relief.
- 3. The nurse should be called before giving the child any over-the-counter medications.
- 4. If a dose is forgotten or missed, that dose is not made up.

### The Client with a Fracture

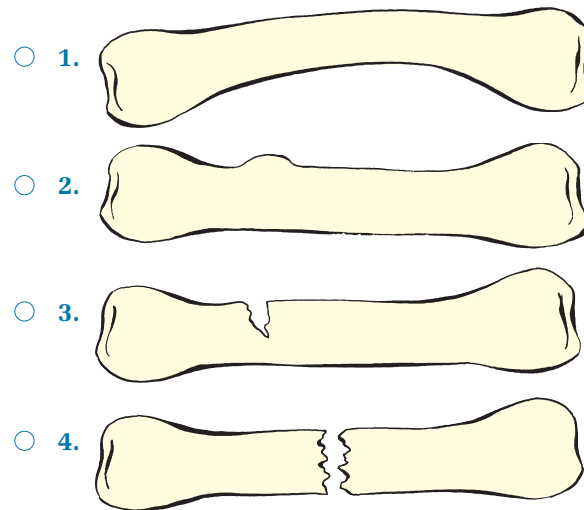
**36.** A 10-year-old has 5 lb of Buck's extension traction on his left leg. The nurse should assess the child for which of the following? Select all that apply.

- 1. Dryness of the skin, by removing the foam wraps and boot.
- 2. Alignment of the shoulder, hips, and knees.
- 3. Frayed rope near pulleys.
- 4. Correct amount of traction weight on fracture.
- 5. Pressure on the coccyx.

**37.** A 14-year-old has just had a plaster cast placed on his lower left leg. To provide safe cast care, the nurse should?

- 1. Petal the cast as soon as it is put on.
- 2. Keep the child in the same position for 24 hours until the cast is dry.
- 3. Use only the palms of the hand when handling the cast.
- 4. Notify the physician if the client complains of heat.

**38.** The nurse is explaining the nature of the fracture to the parents of a 10-year-old who has a greenstick fracture. Which drawing should the nurse choose to explain the fracture to the parents?



**39.** A 9-year-old is given morphine for postoperative pain. As the nurse is assessing the client for pain 4 hours later, his mother leaves the room and the child begins to cry. The nurse's initial assessment of the child's pain is that he is:

- 1. Not in pain because the crying began after the mother leaves.
- 2. Less tolerant of pain because he is upset.
- 3. In pain because he is crying.
- 4. Not in pain because he was medicated 4 hours ago.

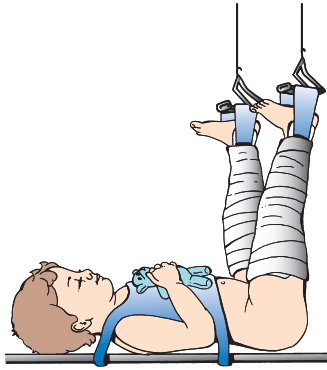
**40.** A 12-year-old is having surgery to repair a fractured left femur. As a part of the preoperative safety procedures, the nurse should ask the client to:

- 1. Point to the area of the fracture.
- 2. Mark the location of the fracture with an "x" and sign his name.
- 3. Confirm with his parents that they have signed the operative permit.
- 4. State the surgery risks as understood from the surgeon.

**41.** A child is admitted with a fracture of the femur and placed in skeletal traction. What should the nurse assess **first**?

- 1. The pull of traction on the pin.
- 2. The Ace bandage.
- 3. The pin sites for signs of infection.
- 4. The dressings for tightness.

**42.** The nurse is caring for a child in Bryant's traction (see figure). The nurse should:



- 1. Adjust the weights on the legs until the buttocks rest on the bed.
- 2. Provide frequent skin care.
- 3. Place a pillow under the buttocks.
- 4. Remove the elastic leg wraps every 8 hours for 10 minutes.

**43.** A preschooler with a fractured femur of the left leg in traction tells the nurse that his leg hurts. It is too early for pain medication. The nurse should:

- 1. Place a pillow under the child's buttocks to provide support.
- 2. Remove the weight from the left leg.
- 3. Assess the feet for signs of neurovascular impairment.
- 4. Reposition the pulleys so the traction is looser.

**44.** The nurse in the emergency department is caring for a 3-year-old child with a fractured humerus. The child is crying and screaming, "I hate you." Which of the following would be **most** appropriate?

- 1. Tell the parents they will need to wait out in the lobby.
- 2. Ask the charge nurse to assign this client to another nurse.
- 3. Reassure the parents that this is a normal behavior under the circumstances.
- 4. Ask the parents to discipline the child so that the physician can treat her.

**45.** After a plaster cast has been applied to the arm of a child with a fractured right humerus, the nurse completes discharge teaching. The nurse should evaluate the teaching as successful when the mother agrees to seek medical advice if the child experiences which of the following?

- 1. Inability to extend the fingers on the right hand.
- 2. Vomiting after the cast is applied.
- 3. Coolness and dampness of the cast after 5 hours.
- 4. Fussiness with complaints that the cast is heavy.

**46.** The nurse should teach the mother of a child who has a new cast for a fractured radius to do which of the following for the first few days at home?

- 1. Use a hair dryer to dry the cast more quickly.
- 2. Have the child refrain from strenuous activities.
- 3. Check movement and sensation of the child's fingers once a day.
- 4. Administer acetaminophen every 8 to 12 hours for discomfort.

**47.** While assessing a 3-year-old child who has had an injury to the leg, has pain, and refuses to walk, the nurse notes that the child's left thigh is swollen. What should the nurse do **next**?

- 1. Assess the neurologic status of the toes.
- 2. Determine the circulatory status of the upper thigh.
- 3. Obtain the child's vital signs.
- 4. Notify the physician immediately.

**48.** Anticipating that a 3-year-old child in traction will have need for diversion, what should the nurse offer the child? Synthesize

- 1. A video game.
- 2. Blocks.
- 3. Hand puppets.
- 4. Marbles.

**49.** The parents of a child who requires skeletal traction are unable to visit their child for more than 1 hour a day because there are five other children at home and both parents work outside of the home. The nurse recognizes expressions of guilt in both parents. To help alleviate this guilt, the nurse should make which of the following remarks?

- 1. "I'm sure you feel guilty about not being able to visit often."
- 2. "It's important that you visit even for 1 hour."
- 3. "Not all parents can stay all the time."
- 4. "Perhaps you could take turns visiting for a bit longer."

**50.** The child in a new hip spica cast seems to be adjusting to the cast, except that after each meal the child tells the nurse that the cast is too tight. Which of the following should the nurse plan to do?

- 1. Administer a laxative prior to each meal.
- 2. Offer smaller, more frequent meals.
- 3. Give the child a mechanical soft diet.
- 4. Offer the child more fruits and grains.

**51.** The nurse is helping a family plan for the discharge of their child, who will be going home in a spica cast. Which of the following points of information should be **most** important for the nurse to consider?

- 1. The bathrooms are all on the second floor.
- 2. The child's bedroom is on the second floor.
- 3. A 16-year-old sister will care for the child during the day.
- 4. There are three steps up to the front door.

**52.** The nurse is measuring a child for crutches. What should the nurse consider? Select all that apply.

- 1. Type of gait child will be using.
- 2. Degree of child's elbow flexion.
- 3. Space above the crutch to child's axilla.
- 4. Weight of the child.
- 5. Whether child has to use the stairs.

### The Client with Osteomyelitis

**53.** During the initial assessment of a child admitted to the pediatric unit with osteomyelitis of the left tibia, when assessing the area over the tibia, which is an expected finding?

- 1. Diffuse tenderness.
- 2. Decreased pain.
- 3. Increased warmth.
- 4. Localized edema.

**54.** A child is to receive I.V. antibiotics for osteomyelitis. Before the initial dose of antibiotics can be given, the nurse confirms that a blood sample for which of the following tests has been drawn?

- 1. Creatinine.
- 2. Culture.
- 3. Hemoglobin.
- 4. White blood count.

**55.** A child is being treated with vancomycin 40 mg/kg/d I.V. divided in 3 doses for osteomyelitis. The primary care provider has ordered drug protocol management by pharmacy and a trough vancomycin level 30 minutes before the third dose scheduled for 9 a.m. The laboratory report returns prior to the third dose:

#### Laboratory Results

0830 Vancomycin  
7 mcg/mL \*\*

Therapeutic range  
10–15 mcg/mL.

The nurse should:

- 1. Administer the 9 a.m. dose.
- 2. Notify the primary care provider.
- 3. Notify the pharmacist.
- 4. Draw a peak drug level.

**56.** The nurse is caring for a child with osteomyelitis who will be receiving high-dose intravenous antibiotic therapy for 3 to 4 weeks. What should the nurse plan to monitor?

- 1. Blood glucose level.
- 2. Thrombin times.
- 3. Urine glucose level.
- 4. Urine specific gravity.

**57.** To meet the developmental needs of an 8-year-old child who is confined to home with osteomyelitis, what should the nurse include in the care plan?

- 1. Encouraging the child to communicate with schoolmates.
- 2. Encouraging the parents to stay with the child.
- 3. Allowing siblings to visit freely throughout the day.
- 4. Talking to the child about his interests twice daily.

**58.** A child with newly diagnosed osteomyelitis has nausea and vomiting. The parent wishes to give the child ginger snaps to help control the nausea. The nurse should tell the parent:

- 1. "You can try them and see how he does."
- 2. "I will need to get an order."
- 3. "Your child needs medication for the vomiting."
- 4. "We discourage the use of home remedies in children."

### The Client with Scoliosis

**59.** When assessing a female adolescent for scoliosis, what should the nurse ask the client to do?

- 1. Bend forward at the waist with arms hanging freely.
- 2. Lie flat on the floor and extend her legs straight from the trunk.
- 3. Sit in a chair while lifting her feet and legs to a right angle with the trunk.
- 4. Stand against a wall while pressing the length of her back against the wall.

**60.** After teaching the family of a child with scoliosis who needs to wear a Boston brace, which of the following activities, if stated by the child and family as occasions appropriate for removal of the brace, indicates successful teaching?

- 1. When bathing, for about 1 hour per day.
- 2. While eating, for a total of 3 hours a day.
- 3. During school, for about 8 hours a day.
- 4. When sleeping, for a total of 10 hours a day.

**61.** When teaching the child with scoliosis being treated with a Boston brace about exercises, the nurse explains that the exercises are performed primarily for which of the following purposes?

- 1. To decrease back muscle spasms.
- 2. To improve the brace's traction effect.
- 3. To prevent spinal contractures.
- 4. To strengthen the back and abdominal muscles.

**62.** A 14-year-old is being screened for scoliosis. Which of the following statements about scoliosis screening is true?

- 1. Teenagers ages 14 to 16 should be screened yearly.
- 2. A shirt and shorts are worn for screening.
- 3. The girl is assessed standing and bending forward.
- 4. The girl should refrain from eating 8 hours before the examination.

**63.** A 10-year-old with scoliosis has to wear a brace. The nurse should develop a teaching plan with the client to include which of the following instructions?

- 1. Wear the brace during waking hours.
- 2. Use lotions to relieve skin irritations.
- 3. Wear a form-fitting, sleeveless T-shirt under the brace.
- 4. Bathe the skin under the brace once per week.

### Managing Care Quality and Safety

**64.** A child with spastic cerebral palsy receiving intrathecal baclofen therapy is admitted to the pediatric floor with vomiting and dehydration. The family tells the nurse that they were scheduled to refill the baclofen pump today, but had to cancel the appointment when the child became ill. The nurse should:

- 1. Explain that the medication should be discontinued during illness.
- 2. Arrange for the pump to be refilled in the hospital.
- 3. Reschedule the pump refill for the day of discharge.
- 4. Instruct caregivers to call for a refill when the low-volume alarm sounds.

**65.** Which procedures can the nurse working on a pediatric floor safely delegate to the licensed practical nurse (LPN). Select all that apply.

- 1. Refilling a baclofen pump.
- 2. Administering gastrostomy tube feedings.
- 3. Administering gastrostomy medications.
- 4. Giving an IV push medication.
- 5. Calling the AM blood sugars to the physician.

**66.** An 8-year-old child with juvenile idiopathic arthritis (JIA) is being admitted to the hospital for evaluation of progressively increasing symptoms. The child weighs 60 pounds and is 50 inches tall. The nurse is reconciling the medications the parent brought from home with the medications the physician has ordered. (See chart.)

#### Physician Order

Home meds	Ordered meds
Ibuprofen tablet 200 mg po 4x day (for arthritis)	Ibuprofen tablet 200 mg po 4 x day
Purchased over the counter	
Cetirizine hydrochloride (Zyrtec) tablet 10 mg po daily (for allergies)	Methotrexate tablet 10 mg po every Monday
Purchased over the counter	

The nurse should:

- 1. Have the family give the child cetirizine daily using the medication they have from home.
- 2. Explain the need to limit over-the-counter medications while in the hospital.
- 3. Request a cetirizine order from the primary care provider.
- 4. Contact the primary care provider to question the methotrexate.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (8) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.


### The Client with Torticollis, Legg-Calvé-Perthes Disease and Musculoskeletal Dysfunction

**1. 2.** Physical therapy is the most important part of the child's plan of care. Most cases of torticollis respond to gentle stretching exercises which

the parents perform daily. Regular physical therapy is needed to monitor the infant's progress. Botox injections are not approved for children under the age of 2 and would not be an appropriate first-line treatment for an infant. Surgery is only done if physical therapy is not successful after several months. The use of wedges to position children during sleep is not recommended because they increase the risk of SIDS.

 CN: Management of care; CL: Create

**2. 4.** Legg-Calvé-Perthes disease, also known as *coxa plana* or *osteochondrosis*, is characterized by aseptic necrosis at the head of the femur when the blood supply to the area is interrupted. Avoidance of weight bearing is especially important to prevent the head of the femur from leaving the acetabulum, thus preventing hip dislocation. Devices such as an abduction brace, a leg cast, or a harness sling are used to protect the affected joint while revascularization and bone healing occur. Surgical procedures are used in some cases. Although pain control measures may be appropriate, pain is not necessarily more acute at night. Initial therapy involves rest and non-weight bearing to help restore motion. Preventing flexion is not necessary.

 CN: Physiological adaptation; CL: Create

**3. 3.** Because most of the child's care takes place at home, the primary focus of family teaching would be on the care and management of the corrective device. Devices such as an abduction brace, a leg cast, or a harness sling are used to protect the affected joint while revascularization and bone healing occur. As long as the child is eating a well-balanced diet, there is no need for an intake of protein-rich foods. The parents can encourage range of motion in the unaffected leg, but motion in the affected leg is limited until it heals. Once therapy has been initiated, pain is usually not a problem. The key is management of the corrective device.


 CN: Reduction of risk potential;  
CL: Create

**4. 4.** The parent is describing symptoms consistent with torticollis, or wry neck syndrome. With this musculoskeletal disorder, the sternocleidomastoid muscle shortens causing the infant to drop the head toward the affected muscle and tilt the chin upward in the opposite direction. Frequently, a lump may be felt in the affected muscle. Palpating the fontanel is done to assess neurologic status, not musculoskeletal status. Torticollis does not involve the cervical vertebrae or trapezius muscle.

 CN: Physiological adaptation;  
CL: Analyze

**5. 1.** The adolescent's complaint should alert the nurse to the possibility of Osgood-Schlatter disease. This disease, found primarily in boys 10 to

15 years of age and in girls 8 to 13 years of age, occurs when the infrapatellar ligament of the quadriceps muscle is not well anchored to the tibial tubercle. Excessive activity of the quadriceps muscle results in microtrauma, which causes swelling and pain. Track, soccer, and football commonly produce this condition. Osgood-Schlatter disease is self-limited and usually responds to rest and application of ice.

 CN: Physiological adaptation; CL: Analyze

**6. 4.** The adolescent is most likely experiencing heat exhaustion or heat collapse, which are common after vigorous exercise in a hot environment. Symptoms result from loss of fluids and include nausea, vomiting, dizziness, headache, and thirst. Treatment consists of moving the adolescent to a cool environment and giving cool liquids. Cool liquids are easier to drink than cold liquids. Taking the adolescent's temperature would be appropriate once these actions have been completed. However, the adolescent's temperature is likely to be normal or only mildly elevated. The water in a swimming pool would be too cool, possibly causing the adolescent to shiver and thus raising his temperature.

 CN: Basic care and comfort; CL: Synthesize

## The Client with Cerebral Palsy

**7. 3.** It is important to identify primary developmental delays in children with cerebral palsy and to prevent secondary and tertiary delays. The arrested development is worrisome and requires further investigation. It is possible the lack of development indicates hearing loss or may be a sign of autism. The brain damage caused by cerebral palsy is not progressive. The brain of a young child is quite plastic; assuming the child's development has peaked at age 3 would be a serious mistake. The therapy plan will need to be modified, but a better understanding of the underlying problem will lead to the greatest chance of creating a successful therapy plan.


 CN: Health promotion and maintenance;  
CL: Synthesize

**8. 2, 3, 4, 5.** Botox injections can be used to improve many aspects of quality of life for the child with cerebral palsy. The injections can help decrease pain from spasticity. Injections improve motor status by reducing rigidity and allowing for more effective physical therapy to improve range of motion. Decreased spasms enhance self-esteem. Improved motor status facilitates the ability to provide some aspects of care, especially transfers. Botox does not significantly affect nutritional status or speech.

 CN: Management of care; CL: Create




**9. 3.** The term *cerebral palsy* (CP) refers to a group of nonprogressive disorders of upper motor neuron impairment that result in motor dysfunction due to injury. In addition, a child may have speech or ocular difficulties, seizures, hyperactivity, or cognitive impairment. The condition of congenital malformed blood vessels in the ventricles is known as arteriovenous malformations. Viral infection and metabolic imbalances do not cause CP.

 CN: Physiological adaptation;  
CL: Evaluate

**10. 4.** Delay in achieving developmental milestones is a characteristic of children with cerebral palsy. Ninety percent of 15-month-old children can put a block in a cup. Walking up steps typically is accomplished at 18 to 24 months. A child usually is able to use a spoon at 18 months. The ability to copy a circle is achieved at approximately 3 to 4 years of age.

 CN: Health promotion and maintenance;  
CL: Analyze

**11. 3.** The parent is the child's primary care provider and may be very in tune to subtle changes in the child's behavior. If the parent thinks the child is in pain, it is very likely to be so. The nurse should administer the pain medication and evaluate if the medication affected the child's behavior. The FLACC scale may be difficult to interpret when the child has spasticity. The FACES scale requires self-report. The physician should be contacted regarding the change in behavior only if other available interventions are unsuccessful.


 CN: Basic care and comfort;  
CL: Synthesize

**12. 3.** The nurse needs to respond honestly to the mother. Most children with hemiparesis due to spastic cerebral palsy are able to walk because the motor deficit is usually greater in the upper extremity. There is no need to refer the mother to the physician. The age at which the mother walked may be important to elicit, but this does not influence when the child will walk. The will to walk is important, but without neurologic stability the child may be unable to do so.

 CN: Physiological adaptation;  
CL: Synthesize

**13. 1.** Limited interaction or lack of interaction with friends and family may lead the nurse to suspect a possible problem with the family's ability to cope with others' reactions and responses to a child with cerebral palsy. Learning measures to meet the child's physical needs demonstrates some understanding and acceptance of the disease. Requesting teaching about the disease suggests curiosity or a desire for understanding, thus demonstrating the

family dealing with the situation. Although not seeking financial help to pay for medical bills may be problem, it does not indicate the type of response the family is having to the child's problems.


 CN: Psychosocial adaptation;  
CL: Evaluate

## The Client with Duchenne's Muscular Dystrophy


**14. 1.** Duchenne's muscular dystrophy is an X-linked recessive disorder. The gene is transmitted through female carriers to affected sons 50% of the time. Daughters have a 50% chance of being carriers.

 CN: Physiological adaptation; CL: Apply

**15. 3.** Usually the first clinical manifestations of Duchenne's muscular dystrophy include difficulty with typical age-appropriate physical activities such as running, riding a bicycle, and climbing stairs. Contractures of the large joints typically occur much later in the disease process. Occasionally enlarged calves may be noted, but they are not typical findings in a child with Duchenne's muscular dystrophy. Muscular atrophy and development of small, weak muscles are later signs.

 CN: Physiological adaptation;  
CL: Analyze

**16. 4.** With Gower's sign, the child walks the hands up the legs in an attempt to stand, a common approach used by children with Duchenne's muscular dystrophy when rising from a sitting to a standing position. Galeazzi's sign refers to the shortening of the affected limb in congenital hip dislocation. Goodell's sign refers to the softening of the cervix, considered a sign of probable pregnancy. Good-enough's sign refers to a test of mental age.

 CN: Physiological adaptation;  
CL: Analyze

**17. 3.** The primary nursing goal is to maintain function in unaffected muscles for as long as possible. There is no effective treatment for childhood muscular dystrophy. Children who remain active are able to forestall being confined in wheelchair. Remaining active also minimizes the risk for social isolation. Preventing rather than encouraging wheelchair use by maintaining function for as long as possible is an appropriate nursing goal. Children with muscular dystrophy become socially isolated as their condition deteriorates and they can no longer keep up with friends. Maintaining function helps prevent social isolation. Circulatory impairment is not associated with muscular dystrophy.

 CN: Physiological adaptation; CL: Create

**18. 3.** The guilt that mothers of children with muscular dystrophy commonly experience usually results from the fact that the disease is genetic and the mother transmitted the defective gene. Although many children die from the disease, the disease is considered chronic and progressive. As the disease progresses, the child becomes more dependent. However, guilt typically stems from the knowledge that the mother transmitted the disease to her son rather than the dependency of the child. The disease onset is usually gradual, not sudden.


 CN: Psychosocial adaptation; CL: Analyze

**19. 1.** Muscular dystrophy is a progressive disease. Children who are affected by this disease usually are unable to walk independently by age 9 to 11 years. There is no effective treatment for childhood muscular dystrophy. Although children who remain active are able to avoid wheelchair confinement for a longer period, activity does not prevent disease progression.


 CN: Physiological adaptation; CL: Evaluate

### The Client with Developmental Dysplasia of the Hip

**20. 3.** Ortolani's manipulation is used to detect congenital hip dysplasia. The infant is supine and a "click" is heard when flexed legs are abducted. This results from pressure causing the femoral head to slip out of the acetabulum. The other maneuvers will not determine the position of the femoral head in the acetabulum.

 CN: Physiological adaptation;  
CL: Analyze

**21. 4.** In a toddler, weight bearing causes the pelvis to tilt downward on the unaffected side instead of upward as it would normally. This is Trendelenburg's sign, and it indicates developmental dysplasia of the hip. Ortolani's maneuver is used during the neonatal period to assess developmental dysplasia of the hip in infants. With the infant quiet, relaxed, and lying on the back, the hips and knees are flexed at right angles. The knees are moved to abduction and pressure is exerted. If the femoral head moves forward, then it is dislocated. Barlow's maneuver is used to assess developmental dysplasia of the hip in infants. As the femur is moved into or out of the acetabulum, a "clunk" is heard, indicating dislocation. Adam's position is used to evaluate for structural scoliosis. The child bends forward with feet together and arms hanging freely or with palms together.

 CN: Reduction of risk potential;  
CL: Analyze

**22. 4.** This infant with congenital hip dysplasia has asymmetric gluteal folds. The Ortolani "click" occurs when the nurse feels the femur sliding into the acetabulum with a "click." Limited abduction may be observed during an attempt to abduct the infant's thighs. Galeazzi's sign reveals femoral foreshortening and is observed by flexing the thighs.

 CN: Health promotion and maintenance;  
CL: Analyze

**23. 1.** The Pavlik harness is worn over a diaper. Knee socks are also worn to prevent the straps and foot and leg pieces from rubbing directly on the skin. For maximum results, the infant needs to wear the harness continuously. The skin should be inspected several times a day, not every other day, for signs of redness or irritation. Lotions and powders are to be avoided because they can cake and irritate the skin.

 CN: Reduction of risk potential;  
CL: Synthesize


**24. 2.** Assessing the learner's knowledge level is the initial step in any teaching plan to promote the maximum amount of learning. This assessment also provides the nurse with a starting point for teaching. Assessing coping strategies can provide important information to the development of the teaching plan but is not the initial step. Giving parents written instructions or a list of community resources is appropriate once the parents' knowledge level has been determined and teaching has begun.

 CN: Reduction of risk potential;  
CL: Create

**25. 3.** The abduction bar is incorporated into the cast to increase the cast's strength and maintain the legs in alignment. The bar cannot be removed or adjusted, unless the cast is removed and a new cast is applied. The bar should never be used to lift or turn the client, because doing so may weaken the cast.


 CN: Reduction of risk potential;  
CL: Synthesize

**26. 2.** The toddler in a hip spica cast needs a specially designed car seat. The one that the mother already has will not be appropriate because of the need for the car seat to accommodate the cast and abductor bar. Legally, all children younger than 4 years of age are required to be restrained in a car seat.


 CN: Safety and infection control;  
CL: Synthesize

## The Client with Congenital Clubfoot


**27. 2.** Elevating the extremity at different points during the day is helpful to prevent edema, but pillows should not be used in the crib because they increase the risk of sudden infant death syndrome (SIDS). A change in the color of the toes is a sign of impaired circulation and requires medical evaluation. Children typically need a series of 5 to 10 casts to correct the deformity. Infants with club feet still need frequent holding like any other newborn.

 CN: Safety and infection control;  
CL: Evaluate

**28. 3.** When an infant is born with an unexpected anomaly, parents are faced with questions, uncertainties, and possible disappointments. They may feel inadequate, helpless, and anxious. The nurse can help the parents initially by assessing their concerns and providing appropriate information to help them clarify or resolve the immediate problems. Referring the parents to the physician is not necessary at this time. The nurse can assist the parents by listening to their concerns. Having them talk with other parents would be helpful a little bit later, once the nurse assesses their concerns and discusses the problem and the parents' current feelings. If the parents continue to have difficulties expressing and working through their feelings, referral to a counselor would be appropriate.

 CN: Psychosocial adaptation;  
CL: Synthesize

**29. 3.** A cast that is too tight can cause a tourniquet effect, compromising the neurovascular integrity of the extremity. Manifestations of neurovascular impairment include pain, edema, pulselessness, coolness, altered sensation, and inability to move the distal exposed extremity. The toes of the casted extremity should be assessed frequently to evaluate for changes in neurovascular integrity. Wetting a plaster cast with water and soap softens the plaster, which may alter the cast's effectiveness. There is no reason to elevate the casted extremities when a child with clubfoot is being treated with nonsurgical measures. The legs would be elevated if swelling were present. Pads, which are applied to cover the rough edges of the cast, are to be left in place to minimize the risk for skin irritation from the cast edges.

 CN: Reduction of risk potential;  
CL: Evaluate

## The Client with Juvenile Idiopathic Arthritis


**30. 4.** The nurse's response to the father is based on the knowledge that there is no definitive test for JIA. The latex fixation test, which is commonly used to diagnose arthritis in adults, is negative in 90% of children. The erythrocyte sedimentation rate may or may not be increased during active disease. This test identifies the presence of inflammation only. Synovial fluid cultures are done to rule out septic arthritis, not to diagnose JIA.

 CN: Reduction of risk potential;  
CL: Analyze


**31. 1.** In half of the children diagnosed with JIA, recovery occurs without joint deformity. Approximately one third of the children will continue to have the disease into adulthood, and approximately one sixth will experience severe, crippling deformities.

 CN: Physiological adaptation; CL: Apply


**32. 2.** Socialization is important for this preschool-age child, and activity is important to maintain function. Because children with JIA commonly experience the most problems in the early morning after arising, they need more time to "warm up." Adverse effects may or may not occur. The child's normal routine needs to be maintained as much as possible. Although splints and braces may be needed, they are worn during periods of rest, not activity, to maintain function.

 CN: Physiological adaptation;  
CL: Synthesize


**33. 4.** Because the child is dealing with grief and loss associated with a chronic illness, parents need to be supportive and understanding. The child needs to feel valued and worthwhile. Introducing the child to others of the same age who also have JIA most probably would be ineffective because preschoolers are developmentally egocentric. Although the child needs to feel valued, the mother's spending more time with the child and less time with her other children is inappropriate because the child with JIA may experience secondary gain from the illness if the family interaction patterns are altered. Also, this action reinforces the child's withdrawal behavior. Psychological counseling is not needed at this time because the child's reaction is normal.

 CN: Psychosocial adaptation;  
CL: Synthesize

**34. 2, 3, 5.** Adverse effects from nonsteroidal anti-inflammatory drugs include abdominal pain, blood in stool, and reduced clotting ability. Weight gain is common with corticosteroids. Folic acid deficiency is associated with methotrexate therapy.


 CN: Pharmacological and parenteral therapies; CL: Apply

**35. 3.** The first group of drugs typically prescribed is the nonsteroidal anti-inflammatory drugs, which include naproxen. Naproxen is included in only a few over-the-counter medications but aspirin is in several. The family should check with the nurse before giving any over-the-counter medications. Once therapy is started, it takes hours or days for relief from pain to occur. However, it takes 3 to 4 weeks for the anti-inflammatory effects to occur, including reduction in swelling and less pain with movement. The missed dose will need to be made up to maintain the serum level and to maintain therapeutic effectiveness of the drug.

 CN: Pharmacological and parenteral therapies; CL: Apply

### The Client with a Fracture

**36. 2, 3, 4, 5.** Buck's traction provides a skin traction that keeps the extremity in straight alignment and can be observed by noting a straight line formed between the shoulder, hips, and knees. The rope must be intact to maintain the ordered traction from the weights. The correct amount of traction must be maintained to keep the fractured femur in correct alignment. Because the client is in a recumbent position, the nurse should also inspect the skin on the back and buttocks for integrity. The nurse should not remove the client's wraps and boot unless she has a physician's order to do so.

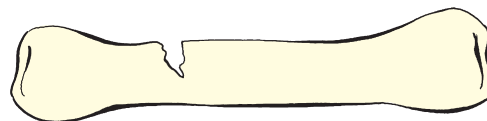
 CN: Physiological adaptation; CL: Analyze

**37. 3.** The wet plaster cast should be handled using only the palms of the hands to prevent indentations of the cast surface. Petaling a cast should be done only when the edges of the cast are rough and are causing irritation to the client's skin. The nurse should not keep the child in the same position until the cast is dry. Doing so would prohibit proper toileting and elimination and would produce undue pressure on the coccyx. The cast typically emits heat as it dries, so notifying a physician is not necessary in this instance. If needed, a fan can be used to circulate the room air.


 CN: Health promotion and maintenance; CL: Evaluate

**38. 3.** The nurse should show the parents the figure of the greenstick fracture as noted in answer 3 in which the fracture does not completely cross through the bone. Answer A is a plastic deformation, or a bend in the bone. Answer B is a buckle. Answer D is a complete fracture.


 CN: Physiological adaptation; CL: Synthesize



**39. 2.** Emotional or physical stress lowers a person's tolerance of pain. The mother's presence may have distracted him and when she left it caused him to focus on the pain he was having. Crying does not automatically indicate pain. The nurse must further assess the client for pain. Although an analgesic was given 4 hours before, pain may be present.

 CN: Physiological adaptation; CL: Analyze

**40. 2.** According to national client safety standards, when possible, the client should mark the surgery site and sign his name on the site. This step should be done prior to receiving preoperative medication. Pointing to the area is not sufficient identification. Because the client is a minor, the parents are responsible for signing the operative permit and accepting the surgery risks. The nurse should determine that the parents understand the surgery risks.

 CN: Safety and infection control; CL: Synthesize


**41. 1.** Skeletal traction applies the pull directly to the skeletal structure by tongs, pin, or wire. The nurse should assess the pull of the traction on the pin first. This is critical to the success of the traction. Once this is assessed, then the pin sites are assessed for signs of infection. The dressings would be examined after the pull of the traction, neurovascular status, and pin sites were assessed. The Ace wrap is used to anchor skin traction nonadherent straps, not skeletal traction.

 CN: Reduction of risk potential; CL: Synthesize


**42. 2.** The traction is positioned correctly; the nurse should provide frequent skin care to the back and shoulder areas. The hips and buttocks should be lifted off the bed to provide counter traction; the nurse should not adjust the weights. The nurse should not place a pillow under the buttocks as this would prevent counter traction. The elastic wraps should remain on the legs unless permitted by the physician.

 CN: Physiological adaptation; CL: Synthesize

**43. 3.** The nurse should assess the client frequently for signs of neurovascular impairment of the feet, such as pallor, coldness, numbness, or tingling. Pillows are not placed under the buttocks because the pillows would alter the alignment of the traction. Weights provide traction and should not be removed. Pulleys help to maintain optimal alignment of the traction and therefore should be left alone.

 CN: Basic care and comfort;  
CL: Synthesize

**44. 3.** Explaining to the parents that this is a normal reaction under the circumstances is most appropriate. The child's outburst is related to the child's fears of the unknown. The child is scared and anxious and needs the parents for support. Asking the parents to wait outside would only add to the child's fear and anxiety. The reaction is normal for a child her age and does not usually call for a change in staff assignments. Asking the parents to discipline their child for her behavior is inappropriate. The nurse needs to handle the situation.

 CN: Health promotion and maintenance;  
CL: Synthesize


**45. 1.** Inability to extend the fingers of the involved arm may indicate neurologic impairment caused by pressure on soft tissue. It is not unusual for a child to vomit after experiencing a traumatic injury. It may take up to 72 hours for a plaster cast to dry. Until the cast dries, the dampness causes the sensation of coolness. The cast will seem heavy until the child adjusts to the extra weight. The child may exhibit fussiness (such as whining, crying or clinging) as a result of numerous causes, such as placement of the cast, the hospital experience, or pain. These reactions are normal and do not warrant medical advice.

 CN: Reduction of risk potential;  
CL: Evaluate


**46. 2.** For the first few days after application of a plaster or fiberglass cast, the child should not engage in strenuous activities, to minimize swelling that would cause the cast to become too tight. Use of a hair dryer to complete the drying of the cast is not encouraged because the hair dryer only dries the outside of the cast. Movement and sensation of the fingers need to be checked several times a day for the first few days. Typically, the mother would be instructed to administer acetaminophen every 4 to 6 hours, not every 8 to 12 hours, for discomfort.

 CN: Reduction of risk potential;  
CL: Synthesize


**47. 1.** Because the nurse suspects a possible fracture based on the child's presentation, assessing the neurologic and circulatory status of the toes, the tissues distal to the fracture, is important. Soft tissue contusions, which accompany femur fractures, can result in severe hemorrhage into the tissue and subsequent circulatory and neurologic impairment. Once this information has been obtained, vital signs can be assessed and the nurse can notify the physician and report the findings. In fractures, circulation impairment will occur distal to the injury.

 CN: Physiological adaptation;  
CL: Synthesize

**48. 3.** Hand puppets would enable a 3-year-old child in traction to act out feelings within the constraints imposed by the traction. A 3-year-old needs creative play. The video game would make the child too active in bed and does not meet the child's developmental need for creative play. Blocks would be more appropriate for a younger child. Marbles are unsafe at this age because they can be swallowed.

 CN: Health promotion and maintenance;  
CL: Synthesize


**49. 2.** Stressing the importance of the parents' visiting when they can helps to alleviate the guilt they feel. It allows the parents to feel that they are doing what they can. Acknowledging the guilt gives the parents an opportunity to talk about it but does not help alleviate it. Comparing the parents with other parents does not alleviate guilt feelings. The parents need reinforcement that what they are doing is appropriate. Suggesting that the parents take turns visiting implies that they should feel guilty because they may not be doing all they could.

 CN: Psychosocial adaptation;  
CL: Synthesize


**50. 2.** A hip spica cast encircles the abdomen. When the child eats a large meal, abdominal pressure increases, causing the cast to feel tight. Therefore, the nurse should plan to offer smaller, more frequent meals to minimize abdominal distention. If the child's appetite were decreased in conjunction with a feeling of fullness, the nurse might suspect that the child was becoming constipated and plan to use laxatives or a higher-fiber diet. A mechanical soft diet is indicated when the child has difficulty chewing food adequately. Giving the child more fruits and grains would contribute to abdominal distention and complaints of the cast tightness after eating.

 CN: Reduction of risk potential;  
CL: Synthesize

**51. 2.** The child with a hip spica cast who is going home and has a bedroom on the second floor of the home needs to have the bed moved to an area that is more central to family life. Negotiating a flight of steps at least twice a day (on awakening in the morning and before going to bed at night) with a child in a hip spica cast would be difficult and most likely dangerous. Because the child in a hip spica cast will need to use a bedpan or urinal, the bathrooms can be on any floor. Because the family is involved in the discharge, the 16-year-old sister should be taught appropriate care along with the rest of the family. The child can be carried up and down the three steps to the house the few times necessary after discharge.


 CN: Safety and infection control;  
CL: Create

**52. 2, 3.** To ensure proper fit of crutches, the child's elbow flexion should be 20 degrees, and the area above the top of the crutch to the child's axilla should be 1 to 1½ inches. The type of gait, weight of the child, and use of stairs are not factors in the measurement.

 CN: Reduction of risk potential;  
CL: Apply

### The Client with Osteomyelitis


**53. 3.** Findings associated with osteomyelitis commonly include pain over the area, increased warmth, localized tenderness, and diffuse swelling over the involved bone. The area over the affected bone is red.

 CN: Physiological adaptation;  
CL: Analyze


**54. 2.** Cultures are used to determine exactly what organism is causing the inflammation. From the culture, sensitivities to various antibiotics may be determined. If the antibiotics are given before obtaining the culture, the antibiotics may inhibit the growth of the organism in the culture medium. This may lead to a delay in the most appropriate treatment. Unless a child has a known renal problem, baseline creatinine levels are not typically needed. However, levels may be needed during treatment depending on the medication. A complete blood count (CBC) with hemoglobin and white blood cell count is typically ordered for any suspected infection, but these tests do not identify the causative organism.

 CN: Reduction of risk potential;  
CL: Apply

**55. 3.** The vancomycin level is not therapeutic and will need to be adjusted. Drug management by the pharmacy is ordered. This is very frequently done in institutions with pediatric clinical pharmacists. Thus, the nurse should notify the pharmacist to adjust the dose. Giving subtherapeutic doses may prolong care. The nurse should contact the health care provider designated to address the issue. If needed, the pharmacist would notify the primary care provider. Peak levels are not ordered on this client.

 CN: Pharmacological and parenteral therapies;  
CL: Synthesize


**56. 4.** Long-term, high-dose antibiotic therapy can adversely affect renal, hepatic, and hematopoietic function. Urine specific gravity would provide valuable information about the kidneys' ability to concentrate or dilute urine, thereby suggesting renal impairment. Blood glucose levels reveal how well the client's body is using glucose. Thrombin times reveal information about the clotting mechanism. Urine glucose levels reveal information about the body's use and excretion of glucose.

 CN: Pharmacological and parenteral therapies;  
CL: Analyze

**57. 1.** Encouraging contact with schoolmates allows the school-age child to maintain and develop socialization with peers, an important developmental task of this age-group. Although having family visits and interacting with the child are important, they do not meet the child's developmental needs. Talking to the child about his interests is important, but encouraging contact with schoolmates is crucial to maintain and develop socialization with peers.

 CN: Health promotion and maintenance;  
CL: Create

**58. 1.** Some clients find ginger snaps help relieve nausea. The National Center for Complimentary and Alternative Medicine has determined that ginger, in small dose such as would be found in the cookies, has few side effects. There is no reason that the parent should not try this dietary intervention, however, the nurse must monitor the client's response. If the child has a diet as tolerated order, there is no need for an additional order. Ultimately, the child may need an antiemetic medication, but dietary strategies are often successful in treating vomiting related to osteomyelitis. Making a universal statement disregarding home remedies is not a client-centered approach.

 CN: Physiological adaptation;  
CL: Synthesize

## The Client with Scoliosis

**59. 1.** Scoliosis, a lateral deviation of the spine, is assessed by having the client bend forward at the waist with arms hanging freely, then looking for lateral curvature of the spine and a rib hump. The other positions will not reveal the deviation of the spine.

 CN: Health promotion and maintenance;  
CL: Analyze

**60. 1.** One of the most effective spinal braces for correcting scoliosis, the Boston brace should be worn for at least 16 to 23 hours a day, except when carrying out personal hygiene measures.

 CN: Reduction of risk potential;  
CL: Evaluate

**61. 4.** Exercises are prescribed for the child with scoliosis wearing a Boston brace to help strengthen spinal and abdominal muscles and provide support. Typically, children wearing a Boston brace do not complain of muscle spasms. Performing exercises provides no effect on the brace's traction ability. Spinal contractures do not occur when a Boston brace is worn.

 CN: Physiological adaptation; CL: Apply

**62. 3.** Screening is done with the child wearing minimal clothing, standing and bending forward. The examination should be done on girls ages 10 to 12 years old so a diagnosis can be made early and the scoliosis can be treated with exercises or bracing. Only underwear should be worn for the examination so that symmetry of the shoulders and hips can be observed. If the deviation on the scoliometer is less than 20 degrees, no treatment is indicated. The child does not need to refrain from eating prior to this test.

 CN: Physiological adaptation; CL: Apply

**63. 3.** A form-fitting, sleeveless T-shirt can be worn under the brace to prevent skin irritation and collect perspiration. Braces are worn 23 hours each day. Lotions may cause irritation and should not be used. The skin under the brace should be bathed daily to help prevent irritation from the brace. The brace can be removed for bathing so all the skin can be bathed.

 CN: Physiological adaptation; CL: Create

## Managing Care Quality and Safety

**64. 2.** To prevent a baclofen withdraw, pump refills are scheduled several days before anticipated low-volume alarms. The nurse should make it a high priority to have the pump refilled as soon as possible. Discontinuing baclofen suddenly can result in a high fever, muscle rigidity, change in level of consciousness, and even death. Waiting until the child leaves the hospital for a refill may lead to a low dose or withdraw. Waiting for the low-volume alarm puts the client at risk because medication and team members who can refill the pump may not be readily available under all circumstances.

 CN: Management of care; CL: Synthesize

**65. 2, 3.** In general, LPNs may perform skills related to feeding and administering of enteral medications. Refilling a baclofen pump constitutes administering an intrathecal medication and is beyond the scope of practice for LPNs in most states. Some states and institutions allow LPNs to give IV push medicines, however special training is required. Communicating with the physician would require discussion of the client's assessments and evaluations which fall under the RN scope of practice.

 CN: Management of care; CL: Synthesize

**66. 3.** If the child was taking cetirizine for allergies, the nurse should contact the primary care provider for an order to continue the medication in the hospital. The provider should either order the medication or provide a valid reason to discontinue its use. Advising the family to take a home supply of medications increases the risk of adverse reactions because the provider would be unaware of potential medication interactions. Many allergy medications that formerly required a prescription are now available over-the-counter and because parents use them the nurse should be aware of the interactions and risks. The nurse does not need to question the methotrexate order as this medication is being added to treat the JIA.

 CN: Safety and infection control;  
CL: Synthesize

**TEST**  
**9**

# The Child with Dermatologic and Endocrine Health Problems

- The Client with Skin Disorders
- The Client with Burns
- The Client with Hyperthyroidism
- The Client with Insulin-Dependent Diabetes Mellitus
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Skin Disorders

**1.** A 17-year-old female with severe nodular acne is considering treatment with isotretinoin (Accutane). Prior to beginning the medication, the nurse explains that the client will be required to:

- 1. Enroll in a risk management plan.
- 2. Have proof of a mental health evaluation.
- 3. Begin an effective form of birth control.
- 4. Temporarily give up sports.

**2.** When teaching an adolescent with facial acne about skin care, the nurse should instruct the adolescent to:

- 1. Wash the face twice a day with mild soap and water.
- 2. Remove whiteheads and comedones after washing his face with antibacterial soap.
- 3. Apply vitamin E ointment twice daily to the affected skin.
- 4. Apply tretinoin (Retin-A) daily in the morning and expose the face to the sun.

**3.** A 9-month-old infant with eczema has lesions that are secondarily infected. Which of the following is **most** appropriate to help the parents best meet the needs of the child?

- 1. Preventing siblings from being in close contact.
- 2. Sending the child to day care as usual.
- 3. Playing video games for several hours each evening.
- 4. Playing with the child every day.

**4.** After the nurse teaches the mother of a child with atopic dermatitis how to bathe her child, which of the following statements by the mother indicates effective teaching?

- 1. "I let my child play in the tub for 30 minutes every night."
- 2. "My child loves the bubble bath I put in the tub."
- 3. "When my child gets out of the tub I just pat the skin dry."
- 4. "I make sure my child has a bath every night."

**5.** A 5-year-old child brought to the clinic with several superficial sores on the front of the left leg is diagnosed with impetigo. Which of the following instructions should the nurse give the parent?

- 1. Wash the child's legs gently three times per day with a mild soap.
- 2. Cover the sores with loose gauze.
- 3. Allow the child to go back to school after 24 hours of treatment.
- 4. Have the child return to the clinic the next week for a follow-up examination.

**6.** When developing the teaching plan for the mother of a 2-year-old child diagnosed with scabies, which of the following points should the nurse expect to include?

- 1. The floors of the house should be cleaned with a damp mop.
- 2. The child should be held frequently.
- 3. Itching should cease in a few days.
- 4. The entire family should be treated.

## The Client with Burns

**7.** A 10-year-old has just spilled hot liquid on his arm, and a 4-inch area on his forearm is severely burned. His mother calls the emergency department. What should the nurse advise the mother to do?

- 1. Keep the child warm.
- 2. Cover the burned area with an antibiotic cream.
- 3. Apply cool water to the burned area.
- 4. Call 911 to transport the child to the hospital.

**8.** The nurse is assessing a 9-year-old child who has third-degree burns as shown below. Using the "Rule of Nines" adapted for children, the nurse estimates that the extent of burns for this child is:

- 1. 9%.
- 2. 14%.
- 3. 18%.
- 4. 24%.



**9.** A school-age child who has received burns over 60% of his body is to receive 2,000 mL of I.V. fluid over the next 8 hours. At what rate (in milliliters per hour) should the nurse set the infusion pump?

\_\_\_\_\_ mL/hour.

**10.** Which of the following would be **most** appropriate to institute when a school-age child with burns becomes angry and combative when it is time to change the dressings and apply mafenide acetate (Sulfamylon)?

- 1. Ensure parental support during the dressing changes.
- 2. Allow the child to assist in removing the dressings and applying the cream.
- 3. Give the child permission to cry during the procedure.
- 4. Allow the child to schedule the time for dressing changes.

**11.** A 5-year-old child with burns on the trunk and arms has no appetite. The nurse and mother develop a plan of care to stimulate the child's appetite. Which of the following suggestions made by the mother would indicate that she needs additional teaching?

- 1. Deciding that she will feed the child herself.
- 2. Withholding dessert and treats unless meals are eaten.
- 3. Offering the child finger foods that the child likes.
- 4. Serving smaller and more frequent meals.

**12.** After teaching the mother of a child with severe burns about the importance of specific nutritional support in burn management, which of the following, if chosen by the mother from the child's diet menu, indicates the need for further instruction?

- 1. Bacon, lettuce, and tomato sandwich; milk; and celery and carrot sticks.
- 2. Cheeseburger, cottage cheese and pineapple salad, chocolate milk, and a brownie.
- 3. Chicken nuggets, orange and grapefruit sections, and a vanilla milkshake.
- 4. Beef, bean, and cheese burrito; a banana; fruit-flavored yogurt; and skim milk.

**13.** When caring for a child with moderate burns from the waist down, which of the following should the nurse do when positioning the child?

- 1. Place the child in a position of comfort.
- 2. Allow the child to lie on the abdomen.
- 3. Ensure the application of leg splints.
- 4. Have the child flex the hips and knees.

## The Client with Hyperthyroidism

**14.** An adolescent is to receive radioactive iodine for Graves' disease. Which statement by the client reflects the need for more teaching?

- 1. "I plan to talk on Facebook since I have to keep several feet from my friends for 3 days."
- 2. "Taking radioactive iodine will not affect my ability to have children in the future."
- 3. "The advantage of radioactive iodine is that I will not need future medication for my disease."
- 4. "I should try to use a separate bathroom from the rest of my family for several days."

**15.** The nurse should instruct the family of a child with newly diagnosed hyperthyroidism to:

- 1. Keep their home warmer than usual.
- 2. Encourage plenty of outdoor activities.
- 3. Promote interactions with one friend instead of groups.
- 4. Limit bathing to prevent skin irritation.

**16.** An 11-year-old child has been diagnosed with Grave's disease and is to start drug therapy. Which of the following instructions should the nurse include in the teaching plan for the child's mother and teacher?

- 1. Continue with the same amount of school-work and homework.
- 2. Understand that mood swings are rare with this disorder.
- 3. Limit the amount of food that is offered to the child.
- 4. Provide the child with a calm, nonstimulating environment.

## The Client with Insulin-Dependent Diabetes Mellitus

**17.** A student with type 1 diabetes tells the nurse she is feeling light-headed. The student's blood sugar is 60 mg/dL. Using the 15-15 rule, the nurse should:

- 1. Give 15 mL of juice and give another 15 mL in 15 minutes.
- 2. Give 15 g of carbohydrate and retest the blood sugar in 15 minutes.
- 3. Give 15 g of carbohydrate and 15 g of protein.
- 4. Give 15 oz of juice and retest in 15 minutes

**18.** An overweight adolescent has been diagnosed with type 2 diabetes. To increase the client's self-efficacy to manage their disease, the nurse should:

- 1. Provide the client with a written daily food and exercise plan.
- 2. Discuss eliminating junk food in the home with the parents.
- 3. Arrange for the school nurse to weigh the child weekly.
- 4. Utilize a peer with type 2 diabetes to role model lifestyle changes.

**19.** After 6 months of treatment with diet and exercise, a 12-year-old with type 2 diabetes still has a fasting blood glucose level of 140 mg/dL. The primary care provider has decided to begin metformin (Glucophage). The adolescent asks how the medication works. The nurse should tell the client that the medicine decreases the glucose production and:

- 1. Replaces natural insulin.
- 2. Helps the body make more insulin.
- 3. Increases insulin sensitivity.
- 4. Decreases carbohydrate adsorption.

**20.** The nurse is evaluating a child's skills in self-administering insulin (see figure). The nurse should:



- 1. Have the child use both hands on the syringe.
- 2. Ask the child to place the needle at a 45 degree angle.
- 3. Tell the child to use a site lower on her thigh.
- 4. Remind the child to rotate sites.

**21.** An 8-year-old with newly diagnosed diabetes is in the hospital for regulation of diet and medications. The child is using an exchange method for the diet. The nurse should instruct the client that the American Diabetes Association's (ADA's) exchange method for dietary regulation includes:

- 1. Choosing food from each exchange list.
- 2. Using a scale to weigh all food.
- 3. Selecting from lists that group food according to protein, fat, and carbohydrate content.
- 4. Carbohydrate counting for each meal and snack.

**22.** A 14-year-old is using glargine (Lantus) and lispro (Humalog) to manage type I diabetes. The order for sliding scale lispro reads: Lispro subcutaneous give units according to sliding scale:

Blood glucose: 70 – 150 mg/dL = 0 units

151–200 mg/dL = 1 unit

201–250 mg/dL = 2 units

251–300 mg/dL = 3 units

301–350 mg/dL = 4 units

Call for Blood glucose > 350

In addition give 1 unit for every 15 grams of carbohydrate.

The morning blood glucose is 202 mg/dL and the client is going to eat 2 carbohydrate exchanges. The nurse has the client administer how many units of lispro?

\_\_\_\_\_ units.

**23.** An 8-year-old with diabetes is placed on neutral protamine Hagedorn (NPH) and regular insulin before breakfast and before dinner. She will receive a snack of milk and cereal at bedtime. The snack will:

- 1. Help her regain lost weight.
- 2. Provide carbohydrates for immediate use.
- 3. Prevent late night hypoglycemia.
- 4. Help her stay on her diet.

**24.** A nurse is teaching an 8-year-old with diabetes and her parents about managing diabetes during illness. The nurse determines the parents understand the instruction when they indicate that, when the child is ill, they will provide:

- 1. More calories.
- 2. More insulin.
- 3. Less insulin.
- 4. Less protein and fat.

**25.** A nurse is assessing an 8-year-old with diabetes who is experiencing hyperglycemia. Which symptom (s) indicate (s) that the hyperglycemia requires immediate intervention? Select all that apply.

- 1. Weakness.
- 2. Thirst.
- 3. Shakiness.
- 4. Hunger.
- 5. Headache.
- 6. Irritability.
- 7. Dizziness.

**26.** The nurse talks to an adolescent about how she can tell her friends about her new diagnosis of diabetes. Which of the following behaviors by the adolescent indicates that the adolescent has responded positively to the discussion?

- 1. She asks the nurse for material on diabetes for a school paper.
- 2. She introduces the nurse to her friends as “the one who taught me all about my diabetes.”
- 3. She says, “I’ll try to tell my friends, but they’ll probably quit hanging out with me.”
- 4. She asks her friends what they think about someone who has a lifelong illness.

**27.** When developing the teaching plan for the mother and a child with insulin-dependent diabetes about sick-day management, which of the following instructions should the nurse include?

- 1. Adhere to the same schedule and type and amount of insulin.
- 2. Immediately call the physician for information about what to do.
- 3. Adjust insulin based on more frequent testing of blood glucose levels.
- 4. Take the child to the emergency department for immediate care.

**28.** An adolescent with insulin-dependent diabetes is being taught the importance of rotating the sites of insulin injections. The nurse should judge that the teaching was successful when the adolescent identifies which of the following as a result of using the same site?

- 1. Destruction of the fat tissue and poor absorption.
- 2. Destruction of nerves and painful neuritis.
- 3. Destruction of the tissue and too-rapid insulin uptake.
- 4. Development of resistance to insulin and need for increased amounts.

## Managing Care Quality and Safety

**29.** The parent of a 17-year-old boy, who is hospitalized for complications related to type I diabetes, requests to review the adolescent’s medical record. The client reported receiving mental health counseling during the admission history, but did not want his parent to know. The nurse, who is uncertain of how to protect the adolescent’s privacy and accommodate the parent’s request, should consult:

- 1. The unit nurse manager.
- 2. The primary care provider.
- 3. The organization’s privacy officer.
- 4. The customer service representative.

**30.** The charge nurse on the pediatric floor has assigned a 6-year-old girl of Arab-American ethnicity with newly diagnosed type 1 diabetes and an 8-year-old girl recovering from ketoacidosis to the same semi-private room. The 6-year-old’s mother is upset because the parent staying with the other child is the father. The nurse should:

- 1. Explain to the parents that this room arrangement facilitates teaching.
- 2. Reassign the children to different rooms.
- 3. Offer the Arab-American parent another place to sleep.
- 4. Refer the parent to the customer service representative.

**31.** A 10-year old child is admitted to the hospital with complications related to chickenpox. The nurse should do which of the following to prevent the transmission of the infection to other children on the unit? Select all that apply.

- 1. Place the child on contact isolation.
- 2. Wear a gown, mask, and gloves before entering the room.
- 3. Place the child in a room with a 10-year-old who has had chickenpox.
- 4. Place the child in a negative air-flow room.
- 5. Maintain isolation until lesions have disappeared.

**32.** The mother of an 8-year-old with diabetes tells the nurse that she does not want the school to know about her daughter’s condition. The nurse should reply:

- 1. “I think that would be a good idea.”
- 2. “What is it that concerns you about having the school know about your daughter’s condition?”
- 3. “It would be fine not to tell your daughter’s friends, but the teacher must know.”
- 4. “In order to keep your daughter safe, it is necessary for all adults in the school to know her condition.”

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Skin Disorders

**1. 1.** Because of the risk of birth defects with isotretinoin, the FDA has created a web-based risk management plan known as iPLEDGE. The program requires that all clients meet qualification criteria and monthly program requirements to obtain the medication. Currently, only providers enrolled in the iPLEDGE program can prescribe this medication and only clients who enroll in iPLEDGE can receive the drug. Providers are advised to closely monitor clients for signs of depression, but a mental health evaluation is not universally required. Women of child bearing age must use two forms of effective birth control for two months before, during, and 1 month after taking the drug. Isotretinoin may cause muscle aches and extreme exercise should be avoided, but general participation in sports should be considered on an individual basis.

🔑 CN: Safety and infection control;  
CL: Synthesize

**2. 1.** Washing the face once or twice a day with a mild soap removes fatty acids from the skin. Acne is an inflammation of the sebaceous glands that produce sebum. Washing the face with mild soap and water keeps the sebaceous glands from becoming plugged. Excessive washing or squeezing the eruptions can cause rupture of these glands, spreading the sebum and causing further inflammation. Applying vitamin E to the lesions does not reduce the inflammation and, due to the greasiness of the preparation, may plug the ducts. Retin-A should be applied at night. Exposure to the sun can result in sunburn and an increased risk of skin cancer and should be avoided. Sunscreen with a sun protection factor of at least 15 must be applied before the client can be exposed to the sun.

🔑 CN: Physiological adaptation;  
CL: Synthesize

**3. 4.** The parents can best meet the needs of their 9-month-old infant by playing with the child every day. All infants need time with their parents

to develop trust and thus attain optimal development. The parents of a child with a chronic problem may need more guidance to meet the child's needs because of the focus on medical problems. The child's lesions are secondarily infected and therefore should not be contagious. Siblings do not need to stay away. Even with lesions that are infected, the child can still attend day care, but the child needs attention from the parents as well. Playing video games for several hours is not appropriate for a 9-month-old infant.

🔑 CN: Health promotion and maintenance;  
CL: Synthesize

**4. 3.** Atopic dermatitis is a chronic pruritic dermatitis that usually begins in infancy. Many of the children diagnosed with it have a family history of eczema, allergies, or asthma. Atopic dermatitis is best treated with hydrating the skin, controlling the pruritus, and preventing secondary infection. Patting the skin dry removes less natural skin moisturizer and thus maintains skin hydration. Water has a drying effect on the skin. Playing in the tub for 30 minutes each night would deplete the skin of its natural moisturizers, thereby leading to increased pruritus and dry skin. Bubble baths are to be avoided in children with atopic dermatitis because they may act as an irritant, possibly exacerbating the condition. Also, bubble baths deplete the skin of its natural moisturizers. The issue is not whether the child bathes every night. Rather, the goal is to decrease dryness and itching.


🔑 CN: Physiological adaptation;  
CL: Evaluate

**5. 3.** Impetigo involving several superficial lesions is usually treated topically, including washing the affected areas, removing crusts, and applying antibiotic ointment several times a day. The child can return to day care or school after being treated for 24 hours. The lesions do not need to be covered, they can remain open to the air. There is no need for follow-up unless the lesions have not resolved or have become more severe.

🔑 CN: Physiological adaptation;  
CL: Create

**6. 4.** Scabies is caused by the scabies mite, *Sarcoptes scabiei*. The mite burrows into the stratum corneum of the epidermis, where the female deposits eggs and fecal material. These burrows are linear. Scabies is highly contagious. The length of time from infestation to physical symptoms is 30 to 60 days, so everyone in close contact with the child will need to be treated. The bed linens and the child's clothing should be washed in hot water and dried on the hot setting. It is not necessary to damp mop the floors to prevent the spread of scabies. The child should be held minimally

until treatment is completed. Family members should wash their hands after contact with the child. Itching lasts for 2 to 3 weeks until the stratum corneum is replaced.


 CN: Safety and infection control;  
CL: Create

## The Client with Burns

**7. 3.** To prevent further injury to the skin, the mother should apply cool water to the burn site. Doing so causes vasoconstriction, retards further damage to tissues, and decreases fluid loss. Keeping the child warm promotes vasodilation, increases fluid loss, and decreases blood pressure and, thus, circulation to the area. Applying ointment to the burn is contraindicated because it does not allow healing to occur and may need to be removed in the hospital. Only a clean cloth should be used to cover the wound to prevent contamination or decrease pain or chilling. If only the arm is burned, a call to 911 for emergency care is not necessary, but the mother should seek health care services immediately.


 CN: Health promotion and maintenance;  
CL: Synthesize

**8. 2.** The child has burns of the entire leg. Because of the smaller size of children's legs, the estimate of 14% is used instead of 18%, which is used with adults. The arms of children are estimated at 9%, and the anterior and posterior trunk at 18% each. The head of the child is estimated at 18%, rather than the 9% used for adults.

 CN: Physiological adaptation;  
CL: Analyze


### 9. 250 mL/hour

$$2,000 \text{ mL} \div 8 \text{ hours} = 250 \text{ mL/hour}$$


 CN: Pharmacological and parenteral therapies; CL: Apply

**10. 2.** Expressions of anger and combativeness are often the result of loss of control and a feeling of powerlessness. Some control over the situation is regained by allowing the child to participate in care. Although having parental support during the dressing changes may be helpful, this action does nothing to allow the child control. Giving the child permission to cry may help with verbalizing feelings, but doing so does nothing to provide the child with control over the situation. Although allowing the child to determine the time for dressing changes may provide a sense of control over the situation,


doing so is inappropriate because the dressing changes need to be performed as ordered to ensure effectiveness and healing.

 CN: Physiological adaptation;  
CL: Synthesize

**11. 2.** Withholding certain foods until the child complies is punitive and rarely successful. Allowing the mother to feed the child, serving smaller and more frequent meals, and offering finger foods are all acceptable interventions for a 5-year-old child. This is true whether the child is well or ill.

 CN: Basic care and comfort;  
CL: Evaluate

**12. 1.** Hypoproteinemia is common after severe burns. The child's diet should be high in protein to compensate for protein loss and to promote tissue healing. The child will also require a diet that is high in calories and rich in iron. The menu of bacon, lettuce, and tomato sandwich; milk; and celery sticks is lacking in sufficient protein and calories.

 CN: Physiological adaptation;  
CL: Evaluate

**13. 3.** A child with moderate burns is at high risk for contractures. A position of comfort would encourage contracture formation. Therefore, splints need to be applied to maintain proper positioning and joint function, thereby preventing contractures and loss of function. Allowing the child to lie on the abdomen or with hips and knees flexed often encourages contracture formation.


 CN: Reduction of risk potential;  
CL: Synthesize

## The Client with Hyperthyroidism

**14. 3.** Most clients will need lifelong thyroid replacement after treatments with radioactive iodine. Most clients are treated as outpatients. To reduce the risk of exposure to radioactivity to others, clients are advised to avoid public places for at least 1 day and maintain a prudent distance from others for 2 to 3 days. Additionally, clients are advised to avoid close contact with pregnant women and children for 5 to 11 days. The use of radioiodine to treat Graves' disease has not been found to affect long-term fertility. Clients are taught not to share food, utensils, and towels. Use of a private bathroom is desirable. Clients are also instructed to flush the toilet more than one time after each use.

 CN: Safety and infection control;  
CL: Evaluate

**15. 3.** Children with hyperthyroidism experience emotional lability that may strain interpersonal relationships. Focusing on one friend is easier than adapting to group dynamics until the child's condition improves. Because of their high metabolic rate, children with hyperthyroidism complain of being too warm. Bright sunshine may be irritating because of disease-related ophthalmopathy. Sweating is common and bathing should be encouraged.


 CN: Physiological adaptation;  
CL: Synthesize

**16. 4.** Because it takes approximately 2 weeks before the response to drug treatment occurs, much of the child's care focuses on managing the child's physical symptoms. Signs and symptoms of the disorder include inability to sit still or concentrate, increased appetite with weight loss, emotional lability, and fatigue. Nursing care is directed toward ensuring that the mother and teacher know how to handle the child, suggesting a shortened school day, a nonstimulating environment, and decreased stress and workload. The child should be encouraged to eat a well-balanced diet.

 CN: Physiological adaptation; CL: Create

### The Client with Insulin-Dependent Diabetes Mellitus

**17. 2.** The 15-15 rule is a general guideline for treating hypoglycemia where the client consumes 15 g of carbohydrate and repeats testing the blood sugar in 15 minutes. Fifteen grams of carbohydrate equals 60 calories and is roughly equal to ½ cup of juice or soda, 6 to 8 lifesavers, or a tablespoon of honey or sugar. The general recommendation is if the blood sugar is still low, the client may repeat the sequence. Fifteen milliliters of juice would only provide 15 calories. This would not be sufficient carbohydrates to treat the hypoglycemia. Protein does not treat insulin-related hypoglycemia; however a protein-starch snack may be offered after the blood glucose improves. Fifteen ounces of juice would be almost 4 times the recommended 4 oz of juice.


 CN: Physiological adaptation;  
CL: Synthesize

**18. 4.** Self-efficacy, or the belief that one can act in a way to produce a desired outcome, can be promoted through the observation of role models. Peers are particularly effective role models because clients can more readily identify with them and believe they are capable of similar behaviors. Providing a written plan alone does not promote self-efficacy. Having parents eliminate junk food

and having the school nurse weigh the adolescent can be part of the plan, but these actions do not empower the client.

 CN: Management of care; CL: Synthesize


**19. 3.** Metformin is currently approved by the FDA to treat type 2 diabetes in children. The medication decreases gluconeogenesis in the liver and increases insulin sensitivity in the peripheral tissues. Only insulin can actually replace insulin. This treatment is reserved for clients with type 1 diabetes or those with type 2 who do not respond to diet, exercise, and an oral diabetic agent. Other oral medications used to treat diabetes augment insulin production or decrease carbohydrate absorption, but those medications are primarily used in adults.

 CN: Pharmacological and parenteral therapies; CL: Apply

**20. 4.** The child is using correct injection technique, and the nurse can remind the child to rotate sites. The nurse should also reinforce that the child has used correct technique and praise the child for doing so. If the child can manipulate the plunger of the syringe with one hand, this is appropriate. Insulin is administered at a 90 degree angle as shown. The child should identify appropriate sites on the thighs as one handbreadth below the hip and above the knee; the child is using appropriate sites.

 CN: Health promotion and maintenance;  
CL: Apply

**21. 4.** Carbohydrate counting identifies the number of grams of carbohydrate to be eaten at each meal and snack. The ADA's exchange diet allows the substitution of one food for another on the same diet list. The exchange list does not require that all food is weighed. Choices are made from lists referred to as *carbohydrate*, *meat* or *meat substitute*, and *fat*. The client's prescription identifies how many items from each food group are to be consumed at each meal and snack. The exchange assumes that foods with similar nutrient content affect blood glucose levels in a similar manner.

 CN: Physiological adaptation;  
CL: Apply

**22. 4 units.** Each carbohydrate food exchange has 15 grams of carbohydrate. Two units are needed to cover the current blood glucose and 2 units are needed to cover the anticipated carbohydrate intake.

 CN: Pharmacological and parenteral therapies; CL: Apply

**23. 3.** NPH insulin peaks in 6 to 8 hours, which would occur during sleep. A bedtime snack is needed to prevent late night hypoglycemia. The

snack is not given to help regain weight. Milk contains fat and protein which cause delayed absorption into the blood stream and maintains the blood glucose level at night when the NPH insulin will peak. The snack is not used to provide carbohydrates for immediate use because NPH insulin, unlike regular insulin, does not peak immediately. The snack has nothing to do with a diet.

 CN: Psychosocial adaptation; CL: Apply


**24. 2.** The child needs more insulin during an illness, because the cells becomes more insulin resistant during illness and need more insulin to achieve a normal blood glucose level. During an acute illness, simple carbohydrates and fluids are usually tolerated best.

 CN: Physiological adaptation;  
CL: Evaluate

**25. 1, 2, 7.** Weakness, thirst, and dizziness are symptoms related to dehydration caused by excretion of large amounts of glucose and water in the urine. The nurse should notify the physician. Shakiness, hunger, headache, and irritability are related to hypoglycemia and result from the brain and other cells being starved for nutrients.

 CN: Physiological adaptation;  
CL: Analyze

**26. 2.** The ability to talk about her diabetes indicates that the adolescent feels good enough about herself to share her problem with her peers. Asking for reference material does not specifically indicate that the client's self-esteem has improved or that she has accepted her diagnosis. Saying that her friends will probably desert her if she tells them about the illness indicates that the adolescent still needs to work on her self-esteem and her feelings about the disease. Asking her friends what they think of someone with a lifelong illness would not indicate that the nurse's interventions targeted toward improving self-esteem have been successful. Rather, this statement demonstrates the adolescent's uncertainty about herself.


 CN: Psychosocial adaptation;  
CL: Evaluate

**27. 3.** Sick-day management requires more frequent monitoring of the child's blood glucose to evaluate for changes associated with a decreased intake and absorption of food, commonly associated with illness. Based on the child's glucose levels, insulin adjustments may be needed. In this case, regular insulin is used. Adhering to the same schedule, type, and amount of insulin is inappropriate because the child's ability to take in food and absorb nutrients can change rapidly. Typically, the child and parents are provided with specific instructions about sick-day management rules. Commonly the

physician will prescribe adjustments to insulin (e.g., on a sliding scale) based on the child's blood glucose levels. Therefore, calling the physician to report that the child is ill and ask what to do is inappropriate. However, the parents do need to notify the physician should any problems arise with management of the child's blood glucose levels. The child who can tolerate oral feedings of simple sugars can be kept at home as long as the parents monitor the child's blood glucose levels frequently for changes.

 CN: Physiological adaptation; CL: Create

**28. 1.** Repeated use of the same injection site can result in atrophy of the fat in the subcutaneous tissue and lead to poor insulin absorption. The neuritis that develops from diabetes is related to microvascular changes that occur. Subcutaneous tissue is not destroyed and insulin is not rapidly absorbed. Resistance to insulin is caused by an immune response to the insulin protein.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

## Managing Care Quality and Safety

**29. 3.** The Health Insurance Portability and Accountability Act (HIPAA) specifies that institutions designate a "privacy officer" who is responsible for developing and implementing privacy policies. This person or office also handles HIPAA complaints. This would be the very best resource for the nurse to contact. Depending on the nurse manager's experience, he or she may or may not know the answer and may have to consult the privacy officer. While primary care providers would have an understanding of HIPAA, it is unlikely they understand the specifics of nursing policies. The customer service representatives typically address client concerns or complaints. At this time, the family has not voiced a complaint.

 CN: Management of care; CL: Apply


**30. 2.** Arab-Americans most frequently practice Islam. Sleeping in the same room with a person of the opposite sex most likely would be viewed as a violation of their faith. If at all possible, the charge nurse should reassign the family to a different room. While it makes sense to have two clients with similar educational needs in the same room, it is likely that the arrangement would be sufficiently distressing enough to create a learning barrier. Offering the mother another place to sleep deprives the child of her parent at night. The customer service representative would only need to be involved if it became impossible to accommodate the mother's needs.

 CN: Management of care; CL: Synthesize

**31. 2, 4.** Gowns, mask, and gloves are needed before the nurse or anyone can enter the room of a client who has chickenpox because the varicella virus is spread by air, droplets, and contact. It is very contagious so a negative-air flow room is recommended. Contact isolation only includes a gown and gloves. Because varicella is spread by air and contact, a private room is needed. The child should remain in isolation until all lesions have crusted.

 CN: Physiological adaptation;  
CL: Synthesize

**32. 2.** The nurse's first response should be to obtain more information about the mother's concerns. It is true that the child may have a diabetic reaction anywhere at school, and it is advisable that her teacher, classmates, and other adults know about her diabetes in order to help her; however, it is ultimately the client and her parents who will make the decision about informing the school. The nurse can facilitate a dialogue that will help the mother reach this decision. Dictating to the mother does not explain any rationale for the necessity of the information.

 CN: Safety and infection control;  
CL: Synthesize



# 3

## The Nursing Care of Adults with Medical and Surgical Health Problems

### TEST 1

### The Client with Cardiac Health Problems

- The Client with Acute Coronary Syndromes
- The Client with Heart Failure
- The Client with Valvular Heart Disease
- The Client with Hypertension
- The Client with a Permanent Pacemaker
- The Client Requiring Cardiopulmonary Resuscitation
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

#### The Client with Acute Coronary Syndromes

**1.** A client has chest pain rated at 8 on a 10 point visual analog scale. The 12-lead electrocardiogram reveals ST elevation in the inferior leads and Troponin levels are elevated. What is the **highest** priority for nursing management of this client at this time?

- 1. Monitor daily weights and urine output.
- 2. Permit unrestricted visitation by family and friends.
- 3. Provide client education on medications and diet.
- 4. Reduce pain and myocardial oxygen demand.

**2.** A client with chest pain is prescribed intravenous nitroglycerin (Tridil). Which assessment is of **greatest** concern for the nurse initiating the nitroglycerin drip?

- 1. Serum potassium is 3.5 mEq/L.
- 2. Blood pressure is 88/46.
- 3. ST elevation is present on the electrocardiogram.
- 4. Heart rate is 61.

**3.** The nurse is caring for a client diagnosed with an anterior myocardial infarction 2 days ago. Upon assessment, the nurse identifies a new systolic murmur at the apex. The nurse should **first**:

- 1. Assess for changes in vital signs.
- 2. Draw an arterial blood gas.
- 3. Evaluate heart sounds with the client leaning forward.
- 4. Obtain a 12 Lead electrocardiogram.

**4.** A client with acute chest pain is receiving I.V. morphine sulfate. Which of the following results are intended effects of morphine in this client? Select all that apply.

- 1. Reduces myocardial oxygen consumption.
- 2. Promotes reduction in respiratory rate.
- 3. Prevents ventricular remodeling.
- 4. Reduces blood pressure and heart rate.
- 5. Reduces anxiety and fear.

**5.** A client receives fibrinolytic therapy upon admission following a myocardial infarction. He is now receiving an I.V. infusion of heparin sodium at 1,200 units/hour. The dilution is 25,000 units/500 mL. How many milliliters per hour will this client receive?

\_\_\_\_\_ mL/hour.

**6.** A 65-year-old client is admitted to the emergency department with a fractured hip. The client has chest pain and shortness of breath. The health care provider orders nitroglycerin tablets. Which should the nurse instruct the client to do?

- 1. Put the tablet under the tongue until it is absorbed.
- 2. Swallow the tablet with 120 mL of water.
- 3. Chew the tablet until it is dissolved.
- 4. Place the tablet between his cheek and gums.

**7.** The nurse has completed an assessment on a client with a decreased cardiac output. Which findings should receive the **highest** priority?

- 1. BP 110/62, atrial fibrillation with HR 82, bibasilar crackles.
- 2. Confusion, urine output 15 mL over the last 2 hours, orthopnea.
- 3. SpO<sub>2</sub> 92 on 2 liters nasal cannula, respirations 20, 1+ edema of lower extremities.
- 4. Weight gain of 1 kg in 3 days, BP 130/80, mild dyspnea with exercise.

**8.** The nurse notices that a client's heart rate decreases from 63 to 50 beats per minute on the monitor. The nurse should **first**:

- 1. Administer Atropine 0.5 mg I.V. push.
- 2. Auscultate for abnormal heart sounds.
- 3. Prepare for transcutaneous pacing.
- 4. Take the client's blood pressure.

**9.** A client is admitted with a myocardial infarction and new onset atrial fibrillation. While auscultating the heart, the nurse notes an irregular heart rate and hears an extra heart sound at the apex after the S2 that remains constant throughout the respiratory cycle. The nurse should document these findings as:

- 1. Heart rate irregular with S3.
- 2. Heart rate irregular with S4.
- 3. Heart rate irregular with aortic regurgitation.
- 4. Heart rate irregular with mitral stenosis.

**10.** A 60-year-old male client comes into the emergency department with a complaint of crushing substernal chest pain that radiates to his shoulder and left arm. The admitting diagnosis is acute myocardial infarction (MI). Immediate admission orders include oxygen by nasal cannula at 4 L/minute, blood work, a chest radiograph, a 12-lead electrocardiogram (ECG), and 2 mg of morphine sulfate given I.V. The nurse should **first**:

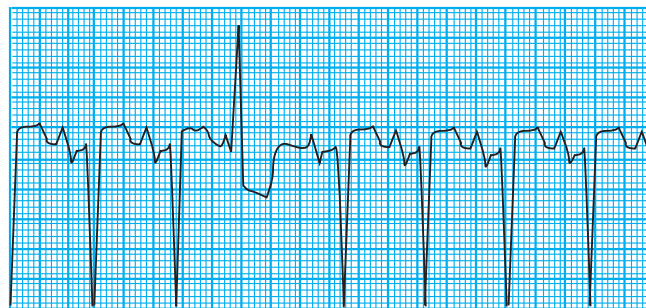
- 1. Administer the morphine.
- 2. Obtain a 12-lead ECG.
- 3. Obtain the blood work.
- 4. Order the chest radiograph.

**11.** When administering a thrombolytic drug to the client experiencing a myocardial infarction (MI), the nurse explains that the purpose of the drug is to:

- 1. Help keep him well hydrated.
- 2. Dissolve clots that he may have.
- 3. Prevent kidney failure.
- 4. Treat potential cardiac arrhythmias.

**12.** The nurse is assessing a client who has had a myocardial infarction (MI). The nurse notes the cardiac rhythm shown on the electrocardiogram strip below. The nurse identifies this rhythm as which of the following?

- 1. Atrial fibrillation.
- 2. Ventricular tachycardia.
- 3. Premature ventricular contractions (PVCs).
- 4. Third-degree heart block.



**13.** A client admitted for a myocardial infarction (MI) develops cardiogenic shock. An arterial line is inserted. Which of the following orders should the nurse question?

- 1. Call for urine output < 30 mL/hour for 2 consecutive hours.
- 2. Metoprolol (Lopressor) 5 mg I.V. push.
- 3. Prepare for a pulmonary artery catheter insertion.
- 4. Titrate Dobutamine (Dobutrex) to keep systolic BP > 100.

**14.** If the client who was admitted for myocardial infarction (MI) develops cardiogenic shock, which characteristic sign should the nurse expect to observe?

- 1. Oliguria.
- 2. Bradycardia.
- 3. Elevated blood pressure.
- 4. Fever.

**15.** The physician orders continuous I.V. nitroglycerin infusion for the client with myocardial infarction. Essential nursing actions include which of the following?

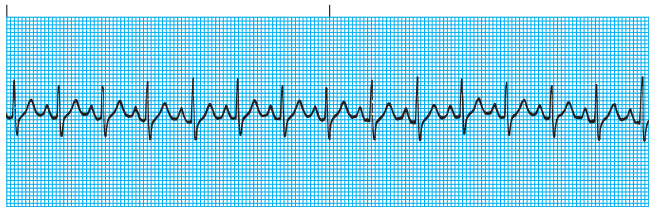
- 1. Obtaining an infusion pump for the medication.
- 2. Monitoring blood pressure every 4 hours.
- 3. Monitoring urine output hourly.
- 4. Obtaining serum potassium levels daily.

**16.** When teaching the client with myocardial infarction (MI), the nurse explains that the pain associated with MI is caused by:

- 1. Left ventricular overload.
- 2. Impending circulatory collapse.
- 3. Extracellular electrolyte imbalances.
- 4. Insufficient oxygen reaching the heart muscle.

**17.** The nurse is assessing a client who has had a myocardial infarction. The nurse notes the cardiac rhythm shown on the electrocardiogram strip below. The nurse identifies this rhythm as which of the following?

- 1. Atrial fibrillation.
- 2. Ventricular tachycardia.
- 3. Premature ventricular contractions.
- 4. Sinus tachycardia.



**18.** While caring for a client who has sustained a myocardial infarction (MI), the nurse notes eight premature ventricular contractions (PVCs) in 1 minute on the cardiac monitor. The client is receiving an I.V. infusion of 5% dextrose in water (D<sub>5</sub>W) and oxygen at 2 L/minute. The nurse's **first** course of action should be to:

- 1. Increase the I.V. infusion rate.
- 2. Notify the physician promptly.
- 3. Increase the oxygen concentration.
- 4. Administer a prescribed analgesic.

**19.** Which of the following is an expected outcome for a client on the second day of hospitalization after a myocardial infarction (MI)? The client:

- 1. Has severe chest pain.
- 2. Can identify risk factors for MI.
- 3. Agrees to participate in a cardiac rehabilitation walking program.
- 4. Can perform personal self-care activities without pain.

**20.** Which of the following is an expected outcome when a client is receiving an I.V. administration of furosemide?

- 1. Increased blood pressure.
- 2. Increased urine output.
- 3. Decreased pain.
- 4. Decreased premature ventricular contractions.

**21.** After a myocardial infarction, the hospitalized client is taught to move the legs while resting in bed. This type of exercise is recommended primarily to help:

- 1. Prepare the client for ambulation.
- 2. Promote urinary and intestinal elimination.
- 3. Prevent thrombophlebitis and blood clot formation.
- 4. Decrease the likelihood of pressure ulcer formation.

**22.** Which of the following reflects the principle on which a client's diet will **most** likely be based during the acute phase of myocardial infarction?

- 1. Liquids as desired.
- 2. Small, easily digested meals.
- 3. Three regular meals per day.
- 4. Nothing by mouth.

**23.** The nurse is assessing clients at a health fair. Which client is at **greatest** risk for coronary artery disease?

- 1. A 32-year-old female with mitral valve prolapse who quit smoking 10 years ago.
- 2. A 43-year-old male with a family history of CAD and cholesterol level of 158.
- 3. A 56-year-old male with an HDL of 60 who takes atorvastatin (Lipitor).
- 4. A 65-year-old female who is obese with an LDL of 188.

**24.** A 58-year-old female with a family history of CAD is being seen for her annual physical exam. Fasting lab test results include: Total cholesterol 198; LDL cholesterol 120; HDL cholesterol 58; Triglycerides 148; Blood sugar 102; and C-reactive protein (CRP) 4.2. The health care provider informs the client that she will be started on a statin medication and aspirin. The client asks the nurse why she needs to take these medications. Which is the **best** response by the nurse?

- 1. "The labs indicate severe hyperlipidemia and the medications will lower your LDL, along with a lowfat diet."
- 2. "The triglycerides are elevated and will not return to normal without these medications."
- 3. "The CRP is elevated indicating inflammation seen in cardiovascular disease, which can be lowered by the medications ordered."
- 4. "The medications are not indicated since your lab values are all normal."

**25.** If a client displays risk factors for coronary artery disease, such as smoking cigarettes, eating a diet high in saturated fat, or leading a sedentary lifestyle, techniques of behavior modification may be used to help the client change the behavior. The nurse can **best** reinforce new adaptive behaviors by:

- 1. Explaining how the old behavior leads to poor health.
- 2. Withholding praise until the new behavior is well established.
- 3. Rewarding the client whenever the acceptable behavior is performed.
- 4. Instilling mild fear into the client to extinguish the behavior.

**26.** Alteplase recombinant, or tissue plasminogen activator (t-PA), a thrombolytic enzyme, is administered during the first 6 hours after onset of myocardial infarction (MI) to:

- 1. Control chest pain.
- 2. Reduce coronary artery vasospasm.
- 3. Control the arrhythmias associated with MI.
- 4. Revascularize the blocked coronary artery.

**27.** After the administration of t-PA, the assessment priority is to:

- 1. Observe the client for chest pain.
- 2. Monitor for fever.
- 3. Monitor the 12-lead electrocardiogram (ECG) every 4 hours.
- 4. Monitor breath sounds.

**28.** When monitoring a client who is receiving tissue plasminogen activator (t-PA), the nurse should have resuscitation equipment available because reperfusion of the cardiac tissue can result in which of the following?

- 1. Cardiac arrhythmias.
- 2. Hypertension.
- 3. Seizure.
- 4. Hypothermia.

**29.** Contraindications to the administration of tissue plasminogen activator (t-PA) include which of the following?

- 1. Age greater than 60 years.
- 2. History of cerebral hemorrhage.
- 3. History of heart failure.
- 4. Cigarette smoking.

**30.** A client has driven himself to the emergency department. He is 50 years old, has a history of hypertension, and informs the nurse that his father died from a heart attack at age 60. The client is presently complaining of indigestion. The nurse connects him to an electrocardiogram monitor and begins administering oxygen at 2 L/minute per nasal cannula. The nurse's **next** action would be to:

- 1. Call for the physician.
- 2. Start an I.V. line.
- 3. Obtain a portable chest radiograph.
- 4. Draw blood for laboratory studies.

**31.** Crackles heard on lung auscultation indicate which of the following?

- 1. Cyanosis.
- 2. Bronchospasm.
- 3. Airway narrowing.
- 4. Fluid-filled alveoli.

**32.** A 68-year-old female client on day 2 after hip surgery has no cardiac history but reports having chest heaviness. The **first** nursing action should be to:

- 1. Inquire about the onset, duration, severity, and precipitating factors of the heaviness.
- 2. Administer oxygen via nasal cannula.
- 3. Offer pain medication for the chest heaviness.
- 4. Inform the physician of the chest heaviness.

**33.** The nurse receives emergency laboratory results for a client with chest pain and immediately informs the physician. An increased myoglobin level suggests which of the following?

- 1. Cancer.
- 2. Hypertension.
- 3. Liver disease.
- 4. Myocardial damage.

**34.** An older, sedentary adult may not respond to emotional or physical stress as well as a younger individual because of:

- 1. Left ventricular atrophy.
- 2. Irregular heartbeats.
- 3. Peripheral vascular occlusion.
- 4. Pacemaker placement.

**35.** During the previous few months, a 56-year-old woman felt brief twinges of chest pain while working in her garden and has had frequent episodes of indigestion. She comes to the hospital after experiencing severe anterior chest pain while raking leaves. Her evaluation confirms a diagnosis of stable angina pectoris. After stabilization and treatment, the client is discharged from the hospital. At her follow-up appointment, she is discouraged because she is experiencing pain with increasing frequency. She states that she visits an invalid friend twice a week and now cannot walk up the second flight of steps to the friend's apartment without pain. Which of the following measures that the nurse could suggest would **most** likely help the client prevent this problem?

- 1. Visit her friend early in the day.
- 2. Rest for at least an hour before climbing the stairs.
- 3. Take a nitroglycerin tablet before climbing the stairs.
- 4. Lie down once she reaches the friend's apartment.

**36.** The client who experiences angina has been told to follow a low-cholesterol diet. Which of the following meals should the nurse tell the client would be **best** on her low-cholesterol diet?

- 1. Hamburger, salad, and milkshake.
- 2. Baked liver, green beans, and coffee.
- 3. Spaghetti with tomato sauce, salad, and coffee.
- 4. Fried chicken, green beans, and skim milk.

**37.** Which of the following symptoms should the nurse teach the client with unstable angina to report immediately to her physician?

- 1. A change in the pattern of her pain.
- 2. Pain during sexual activity.
- 3. Pain during an argument with her husband.
- 4. Pain during or after an activity such as lawn-mowing.

**38.** The physician refers the client with unstable angina for a cardiac catheterization. The nurse explains to the client that this procedure is being used in this specific case to:

- 1. Open and dilate blocked coronary arteries.
- 2. Assess the extent of arterial blockage.
- 3. Bypass obstructed vessels.
- 4. Assess the functional adequacy of the valves and heart muscle.

**39.** The client is scheduled for a percutaneous transluminal coronary angioplasty (PTCA) to treat angina. Priority goals for the client immediately after PTCA should include:

- 1. Minimizing dyspnea.
- 2. Maintaining adequate blood pressure control.
- 3. Decreasing myocardial contractility.
- 4. Preventing fluid volume deficit.

**40.** Which of the following is **not** a risk factor for the development of atherosclerosis?

- 1. Family history of early heart attack.
- 2. Late onset of puberty.
- 3. Total blood cholesterol level greater than 220 mg/dL.
- 4. Elevated fasting blood glucose concentration.

**41.** As an initial step in treating a client with angina, the physician prescribes nitroglycerin tablets, 0.3 mg given sublingually. This drug's principal effects are produced by:

- 1. Antispasmodic effects on the pericardium.
- 2. Causing an increased myocardial oxygen demand.
- 3. Vasodilation of peripheral vasculature.
- 4. Improved conductivity in the myocardium.

**42.** A client has a throbbing headache when nitroglycerin is taken for angina.

The nurse should instruct the client that:

- 1. Acetaminophen (Tylenol) or Ibuprofen (Advil) can be taken for this common side effect.
- 2. Nitroglycerin should be avoided if the client is experiencing this serious side effect.
- 3. Taking the nitroglycerin with a few glasses of water will reduce the problem.
- 4. The client should lie in a supine position to alleviate the headache.

**43.** Sublingual nitroglycerin tablets begin to work within 1 to 2 minutes. How should the nurse instruct the client to use the drug when chest pain occurs?

- 1. Take one tablet every 2 to 5 minutes until the pain stops.
- 2. Take one tablet and rest for 10 minutes. Call the physician if pain persists after 10 minutes.
- 3. Take one tablet, then an additional tablet every 5 minutes for a total of three tablets. Call the physician if pain persists after three tablets.
- 4. Take one tablet. If pain persists after 5 minutes, take two tablets. If pain still persists 5 minutes later, call the physician.

**44.** A client with angina has been taking nifedipine. The nurse should teach the client to:

- 1. Monitor blood pressure monthly.
- 2. Perform daily weights.
- 3. Inspect gums daily.
- 4. Limit intake of green leafy vegetables.

## The Client with Heart Failure

**45.** Captopril (Capoten), furosemide (Lasix), and metoprolol (Toprol XL) are ordered for a client with systolic heart failure. The client's blood pressure is 136/82 and the heart rate is 65. Prior to medication administration at 9 a.m., the nurse reviews the following lab tests (see chart). Which of the following should the nurse do **first**?

- 1. Administer the medications.
- 2. Call the physician.
- 3. Withhold the captopril.
- 4. Question the metoprolol dose.

### Laboratory Results

Sodium	140 mEq/L
Potassium	6.8 mEq/L
Chloride	101 meq/L
CO <sub>2</sub> Content	26 mEq/L
BU <sub>N</sub>	18 mg/dL
Creatinine	1.0 mg/dL
Hemoglobin	12 g/dL
Hematocrit	37%

**46.** A client with chronic heart failure has atrial fibrillation and a left ventricular ejection fraction of 15%. The client is taking warfarin (Coumadin). The expected outcome of this drug is to:

- 1. Decrease circulatory overload.
- 2. Improve the myocardial workload.
- 3. Prevent thrombus formation.
- 4. Regulate cardiac rhythm.

**47.** A client has a history of heart failure and has been taking several medications, including furosemide (Lasix), digoxin (Lanoxin) and potassium chloride. The client has nausea, blurred vision, headache, and weakness. The nurse notes that the client is confused. The telemetry strip shows first-degree atrioventricular block. The nurse should assess the client for signs of which condition?

- 1. Hyperkalemia.
- 2. Digoxin toxicity.
- 3. Fluid deficit.
- 4. Pulmonary edema.

**48.** A nurse is assessing a client with heart failure. The nurse should assess the client based on which compensatory mechanisms that are activated in the presence of heart failure? Select all that apply.

- 1. Ventricular hypertrophy.
- 2. Parasympathetic nervous stimulation.
- 3. Renin-angiotensin-aldosterone system.
- 4. Jugular venous distention.
- 5. Sympathetic nervous stimulation.

**49.** Which of the following sets of conditions is an indication that a client with a history of left-sided heart failure is developing pulmonary edema?

- 1. Distended jugular veins and wheezing.
- 2. Dependent edema and anorexia.
- 3. Coarse crackles and tachycardia.
- 4. Hypotension and tachycardia.

**50.** A 69-year-old female has a history of heart failure. She is admitted to the emergency department with heart failure complicated by pulmonary edema. On admission of this client, which of the following should the nurse assess **first**?

- 1. Blood pressure.
- 2. Skin breakdown.
- 3. Serum potassium level.
- 4. Urine output.

**51.** Which of the following nursing diagnoses would be appropriate for a client with systolic heart failure? Select all that apply.

- 1. Ineffective peripheral tissue perfusion related to a decreased stroke volume.
- 2. Activity intolerance related to impaired gas exchange and perfusion.
- 3. Dyspnea related to pulmonary congestion and impaired gas exchange.
- 4. Decreased cardiac output related to impaired cardiac filling.
- 5. Impaired renal perfusion related to a decreased cardiac output.

**52.** In which of the following positions should the nurse place a client with suspected heart failure?

- 1. Semi-sitting (low Fowler's position).
- 2. Lying on the right side (Sims' position).
- 3. Sitting almost upright (high Fowler's position).
- 4. Lying on the back with the head lowered (Trendelenburg's position).

**53.** The major goal of therapy for a client with heart failure and pulmonary edema should be to:

- 1. Increase cardiac output.
- 2. Improve respiratory status.
- 3. Decrease peripheral edema.
- 4. Enhance comfort.

**54.** A client with heart failure is receiving digoxin intravenously. The nurse should determine the effectiveness of the drug by assessing which of the following?

- 1. Dilated coronary arteries.
- 2. Increased myocardial contractility.
- 3. Decreased cardiac arrhythmias.
- 4. Decreased electrical conductivity in the heart.

**55.** Furosemide is administered intravenously to a client with heart failure. How soon after administration should the nurse begin to see evidence of the drug's desired effect?

- 1. 5 to 10 minutes.
- 2. 30 to 60 minutes.
- 3. 2 to 4 hours.
- 4. 6 to 8 hours.

**56.** The nurse teaches a client with heart failure to take oral furosemide in the morning. The **primary** reason for this is to help:

- 1. Prevent electrolyte imbalances.
- 2. Retard rapid drug absorption.
- 3. Excrete excessive fluids accumulated during the night.
- 4. Prevent sleep disturbances during the night.

**57.** Clients with heart failure are prone to atrial fibrillation. During physical assessment, the nurse should suspect atrial fibrillation when palpation of the radial pulse reveals:

- 1. Two regular beats followed by one irregular beat.
- 2. An irregular pulse rhythm.
- 3. Pulse rate below 60 bpm.
- 4. A weak, thready pulse.

**58.** When teaching the client about complications of atrial fibrillation, the nurse should instruct the client to avoid which of the following?

- 1. Stasis of blood in the atria.
- 2. Increased cardiac output.
- 3. Decreased pulse rate.
- 4. Elevated blood pressure.

**59.** The nurse should teach the client that signs of digoxin toxicity include which of the following?

- 1. Rash over the chest and back.
- 2. Increased appetite.
- 3. Visual disturbances such as seeing yellow spots.
- 4. Elevated blood pressure.

**60.** The nurse should be especially alert for signs and symptoms of digoxin toxicity if serum levels indicate that the client has a:

- 1. Low sodium level.
- 2. High glucose level.
- 3. High calcium level.
- 4. Low potassium level.

**61.** Which of the following foods should the nurse teach a client with heart failure to limit when following a 2-g sodium diet?

- 1. Apples.
- 2. Tomato juice.
- 3. Whole wheat bread.
- 4. Beef tenderloin.

**62.** A client receiving a loop diuretic should be encouraged to eat which of the following foods? Select all that apply.

- 1. Angel food cake.
- 2. Banana.
- 3. Dried fruit.
- 4. Orange juice.
- 5. Peppers.

**63.** The nurse finds the apical impulse below the fifth intercostal space. The nurse suspects:

- 1. Left atrial enlargement.
- 2. Left ventricular enlargement.
- 3. Right atrial enlargement.
- 4. Right ventricular enlargement.

**64.** The nurse is admitting a 68-year-old male to the medical floor. The echocardiogram report revealed left ventricular enlargement. The nurse notes 2+ pitting edema in the ankles when getting the client into bed. Based on this finding, what should the nurse do **first**?

- 1. Assess respiratory status.
- 2. Draw blood for laboratory studies.
- 3. Insert a Foley catheter.
- 4. Weigh the client.

**65.** The nurse's discharge teaching plan for the client with heart failure should stress the importance of which of the following?

- 1. Maintaining a high-fiber diet.
- 2. Walking 2 miles every day.
- 3. Obtaining daily weights at the same time each day.
- 4. Remaining sedentary for most of the day.

**66.** When teaching a client with heart failure about preventing complications and future hospitalizations, which problems stated by the client as reasons to call the physician would indicate to the nurse that the client has understood the teaching? Select all that apply.

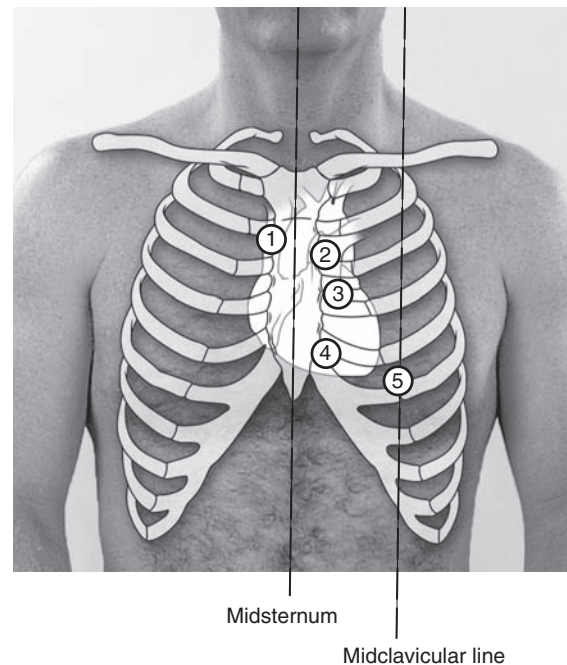
- 1. Becoming increasingly short of breath at rest.
- 2. Weight gain of 2 lb or more in 1 day.
- 3. High intake of sodium for breakfast.
- 4. Having to sleep sitting up in a reclining chair.
- 5. Weight loss of 2 lb in 1 day.

### The Client with Valvular Heart Disease

**67.** A client has returned from the cardiac catheterization laboratory after a balloon valvuloplasty for mitral stenosis. Which of the following requires immediate nursing action?

- 1. A low, grade 1 intensity mitral regurgitation murmur.
- 2. SpO<sub>2</sub> is 94% on 2 liters of oxygen via nasal cannula.
- 3. The client has become more somnolent.
- 4. Urine output has decreased from 60 mL/hour to 40 mL over the last hour.

**68.** A client with aortic stenosis complains of increasing dyspnea and dizziness. Identify the area where the nurse would place the stethoscope to assess a murmur from aortic stenosis.



**69.** A client is scheduled for a cardiac catheterization. The nurse should do which of the following preprocedure tasks? Select all that apply.

- 1. Administer all ordered oral medications.
- 2. Check for iodine sensitivity.
- 3. Verify that written consent has been obtained.
- 4. Withhold food and oral fluids before the procedure.
- 5. Insert a urinary drainage catheter.

**70.** A client has returned to the medical-surgical unit after a cardiac catheterization. Which is the **most** important initial postprocedure nursing assessment for this client?

- 1. Monitor the laboratory values.
- 2. Observe neurologic function every 15 minutes.
- 3. Observe the puncture site for swelling and bleeding.
- 4. Monitor skin warmth and turgor.

**71.** A 70-year-old female is scheduled to undergo mitral valve replacement for severe mitral stenosis and mitral regurgitation. Although the diagnosis was made during childhood, she did not have symptoms until 4 years ago. Recently, she noticed increased symptoms, despite daily doses of digoxin and furosemide. During the initial interview with the client, the nurse would **most** likely learn that the client's childhood health history included:

- 1. Chickenpox.
- 2. Poliomyelitis.
- 3. Rheumatic fever.
- 4. Meningitis.

**72.** A client experiences initial indications of excitation after having an I.V. infusion of lidocaine hydrochloride started. The nurse should further assess the client when the client reports having:

- 1. Palpitations.
- 2. Tinnitus.
- 3. Urinary frequency.
- 4. Lethargy.

**73.** A pulmonary artery catheter is inserted in a client with severe mitral stenosis and regurgitation. The nurse administers furosemide (Lasix) to treat pulmonary congestion and begins a Nitroprusside (Nipride) drip for afterload reduction per physician orders. The nurse notices a sudden drop in the pulmonary artery diastolic pressure and pulmonary artery wedge pressure. Which of the following has the **highest** priority?

- 1. Assess the 12-lead EKG.
- 2. Assess the blood pressure.
- 3. Assess the lung sounds.
- 4. Assess the urine output.

**74.** A client has mitral stenosis and is a prospective valve recipient. The nurse is instructing the client about health maintenance prior to surgery. Inability to follow which of the following regimens would pose the **greatest** health hazard to this client at this time?

- 1. Medication therapy.
- 2. Diet modification.
- 3. Activity restrictions.
- 4. Dental care.

**75.** In preparing the client and the family for a postoperative stay in the intensive care unit (ICU) after open heart surgery, the nurse should explain that:

- 1. The client will remain in the ICU for 5 days.
- 2. The client will sleep most of the time while in the ICU.
- 3. Noise and activity within the ICU are minimal.
- 4. The client will receive medication to relieve pain.

**76.** A client who has undergone a mitral valve replacement has persistent bleeding from the sternal incision during the early postoperative period. The nurse should do which of the following? Select all that apply.

- 1. Begin Warfarin (Coumadin).
- 2. Check the postoperative CBC, INR, PTT, & platelet levels.
- 3. Confirm availability of blood products.
- 4. Monitor the mediastinal chest tube drainage.
- 5. Start a Dopamine (Intropin) drip for a systolic BP < 100.

**77.** The **most** effective measure the nurse can use to prevent wound infection when changing a client's dressing after coronary artery bypass surgery is to:

- 1. Observe careful hand-washing procedures.
- 2. Clean the incisional area with an antiseptic.
- 3. Use prepackaged sterile dressings to cover the incision.
- 4. Place soiled dressings in a waterproof bag before disposing of them.

**78.** For a client who excretes excessive amounts of calcium during the postoperative period after open heart surgery, which of the following measures should the nurse institute to help prevent complications associated with excessive calcium excretion?

- 1. Ensure a liberal fluid intake.
- 2. Provide an alkaline-ash diet.
- 3. Prevent constipation.
- 4. Enrich the client's diet with dairy products.



**79.** The nurse should teach the client who is receiving warfarin sodium that:

- 1. Partial thromboplastin time values determine the dosage of warfarin sodium.
- 2. Protamine sulfate is used to reverse the effects of warfarin sodium.
- 3. International Normalized Ratio (INR) is used to assess effectiveness.
- 4. Warfarin sodium will facilitate clotting of the blood.

**80.** Good dental care is an important measure in reducing the risk of endocarditis. A teaching plan to promote good dental care in a client with mitral stenosis should include demonstration of the proper use of:

- 1. A manual toothbrush.
- 2. An electric toothbrush.
- 3. An irrigation device.
- 4. Dental floss.

**81.** Before a client's discharge after mitral valve replacement surgery, the nurse should evaluate the client's understanding of postsurgery activity restrictions. Which of the following should the client **not** engage in until after the 1-month postdischarge appointment with the surgeon?

- 1. Showering.
- 2. Lifting anything heavier than 10 lb.
- 3. A program of gradually progressive walking.
- 4. Light housework.

**82.** Three days after mitral valve surgery, a 45-year-old female comments that she hears a "clicking" noise coming from her chest and her "rather large" chest incision. The nurse's response should reflect the understanding that the client may be experiencing which of the following?

- 1. Anxiety related to altered body image.
- 2. Anxiety related to altered health status.
- 3. Altered tissue perfusion.
- 4. Lack of knowledge regarding the postoperative course.

### The Client with Hypertension

**83.** Metoprolol (Toprol XL) is added to the pharmacologic therapy of a diabetic female diagnosed with stage 2 hypertension initially treated with Furosemide (Lasix) and Ramipril (Altace). An expected therapeutic effect is:

- 1. Decrease in heart rate.
- 2. Lessening of fatigue.
- 3. Improvement in blood sugar levels.
- 4. Increase in urine output.

**84.** A client is taking clonidine (Catapres) for treatment of hypertension. The nurse should teach the client about which of the following common adverse effects of this drug? Select all that apply.

- 1. Dry mouth.
- 2. Hyperkalemia.
- 3. Impotence.
- 4. Pancreatitis.
- 5. Sleep disturbance.

**85.** A client with hypertensive emergency is being treated with sodium nitroprusside (Nipride). In a dilution of 50 mg/250 mL, how many micrograms of Nipride are in each milliliter?

\_\_\_\_\_ mcg.

**86.** In teaching the hypertensive client to avoid orthostatic hypotension, the nurse should emphasize which of the following instructions? Select all that apply.

- 1. Plan regular times for taking medications.
- 2. Arise slowly from bed.
- 3. Avoid standing still for long periods.
- 4. Avoid excessive alcohol intake.
- 5. Avoid hot baths.

**87.** An industrial health nurse at a large printing plant finds a male employee's blood pressure to be elevated on two occasions 1 month apart and refers him to his private physician. The employee is about 25 lb overweight and has smoked a pack of cigarettes daily for more than 20 years. The client's physician prescribes atenolol (Tenormin) for the hypertension. The nurse should instruct the client to:

- 1. Avoid sudden discontinuation of the drug.
- 2. Monitor the blood pressure annually.
- 3. Follow a 2-g sodium diet.
- 4. Discontinue the medication if severe headaches develop.

**88.** The nurse teaches a client, who has recently been diagnosed with hypertension, about dietary restrictions: a low-calorie, low-fat, low-sodium diet. Which of the following menu selections would **best** meet the client's needs?

- 1. Mixed green salad with blue cheese dressing, crackers, and cold cuts.
- 2. Ham sandwich on rye bread and an orange.
- 3. Baked chicken, an apple, and a slice of white bread.
- 4. Hot dogs, baked beans, and celery and carrot sticks.

**89.** A client's job involves working in a warm, dry room, frequently bending and crouching to check the underside of a high-speed press, and wearing eye guards. Given this information, the nurse should assess the client for which of the following?

- 1. Muscle aches.
- 2. Thirst.
- 3. Lethargy.
- 4. Orthostatic hypotension.

**90.** An exercise program is prescribed for the client with hypertension. Which intervention would be **most** likely to assist the client in maintaining an exercise program?

- 1. Giving the client a written exercise program.
- 2. Explaining the exercise program to the client's spouse.
- 3. Reassuring the client that he or she can do the exercise program.
- 4. Tailoring a program to the client's needs and abilities.

**91.** The client realizes the importance of quitting smoking, and the nurse develops a plan to help the client achieve this goal. Which of the following nursing interventions should be the **initial** step in this plan?

- 1. Review the negative effects of smoking on the body.
- 2. Discuss the effects of passive smoking on environmental pollution.
- 3. Establish the client's daily smoking pattern.
- 4. Explain how smoking worsens high blood pressure.

**92.** Essential hypertension would be diagnosed in a 40-year-old male whose blood pressure readings were consistently at or above which of the following?

- 1. 120/90 mm Hg.
- 2. 130/85 mm Hg.
- 3. 140/90 mm Hg.
- 4. 160/80 mm Hg.

**93.** When teaching a client about propranolol hydrochloride, the nurse should base the information on the knowledge that propranolol:

- 1. Blocks beta-adrenergic stimulation and thus causes decreased heart rate, myocardial contractility, and conduction.
- 2. Increases norepinephrine secretion and thus decreases blood pressure and heart rate.
- 3. Is a potent arterial and venous vasodilator that reduces peripheral vascular resistance and lowers blood pressure.
- 4. Is an angiotensin-converting enzyme inhibitor that reduces blood pressure by blocking the conversion of angiotensin I to angiotensin II.

**94.** The most important long-term goal for a client with hypertension would be to:

- 1. Learn how to avoid stress.
- 2. Explore a job change or early retirement.
- 3. Make a commitment to long-term therapy.
- 4. Lose weight.

**95.** The client has had hypertension for 20 years. The nurse should assess the client for?

- 1. Renal insufficiency and failure.
- 2. Valvular heart disease.
- 3. Endocarditis.
- 4. Peptic ulcer disease.

**96.** The nurse is developing a care plan with an older adult and is instructing the client that hypertension can be a silent killer. The nurse should instruct the client to be aware of signs and symptoms of other system failures and encourage the client to report signs of which of the following diseases that are often a result of undetected high blood pressure?

- 1. Cerebrovascular accidents (CVAs).
- 2. Liver disease.
- 3. Myocardial infarction.
- 4. Pulmonary disease.

**97.** A client treated for hypertension with furosemide (Lasix), atenolol (Tenormin), and ramipril (Altace) develops a second degree heart block Mobitz type 1. Which of the following actions should the nurse take?

- 1. Administer a 250 mL fluid bolus.
- 2. Withhold the atenolol.
- 3. Prepare for cardioversion.
- 4. Set up for an arterial line.

### The Client with a Permanent Pacemaker

**98.** When teaching a client about self-care following placement of a new permanent pacemaker to his left upper chest, the nurse should include which information? Select all that apply.

- 1. Take and record daily pulse rate.
- 2. Avoid air travel because of airport security alarms.
- 3. Immobilize the affected arm for 4 to 6 weeks.
- 4. Avoid using a microwave oven.
- 5. Avoid lifting anything heavier than 3 lb.

**99.** A client has been admitted to the coronary care unit. The nurse observes third-degree heart block at a rate of 35 bpm on the client's cardiac monitor. The client has a blood pressure of 90/60. The nurse should take which of the following actions **first**?

- 1. Prepare for transcutaneous pacing.
- 2. Prepare to defibrillate the client at 200 joules.
- 3. Administer an I.V. lidocaine infusion.
- 4. Schedule the operating room for insertion of a permanent pacemaker.

**100.** A 74-year-old female is admitted to the telemetry unit for placement of a permanent pacemaker because of sinus bradycardia. A priority goal for the client within 24 hours after insertion of a permanent pacemaker is to:

- 1. Maintain skin integrity.
- 2. Maintain cardiac conduction stability.
- 3. Decrease cardiac output.
- 4. Increase activity level.

**101.** The client who had a permanent pacemaker implanted 2 days earlier is being discharged from the hospital. The client understands the discharge plan when the client:

- 1. Selects a low-cholesterol diet to control coronary artery disease.
- 2. States a need for bed rest for 1 week after discharge.
- 3. Verbalizes safety precautions needed to prevent pacemaker malfunction.
- 4. Explains signs and symptoms of myocardial infarction (MI).

### The Client Requiring Cardiopulmonary Resuscitation

**102.** Upon assessment of third degree heart block on the monitor, the nurse should **first**:

- 1. Call a code.
- 2. Begin cardiopulmonary resuscitation.
- 3. Have transcutaneous pacing ready at the bedside.
- 4. Prepare for defibrillation.

**103.** Ventricular tachycardia is displayed on the cardiac monitor of a client admitted to the telemetry unit. Which should the nurse do **first**?

- 1. Prepare for immediate cardioversion.
- 2. Begin cardiopulmonary resuscitation (CPR).
- 3. Check for a pulse.
- 4. Prepare for immediate defibrillation.

**104.** The nurse is preparing the client for cardioversion. The nurse should do which of the following? Select all that apply.

- 1. Use a conducting agent between the skin and the paddles.
- 2. Place the paddles over the client's clothing.
- 3. Call "clear" before discharging the electrical current.
- 4. Record the delivered energy and the resulting rhythm.
- 5. Exert 5 to 10 lb of pressure on each paddle to ensure good skin contact.

**105.** A client who has been given cardiopulmonary resuscitation (CPR) is transported by ambulance to the hospital's emergency department, where the admitting nurse quickly assesses the client's condition. The **most** effective way to determine the effectiveness of CPR is noting whether the:

- 1. Pulse rate is normal.
- 2. Pupils are reacting to light.
- 3. Mucous membranes are pink.
- 4. Systolic blood pressure is at least 80 mm Hg.

**106.** A client is given amiodarone (Cordarone) in the emergency department for a dysrhythmia. Which of the following indicates the drug is having the desired effect?

- 1. The ventricular rate is increasing.
- 2. The absent pulse is now palpable.
- 3. The number of premature ventricular contractions is decreasing.
- 4. The fine ventricular fibrillation changes to coarse ventricular fibrillation.

**107.** During cardiopulmonary resuscitation (CPR), the xiphoid process at the lower end of the sternum should not be compressed when performing cardiac compressions. Which of the following organs would be **most** likely at risk for laceration by forceful compressions over the xiphoid process?

- 1. Lung.
- 2. Liver.
- 3. Stomach.
- 4. Diaphragm.

**108.** When performing external chest compressions on an adult during cardiopulmonary resuscitation (CPR), the rescuer should depress the sternum:

- 1. 0.5 to 1 inch.
- 2. 1 to 1.5 inches.
- 3. 1.5 to 2 inches.
- 4. 2 to 2.5 inches.

**109.** If a client is receiving rescue breaths and the chest wall fails to rise during cardiopulmonary resuscitation, the rescuer should **first**:

- 1. Try using an ambu bag.
- 2. Decrease the rate of compressions.
- 3. Intubate the client.
- 4. Reposition the airway.

**110.** During rescue breathing in cardiopulmonary resuscitation (CPR), the victim will exhale by:

- 1. Normal relaxation of the chest.
- 2. Gentle pressure of the rescuer's hand on the upper chest.
- 3. The pressure of cardiac compressions.
- 4. Turning the head to the side.

**111.** The rapid response team has been called to manage an unwitnessed cardiac arrest. The estimated maximum time a person can be without cardiopulmonary function and still not experience permanent brain damage is:

- 1. 1 to 2 minutes.
- 2. 4 to 6 minutes.
- 3. 8 to 10 minutes.
- 4. 12 to 15 minutes.

**112.** A nurse is helping a suspected choking victim. The nurse should perform the Heimlich maneuver when the victim:

- 1. Starts to become cyanotic.
- 2. Cannot speak due to airway obstruction.
- 3. Can make only minimal vocal noises.
- 4. Is coughing vigorously.

**113.** When performing the Heimlich maneuver on a conscious adult victim, the rescuer delivers inward and upward thrusts specifically:

- 1. Above the umbilicus.
- 2. At the level of the xiphoid process.
- 3. Over the victim's midabdominal area.
- 4. Below the xiphoid process and above the umbilicus.

**114.** The monitor technician informs the nurse that the client has started having premature ventricular contractions every other beat. Which is the **priority** nursing action?

- 1. Activate the rapid response team.
- 2. Assess the client's orientation and vital signs.
- 3. Call the physician.
- 4. Administer a bolus of lidocaine.

### Managing Care Quality and Safety

**115.** The nurse is caring for a client whose condition has been deteriorating. The client becomes unresponsive, the blood pressure is 80/40, and SpO<sub>2</sub> is 90% on 50% face mask. The nurse should:

- 1. Begin chest compressions.
- 2. Call the rapid response team.
- 3. Remove the family from the room.
- 4. Ventilate the client with an ambu bag.

**116.** Which activity would be appropriate to delegate to unlicensed personnel for a client diagnosed with a myocardial infarction who is stable?

- 1. Evaluate the lung sounds.
- 2. Help the client identify risk factors for CAD.
- 3. Provide teaching on a 2 g sodium diet.
- 4. Record the intake and output.

**117.** The nurse is assessing a client with heart failure who is receiving home health care monitoring using electronic devices including scales, blood pressure monitoring, and structured questions to which the client responds daily on a touch-screen monitor. The nurse reviews data obtained within the last 3 days.

	April 3 2010	April 4 2010	April 5 2010
Weight	160	162	165
Blood Pressure	120/80	130/88	140/90

The nurse calls the client to follow up. The nurse should ask the client which of the following **first**:

- 1. "How are you feeling today?"
- 2. "Are you having shortness of breath?"
- 3. "Did you calibrate the scales before using them?"
- 4. "How much fluid did you drink during the last 24 hours?"

**118.** The nurse is tracking data on a group of clients with heart failure who have been discharged from the hospital and are being followed at a clinic. Which of the following data indicate that nursing interventions of monitoring and teaching have been effective?

- 1. 90 percent of clients have not gained weight.
- 2. 75 percent of the clients viewed the educational DVD.
- 3. 80 percent of the clients reported that they are taking their medications.
- 4. 5 percent of the clients required hospitalization in the last 90 days.

**119.** The nurse in the intensive care unit is giving a report to the nurse in a cardiac step-down unit about a client who had coronary artery bypass surgery. Which of the following is the **most** effective way to assure essential information about the client is reported?

- 1. Give the report face-to-face with both nurses in a quiet room.
- 2. Audiotape the report for future reference and documentation.
- 3. Use a printed checklist with information individualized for the client.
- 4. Document essential transfer information in the client's electronic health record.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Acute Coronary Syndromes

**1. 4.** Nursing management for a client with a myocardial infarction should focus on pain management and decreasing myocardial oxygen demand. Fluid status should be closely monitored. Client education should begin once the client is stable and amenable to teaching. Visitation should be based on client comfort and maintaining a calm environment.

🔑 CN: Physiological adaptation;  
CL: Synthesize

**2. 2.** Nitroglycerin is a vasodilator that will lower blood pressure. The client is having chest pain and the ST elevation indicates injury to the myocardium, which may benefit from nitroglycerin. The potassium and heart rate are within normal range.

🔑 CN: Pharmacological and parenteral therapies; CL: Analyze

**3. 1.** Infarction of the papillary muscles is a potential complication of an MI causing ineffective closure of the mitral valve during systole. Mitral regurgitation results when the left ventricle contracts and blood flows backward into the left atrium, which is heard at the fifth intercostal space, left midclavicular line. The murmur worsens during expiration and in the supine or left-side position. Vital sign changes will reflect the severity of the sudden drop in cardiac output: decrease in blood pressure, increase in heart rate, and increase in respirations. A 12-lead ECG views the electrical activity of the heart; an echocardiogram views valve function.

🔑 CN: Physiological adaptation;  
CL: Synthesize

**4. 1, 4, 5.** Morphine sulfate acts as an analgesic and sedative. It also reduces myocardial oxygen consumption, blood pressure, and heart rate. Morphine also reduces anxiety and fear due to its sedative effects and by slowing the heart rate. It can depress

respirations; however, such an effect may lead to hypoxia, which should be avoided in the treatment of chest pain. Angiotensin-converting enzyme-inhibitor drugs, not morphine, may help to prevent ventricular remodeling.

🔑 CN: Pharmacological and parenteral therapies; CL: Evaluate

#### 5. 24 mL/hour

First, calculate how many units are in each milliliter of the medication:

$$\frac{25,000 \text{ units}}{500 \text{ mL}} = \frac{50 \text{ units}}{1 \text{ mL}}$$

Next, calculate how many milliliters the client receives per hour:

$$\begin{aligned} & \frac{1,200 \text{ units}}{1 \text{ hour}} \div \frac{50 \text{ units}}{1 \text{ mL}} \\ &= \frac{24}{1,200} \text{ units} \times \frac{1 \text{ mL}}{50 \text{ units}} = 24 \text{ mL/hour.} \end{aligned}$$

🔑 CN: Pharmacological and parenteral therapies; CL: Apply

**6. 3.** The client is having symptoms of a myocardial infarction. The first action is to prevent platelet formation and block prostaglandin synthesis. The nitroglycerin tablet will be absorbed fastest if the client chews the tablet.

🔑 CN: Physiological adaptation; CL: Apply

**7. 2.** A low urine output and confusion are signs of decreased tissue perfusion. Orthopnea is a sign of left-sided heart failure. Crackles, edema and weight gain should be monitored closely, but the levels are not as high a priority. With atrial fibrillation there is a loss of atrial kick, but the blood pressure and heart rate are stable.


🔑 CN: Physiological adaptation;  
CL: Analyze

**8. 4.** The nurse should first assess the client's tolerance to the drop in heart rate by checking the blood pressure and level of consciousness and determine if Atropine is needed. If the client is symptomatic, Atropine and transcutaneous pacing are interventions for symptomatic bradycardia. Once the client is stable, further physical assessments can be done.


🔑 CN: Physiological adaptation;  
CL: Synthesize

**9. 1.** An S3 heart sound occurs early in diastole as the mitral and tricuspid valves open and blood rushes into the ventricles. To distinguish an S3 from a physiologic S2 split, a split S2 occurs during


inspiration and S3 remains constant during the respiratory cycle. Its pitch is softer and best heard with the bell at the apex and it is one of the first clinical findings in left ventricular failure. An S4 is heard in late diastole when atrial contraction pumps volume into a stiff, noncompliant ventricle. An S4 is not heard in a client with atrial fibrillation because there is no atrial contraction. Murmurs are sounds created by turbulent blood flow through an incompetent or stenotic valve.

 CN: Physiological adaptation;  
CL: Analyze

**10. 1.** Although obtaining the ECG, chest radiograph, and blood work are all important, the nurse's priority action should be to relieve the crushing chest pain. Therefore, administering morphine sulfate is the priority action.

 CN: Physiological adaptation;  
CL: Synthesize


**11. 2.** Thrombolytic drugs are administered within the first 6 hours after onset of an MI to lyse clots and reduce the extent of myocardial damage.

 CN: Pharmacological and parenteral therapies;  
CL: Apply


**12. 3.** PVCs are characterized by a QRS of longer than 0.10 second and by a wide, notched, or slurred QRS complex. There is no P wave related to the QRS complex, and the T wave is usually inverted.

 CN: Reduction of risk potential;  
CL: Analyze


**13. 2.** Metoprolol is indicated in the treatment of hemodynamically stable clients with an acute MI to reduce cardiovascular mortality. Cardiogenic shock causes severe hemodynamic instability and a beta blocker will further depress myocardial contractility. The metoprolol should be discontinued. The decrease in cardiac output will impair perfusion to the kidneys. Cardiac output, hemodynamic measurements, and appropriate interventions can be determined with a PA catheter. Dobutamine will improve contractility and increase the cardiac output that is depressed in cardiogenic shock.

 CN: Physiological adaptation;  
CL: Synthesize

**14. 1.** Oliguria occurs during cardiogenic shock because there is reduced blood flow to the kidneys. Typical signs of cardiogenic shock include low blood pressure, rapid and weak pulse, decreased urine output, and signs of diminished blood flow to the brain, such as confusion and restlessness. Cardiogenic shock is a serious complication of MI, with a mortality rate approaching 90%. Fever is not a typical sign of cardiogenic shock.

 CN: Reduction of risk potential;  
CL: Analyze

**15. 1.** I.V. nitroglycerin infusion requires an infusion pump for precise control of the medication. Blood pressure monitoring would be done with a continuous system, and more frequently than every 4 hours. Hourly urine outputs are not always required. Obtaining serum potassium levels is not associated with nitroglycerin infusion.

 CN: Pharmacological and parenteral therapies;  
CL: Synthesize


**16. 4.** An MI interferes with or blocks blood circulation to the heart muscle. Decreased blood supply to the heart muscle causes ischemia, or poor myocardial oxygenation. Diminished oxygenation or lack of oxygen to the cardiac muscle results in ischemic pain or angina. The pain is not due to ventricular overload, circulatory collapse, or electrolyte imbalances.

 CN: Physiological adaptation;  
CL: Apply


**17. 4.** Sinus tachycardia is characterized by normal conduction and a regular rhythm, but with a rate exceeding 100 bpm. A P wave precedes each QRS, and the QRS is usually normal.

 CN: Reduction of risk potential;  
CL: Analyze


**18. 2.** PVCs are often a precursor of life-threatening arrhythmias, including ventricular tachycardia and ventricular fibrillation. An occasional PVC is not considered dangerous, but if PVCs occur at a rate greater than five or six per minute in the post-MI client, the physician should be notified immediately. More than six PVCs per minute is considered serious and usually calls for decreasing ventricular irritability by administering medications such as lidocaine hydrochloride. Increasing the I.V. infusion rate would not decrease the number of PVCs. Increasing the oxygen concentration should not be the nurse's first course of action; rather, the nurse should notify the physician promptly. Administering a prescribed analgesic would not decrease ventricular irritability.

 CN: Physiological adaptation;  
CL: Synthesize

**19. 4.** By day 2 of hospitalization after an MI, clients are expected to be able to perform personal care without chest pain. Severe chest pain should not be present on day 2 after an MI. Day 2 of hospitalization may be too soon for clients to be able to identify risk factors for MI or to begin a walking program; however, the client may be sitting up in a chair as part of the cardiac rehabilitation program.

 CN: Physiological adaptation;  
CL: Evaluate

**20. 2.** Furosemide is a loop diuretic that acts to increase urine output. Furosemide does not increase blood pressure, decrease pain, or decrease arrhythmias.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**21. 3.** This type of exercise is a preventive strategy taught to all clients who are hospitalized and on bed rest. This activity is taught to the client to promote venous return. The muscular action aids in venous return and prevents venous stasis in the lower extremities. It is venous stasis that increases one's risk for thrombophlebitis and blood clot formation. These exercises are not intended to prepare the client for ambulation. These exercises are not associated with promoting urinary and intestinal elimination. These exercises are not performed to decrease the risk of pressure ulcer formation.

 CN: Physiological adaptation; CL: Apply

**22. 2.** Recommended dietary principles in the acute phase of MI include avoiding large meals because small, easily digested foods are better tolerated. Fluids are given according to the client's needs, and sodium restrictions may be prescribed, especially for clients with manifestations of heart failure. Cholesterol restrictions may be ordered as well. Clients are not prescribed diets of liquids only or restricted to nothing by mouth unless their condition is very unstable.

 CN: Physiological adaptation; CL: Apply


**23. 4.** The woman who is 65 years old, overweight and has an elevated LDL is at greatest risk. Total cholesterol > 200, LDL > 100, HDL < 40 in men, HDL < 50 in women, men 45 years and older, women 55 years and older, smoking and obesity increase the risk of CAD. Atorvastatin is a medication to reduce LDL and decrease risk of CAD. The combination of postmenopausal, obesity, and high LDL cholesterol places this client at greatest risk.

 CN: Health promotion and maintenance; CL: Analyze


**24. 3.** CRP is a marker of inflammation and is elevated in the presence of cardiovascular disease. The high sensitivity CRP (hs-CRP) is the blood test for greater accuracy in measuring the CRP to evaluate cardiovascular risk. The family history, postmenopausal age, LDL above optimum levels and elevated CRP place the client at risk of CAD. Statin medications can decrease LDL, whereas statins and aspirin can reduce CRP and decrease the risk of MI and stroke.

 CN: Physiological adaptation; CL: Apply

**25. 3.** A basic principle of behavior modification is that behavior that is learned and continued is behavior that has been rewarded. Other reinforcement techniques have not been found to be as effective as reward.

 CN: Psychosocial adaptation; CL: Synthesize


**26. 4.** The thrombolytic agent t-PA, administered intravenously, lyses the clot blocking the coronary artery. The drug is most effective when administered within the first 6 hours after onset of MI. The drug does not reduce coronary artery vasospasm; nitrates are used to promote vasodilation. Arrhythmias are managed by antiarrhythmic drugs. Surgical approaches are used to open the coronary artery and reestablish a blood supply to the area.

 CN: Pharmacological and parenteral therapies; CL: Apply


**27. 1.** Although monitoring the 12-lead ECG and monitoring breath sounds are important, observing the client for chest pain is the nursing assessment priority because closure of the previously obstructed coronary artery may recur. Clients who receive t-PA frequently receive heparin to prevent closure of the artery after administration of t-PA. Careful assessment for signs of bleeding and monitoring of partial thromboplastin time are essential to detect complications. Administration of t-PA should not cause fever.

 CN: Reduction of risk potential; CL: Analyze


**28. 1.** Cardiac arrhythmias are commonly observed with administration of t-PA. Cardiac arrhythmias are associated with reperfusion of the cardiac tissue. Hypotension is commonly observed with administration of t-PA. Seizures and hypothermia are not generally associated with reperfusion of the cardiac tissue.

 CN: Reduction of risk potential; CL: Synthesize


**29. 2.** A history of cerebral hemorrhage is a contraindication to administration of t-PA because the risk of hemorrhage may be further increased. Age greater than 60 years, history of heart failure, and cigarette smoking are not contraindications.

 CN: Pharmacological and parenteral therapies; CL: Apply


**30. 2.** Advanced cardiac life support recommends that at least one or two I.V. lines be inserted in one or both of the antecubital spaces. Calling the physician, obtaining a portable chest radiograph, and drawing blood for the laboratory are important but secondary to starting the I.V. line.

 CN: Physiological adaptation; CL: Synthesize


**31. 4.** Crackles are auscultated over fluid-filled alveoli. Crackles heard on lung auscultation do not have to be associated with cyanosis. Bronchospasm and airway narrowing generally are associated with wheezing sounds.

 CN: Physiological adaptation;  
CL: Analyze

**32. 1.** Further assessment is needed in this situation. It is premature to initiate other actions until further data have been gathered. Inquiring about the onset, duration, location, severity, and precipitating factors of the chest heaviness will provide pertinent information to convey to the physician.

 CN: Reduction of risk potential;  
CL: Synthesize


**33. 4.** Detection of myoglobin is one diagnostic tool to determine whether myocardial damage has occurred. Myoglobin is generally detected about 1 hour after a heart attack is experienced and peaks within 4 to 6 hours after infarction. Myoglobin does not help diagnose cancer, hypertension, or liver disease.

 CN: Reduction of risk potential;  
CL: Analyze


**34. 1.** In older adults who are less active and do not exercise the heart muscle, atrophy can result. Disuse or deconditioning can lead to abnormal changes in the myocardium of the older adult. As a result, under sudden emotional or physical stress, the left ventricle is less able to respond to the increased demands on the myocardial muscle. Decreased cardiac output, cardiac hypertrophy, and heart failure are examples of the chronic conditions that may develop in response to inactivity, rather than in response to the aging process. Irregular heartbeats are generally not associated with an older sedentary adult's lifestyle. Peripheral vascular occlusion or pacemaker placement should not affect response to stress.

 CN: Physiological adaptation; CL: Apply


**35. 3.** Nitroglycerin may be used prophylactically before stressful physical activities such as stair-climbing to help the client remain pain free. Visiting her friend early in the day would have no impact on decreasing pain episodes. Resting before or after an activity is not as likely to help prevent an activity-related pain episode.

 CN: Reduction of risk potential;  
CL: Synthesize

**36. 3.** Pasta, tomato sauce, salad, and coffee would be the best selection for the client following a low-cholesterol diet. Hamburgers, milkshakes, liver, and fried foods tend to be high in cholesterol.

 CN: Basic care and comfort; CL: Apply

**37. 1.** The client should report a change in the pattern of chest pain. It may indicate increasing severity of coronary artery disease. Pain occurring during stress or sexual activity would not be unexpected, and the client may be instructed to take nitroglycerin to prevent this pain. Pain during or after an activity such as lawn-mowing also would not be unexpected; the client may be instructed to take nitroglycerin to prevent this pain or may be restricted from doing such activities.

 CN: Reduction of risk potential;  
CL: Apply


**38. 2.** Cardiac catheterization is done in clients with angina primarily to assess the extent and severity of the coronary artery blockage. A decision about medical management, angioplasty, or coronary artery bypass surgery will be based on the catheterization results. Coronary bypass surgery would be used to bypass obstructed vessels. Although cardiac catheterization can be used to assess the functional adequacy of the valves and heart muscle, in this case the client has unstable angina and therefore would need the procedure to assess the extent of arterial blockage.

 CN: Reduction of risk potential;  
CL: Apply


**39. 4.** Because the contrast medium used in PTCA acts as an osmotic diuretic, the client may experience diuresis with resultant fluid volume deficit after the procedure. Additionally, potassium levels must be closely monitored because the client may develop hypokalemia due to the diuresis. Dyspnea would not be anticipated after this procedure. Maintaining adequate blood pressure control should not be a problem after the procedure. Increased myocardial contractility would be a goal, not decreased contractility.

 CN: Reduction of risk potential;  
CL: Synthesize

**40. 2.** Late onset of puberty is not generally considered to be a risk factor for the development of atherosclerosis. Risk factors for atherosclerosis include family history of atherosclerosis, cigarette smoking, hypertension, high blood cholesterol level, male gender, diabetes mellitus, obesity, and physical inactivity.


 CN: Physiological adaptation; CL: Apply

**41. 3.** Nitroglycerin produces peripheral vasodilation, which reduces myocardial oxygen consumption and demand. Vasodilation in coronary arteries and collateral vessels may also increase blood flow to the ischemic areas of the heart. Nitroglycerin decreases myocardial oxygen demand. Nitroglycerin does not have an effect on pericardial spasticity or conductivity in the myocardium.


 CN: Pharmacological and parenteral therapies; CL: Apply




**42. 1.** Headache is a common side effect of nitroglycerin that can be alleviated with aspirin, acetaminophen or ibuprofen. The sublingual nitroglycerin needs to be absorbed in the mouth, which will be disrupted with drinking. Lying flat will increase blood flow to the head and may increase pain and exacerbate other symptoms, such as shortness of breath.

 CN: Physiological adaptation;  
CL: Synthesize

**43. 3.** The correct protocol for nitroglycerin use involves immediate administration, with subsequent doses taken at 5-minute intervals as needed, for a total dose of three tablets. Sublingual nitroglycerin appears in the bloodstream within 2 to 3 minutes and is metabolized within about 10 minutes.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**44. 3.** The client taking nifedipine should inspect the gums daily to monitor for gingival hyperplasia. This is an uncommon adverse effect but one that requires monitoring and intervention if it occurs. The client taking nifedipine might be taught to monitor blood pressure, but more often than monthly. These clients would not generally need to perform daily weights or limit intake of green leafy vegetables.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

### The Client with Heart Failure


**45. 3.** The nurse should withhold the dose of captopril; captopril is an ACE-inhibitor and a side effect of the medication is hyperkalemia. The BUN and creatinine, which are normal, should be viewed prior to administration since renal insufficiency is another potential side effect of an ACE-I. The heart rate is within normal limits. The nurse should question the dose of metoprolol if the client's heart rate is bradycardic. The hemoglobin and hematocrit are normal for a female. The nurse should report the high potassium level and that the captopril was withheld.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**46. 3.** Coumadin is an anticoagulant, which is used in the treatment of atrial fibrillation and decreased left ventricular ejection fraction (less than 20%) to prevent thrombus formation and release of emboli into the circulation. The client may also take other medication as needed to manage the heart failure. Coumadin does not reduce circulatory load or improve myocardial workload. Coumadin does not affect cardiac rhythm.

 CN: Reduction of risk potential;  
CL: Evaluate


**47. 2.** Early symptoms of digoxin toxicity include anorexia, nausea, and vomiting. Visual disturbances can also occur, including double or blurred vision and visual halos. Hypokalemia is a common cause of digoxin toxicity associated with arrhythmias because low serum potassium can enhance ectopic pacemaker activity. Although vomiting can lead to fluid deficit, given the client's history, the vomiting is likely due to the adverse effects of digoxin toxicity. Pulmonary edema is manifested by dyspnea and coughing.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**48. 1, 3, 5.** When the heart begins to fail, the body activates three major compensatory systems: ventricular hypertrophy, the renin-angiotensin-aldosterone system, and sympathetic nervous stimulation. Parasympathetic stimulation and jugular venous distention are not compensatory mechanisms associated with heart failure.

 CN: Physiological adaptation;  
CL: Apply

**49. 3.** Signs of pulmonary edema are identical to those of acute heart failure. Signs and symptoms are generally apparent in the respiratory system and include coarse crackles, severe dyspnea, and tachypnea. Severe tachycardia may occur due to sympathetic stimulation in the presence of hypoxemia. Blood pressure may be decreased or elevated depending on the severity of the edema. Jugular vein distention, dependent edema, and anorexia are symptoms of right-sided heart failure.

 CN: Physiological adaptation;  
CL: Analyze

**50. 1.** It is a priority to assess blood pressure first because people with pulmonary edema typically experience severe hypertension that requires early intervention. The client probably does not have skin breakdown on admission; however, when the client is stable, the nurse should inspect the skin. Potassium levels are not the first priority. The nurse should monitor urine output after the client is stable.


 CN: Reduction of risk potential;  
CL: Analyze

**51. 1, 2, 3, 5.** A decrease in cardiac output occurs from a decreased stroke volume with impaired contractility in systolic heart failure. This impairs peripheral and renal perfusion. The impaired perfusion and impaired oxygenation cause the symptoms of activity intolerance. The decreased systolic function causes an increase in residual volume and pressure in the left ventricle. A retrograde buildup of pressure from the left ventricle to left atria increases hydrostatic pressure in the pulmonary

vasculature. This causes a leakage of fluid into the interstitial tissue of the lungs resulting in pulmonary symptoms. With diastolic heart failure, there is impaired ventricular filling due to a rigid ventricle and reduced ventricular relaxation.

 CN: Physiological adaptation;  
CL: Analyze


**52. 3.** Sitting almost upright in bed with the feet and legs resting on the mattress decreases venous return to the heart, thus reducing myocardial workload. Also, the sitting position allows maximum space for lung expansion. Low Fowler's position would be used if the client could not tolerate high Fowler's position for some reason. Lying on the right side would not be a good position for the client in heart failure. The client in heart failure would not tolerate the Trendelenburg's position.

 CN: Reduction of risk potential;  
CL: Synthesize


**53. 1.** Increasing cardiac output is the main goal of therapy for the client with heart failure or pulmonary edema. Pulmonary edema is an acute medical emergency requiring immediate intervention. Respiratory status and comfort will be improved when cardiac output increases to an acceptable level. Peripheral edema is not typically associated with pulmonary edema.

 CN: Reduction of risk potential;  
CL: Apply

**54. 2.** Digoxin is a cardiac glycoside with positive inotropic activity. This inotropic activity causes increased strength of myocardial contractions and thereby increases output of blood from the left ventricle. Digoxin does not dilate coronary arteries. Although digoxin can be used to treat arrhythmias and does decrease the electrical conductivity of the myocardium, these are not primary reasons for its use in clients with heart failure and pulmonary edema.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**55. 1.** After intravenous injection of furosemide, diuresis normally begins in about 5 minutes and reaches its peak within about 30 minutes. Medication effects last 2 to 4 hours. When furosemide is given intramuscularly or orally, drug action begins more slowly and lasts longer than when it is given intravenously.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**56. 4.** When diuretics are given early in the day, the client will void frequently during the daytime hours and will not need to void frequently during the night. Therefore, the client's sleep will not be


disturbed. Taking furosemide in the morning has no effect on preventing electrolyte imbalances or retarding rapid drug absorption. The client should not accumulate excessive fluids throughout the night.

 CN: Pharmacological and parenteral therapies; CL: Apply


**57. 2.** Characteristics of atrial fibrillation include pulse rate greater than 100 bpm, totally irregular rhythm, and no definite P waves on the ECG. During assessment, the nurse is likely to note the irregular rate and should report it to the physician. A weak, thready pulse is characteristic of a client in shock. Two regular beats followed by an irregular beat may indicate a premature ventricular contraction.

 CN: Reduction of risk potential;  
CL: Analyze


**58. 1.** Atrial fibrillation occurs when the sinoatrial node no longer functions as the heart's pacemaker and impulses are initiated at sites within the atria. Because conduction through the atria is disturbed, atrial contractions are reduced and stasis of blood in the atria occurs, predisposing to emboli. Some estimates predict that 30% of clients with atrial fibrillation develop emboli. Atrial fibrillation is not associated with increased cardiac output, elevated blood pressure, or decreased pulse rate; rather, it is associated with an increased pulse rate.

 CN: Reduction of risk potential;  
CL: Synthesize

**59. 3.** Colored vision and seeing yellow spots are symptoms of digoxin toxicity. Abdominal pain, anorexia, nausea, and vomiting are other common symptoms of digoxin toxicity. Additional signs of toxicity include arrhythmias, such as atrial fibrillation or bradycardia. Rash, increased appetite, and elevated blood pressure are not associated with digoxin toxicity.

 CN: Pharmacological and parenteral therapies; CL: Apply

**60. 4.** A low serum potassium level (hypokalemia) predisposes the client to digoxin toxicity. Because potassium inhibits cardiac excitability, a low serum potassium level would mean that the client would be prone to increased cardiac excitability. Sodium, glucose, and calcium levels do not affect digoxin or contribute to digoxin toxicity.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**61. 2.** Canned foods and juices such as tomato juice are typically high in sodium and should be avoided in a sodium-restricted diet. Canned foods and juices in which sodium has been removed or limited are available. The client should be taught to


read labels carefully. Apples and whole wheat breads are not high in sodium. Beef tenderloin would have less sodium than canned foods or tomato juice.

 CN: Reduction of risk potential;  
CL: Apply


**62. 2, 3, 4.** Hypokalemia is a side effect of loop diuretics. Bananas, dried fruit, and oranges are examples of food high in potassium. Angel food cake, yellow cake, and peppers are listed by the National Kidney Foundation as low in potassium.

 CN: Pharmacological and parenteral therapies; CL: Apply

**63. 2.** A normal apical impulse is found over the apex of the heart and is typically located and auscultated in the left fifth intercostal space in the midclavicular line. An apical impulse located or auscultated below the fifth intercostal space or lateral to the midclavicular line may indicate left ventricular enlargement.

 CN: Physiological adaptation;  
CL: Analyze

**64. 1.** The ankle edema suggests fluid volume overload. The nurse should assess respiratory rate, lung sounds, and SpO<sub>2</sub> to identify any signs of respiratory symptoms of heart failure requiring immediate attention. The nurse can then draw blood for laboratory studies, insert the Foley catheter, and weigh the client.

 CN: Physiological adaptation;  
CL: Synthesize

**65. 3.** Heart failure is a complex and chronic condition. Education should focus on health promotion and preventive care in the home environment. Signs and symptoms can be monitored by the client. Instructing the client to obtain daily weights at the same time each day is very important. The client should be told to call the physician if there has been a weight gain of 2 lb or more. This may indicate fluid overload, and treatment can be prescribed early and on an outpatient basis, rather than waiting until the symptoms become life-threatening. Following a high-fiber diet is beneficial, but it is not relevant to the teaching needs of the client with heart failure. Prescribing an exercise program for the client, such as walking 2 miles every day, would not be appropriate at discharge. The client's exercise program would need to be planned in consultation with the physician and based on the history and the physical condition of the client. The client may require exercise tolerance testing before an exercise plan is laid out. Although the nurse does not prescribe an exercise program for the client, a sedentary lifestyle should not be recommended.

 CN: Reduction of risk potential;  
CL: Create

**66. 1, 2, 4.** The client stating that he would call the physician with increasing shortness of breath, weight gain over 2 lb in 1 day, and having to sleep sitting up, indicates that he has understood the teaching because these signs and symptoms suggest worsening of the client's heart failure. Although the client will most likely be placed on a sodium-restricted diet, the client would not need to notify the physician if he or she had consumed a high-sodium breakfast. Instead the client would need to be alert for possible signs and symptoms of worsening heart failure and work to reduce sodium intake for the rest of that day and in the future.

 CN: Reduction of risk potential;  
CL: Evaluate

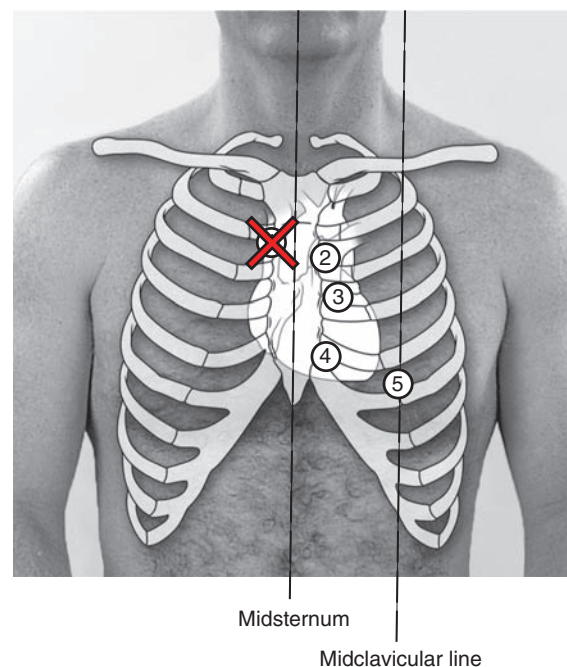
### The Client with Valvular Heart Disease

**67. 3.** A complication of balloon valvuloplasty is emboli resulting in a stroke. The client's increased drowsiness should be evaluated. Some degree of mitral regurgitation is common after the procedure. The oxygen status and urine output should be monitored closely, but do not warrant concern.

 CN: Reduction of risk potential;  
CL: Synthesize

**68.** The stethoscope is placed at the second intercostal space right of sternum (1) to assess the aortic area. (2) is the pulmonic valve area, (3) is Erb's point, (4) is the Tricuspid valve area, and (5) is the Mitral valve area.


 CN: Physiological adaptation; CL: Apply



**69. 2, 3, 4.** For clients scheduled for a cardiac catheterization it is important to assess for iodine sensitivity, verify written consent, and instruct the client to take nothing by mouth for 6 to 18 hours before the procedure. Oral medications are withheld unless specifically ordered. A urinary drainage catheter is rarely required for this procedure.

 CN: Reduction of risk potential;  
CL: Apply


**70. 3.** Assessment of circulatory status, including observation of the puncture site, is of primary importance after a cardiac catheterization. Laboratory values and skin warmth and turgor are important to monitor but are not the most important initial nursing assessment. Neurologic assessment every 15 minutes is not required.

 CN: Reduction of risk potential;  
CL: Analyze


**71. 3.** Most clients with mitral stenosis have a history of rheumatic fever or bacterial endocarditis. Chickenpox, poliomyelitis, and meningitis are not associated with mitral stenosis.

 CN: Physiological adaptation;  
CL: Analyze

**72. 2.** Common adverse effects of lidocaine hydrochloride include dizziness, tinnitus, blurred vision, tremors, numbness and tingling of extremities, excessive perspiration, hypotension, seizures, and finally coma. Cardiac effects include slowed conduction and cardiac arrest. Palpitations, urinary frequency, and lethargy are not considered typical adverse reactions to lidocaine.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**73. 2.** The nurse should immediately assess the blood pressure since Nipride and Lasix can cause severe hypotension from a decrease in preload and afterload. If the client is hypotensive, the Nipride dose should be reduced or discontinued. Urine output should then be monitored to make sure there is adequate renal perfusion. A 12-lead EKG is performed if the client experiences chest pain. A reduction in pulmonary artery pressures should improve the pulmonary congestion and lung sounds.

 CN: Physiological adaptation;  
CL: Synthesize

**74. 1.** Preoperatively, anticoagulants may be prescribed for the client with advanced valvular heart disease to prevent emboli. Postoperatively, all clients with mechanical valves and some clients with bioprostheses are maintained indefinitely on anticoagulant therapy. Adhering strictly to a dosage schedule and observing specific precautions are


necessary to prevent hemorrhage or thromboembolism. Some clients are maintained on lifelong antibiotic prophylaxis to prevent recurrence of rheumatic fever. Episodic prophylaxis is required to prevent infective endocarditis after dental procedures or upper respiratory, gastrointestinal, or genitourinary tract surgery. Diet modification, activity restrictions, and dental care are important; however, they do not have as much significance postoperatively as medication therapy does.

 CN: Reduction of risk potential;  
CL: Evaluate

**75. 4.** Management of postoperative pain is a priority for the client after surgery, including valve replacement surgery, according to the Agency for Health Care Policy and Research. The client and family should be informed that pain will be assessed by the nurse and medications will be given to relieve the pain. The client will stay in the ICU as long as monitoring and intensive care are needed. Sensory deprivation and overload, high noise levels, and disrupted sleep and rest patterns are some environmental factors that affect recovery from valve replacement surgery.

 CN: Reduction of risk potential;  
CL: Synthesize

**76. 2, 3, 4.** The hemoglobin and hematocrit should be assessed to evaluate blood loss. An elevated INR & PTT and decreased platelet count increase the risk for bleeding. The client may require blood products depending on lab values and severity of bleeding, therefore availability of blood products should be confirmed by calling the blood bank. Close monitoring of blood loss from the mediastinal chest tubes should be done. Coumadin is an anticoagulant that will increase bleeding. Anticoagulation should be held at this time. Information is needed on the type of valve replacement. For a mechanical heart valve, the INR is kept at 2 to 3.5. Tissue valves do not require anticoagulation. Dopamine should NOT be initiated if the client is hypotensive from hypovolemia. Fluid volume assessment should always be done first. Volume replacement should be initiated in a hypovolemic client prior to starting an inotrope such as dopamine.


 CN: Physiological adaptation;  
CL: Synthesize

**77. 1.** Many factors help prevent wound infections, including washing hands carefully, using sterile prepackaged supplies and equipment, cleaning the incisional area well, and disposing of soiled dressings properly. However, most authorities say that the single most effective measure in preventing wound infections is to wash the hands carefully before and after changing dressings. Careful hand washing is also important in reducing other


infections often acquired in hospitals, such as urinary tract and respiratory tract infections.

 CN: Reduction of risk potential;  
CL: Synthesize

**78. 1.** In an immobilized client, calcium leaves the bone and concentrates in the extracellular fluid. When a large amount of calcium passes through the kidneys, calcium can precipitate and form calculi. Nursing interventions that help prevent calculi include ensuring a liberal fluid intake (unless contraindicated). A diet rich in acid should be provided to keep the urine acidic, which increases the solubility of calcium. Preventing constipation is not associated with excessive calcium excretion. Limiting foods rich in calcium, such as dairy products, will help in preventing renal calculi.

 CN: Physiological adaptation;  
CL: Synthesize


**79. 3.** INR is the value used to assess effectiveness of the warfarin sodium therapy. INR is the prothrombin time ratio that would be obtained if the thromboplastin reagent from the World Health Organization was used for the plasma test. It is now the recommended method to monitor effectiveness of warfarin sodium. Generally, the INR for clients administered warfarin sodium should range from 2 to 3. In the past, prothrombin time was used to assess effectiveness of warfarin sodium and was maintained at 1.5 to 2.5 times the control value. Partial thromboplastin time is used to assess the effectiveness of heparin therapy. Fresh frozen plasma or vitamin K is used to reverse warfarin sodium's anticoagulant effect, whereas protamine sulfate reverses the effects of heparin. Warfarin sodium will help to prevent blood clots.

 CN: Pharmacological and parenteral therapies; CL: Apply


**80. 1.** Daily dental care and frequent checkups by a dentist who is informed about the client's condition are required to maintain good oral health. Use of an electric toothbrush, an irrigation device, or dental floss may cause gums to bleed and allow bacteria to enter mucous membranes and the bloodstream, increasing the risk of endocarditis.

 CN: Reduction of risk potential;  
CL: Create

**81. 2.** Most cardiac surgical clients have median sternotomy incisions, which take about 3 months to heal. Measures that promote healing include avoiding heavy lifting, performing muscle reconditioning exercises, and using caution when driving. Showering or bathing is allowed as long as the incision is well approximated with no open areas or drainage. Activities should be gradually resumed on discharge.


 CN: Safety and infection control;  
CL: Evaluate

**82. 1.** Verbalized concerns from this client may stem from her anxiety over the changes her body has gone through after open heart surgery. Although the client may experience anxiety related to her altered health status or may have a lack of knowledge regarding her postoperative course, she is pointing out the changes in her body image. The client is not concerned about altered tissue perfusion.

 CN: Psychosocial adaptation;  
CL: Analyze

## The Client with Hypertension

**83. 1.** The effect of a beta blocker is a decrease in heart rate, contractility, and afterload, which leads to a decrease in blood pressure. The client at first may have an increase in fatigue when starting the beta blocker. The mechanism of action does not improve blood sugar or urine output.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**84. 1, 3, 5.** Clonidine (Catapres) is a central-acting adrenergic antagonist. It reduces sympathetic outflow from the central nervous system. Dry mouth, impotence, and sleep disturbances are possible adverse effects. Hyperkalemia and pancreatitis are not anticipated with use of this drug.


 CN: Pharmacological and parenteral therapies; CL: Apply

**85. 200 mcg**  
First, calculate the number of milligrams per milliliter:

$$\frac{50 \text{ mg}}{250 \text{ mL}} = \frac{1 \text{ mg}}{5 \text{ mL}} = \frac{0.2 \text{ mg}}{1 \text{ mL}}$$

Next, calculate the number of micrograms in each milligram:


$$0.2 \text{ mg} \times 1,000 \text{ mcg} = 200 \text{ mcg}.$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**86. 2, 3.** Changing positions slowly and avoiding long periods of standing may limit the occurrence of orthostatic hypotension. Scheduling regular medication times is important for blood pressure management but this aspect is not related to the development of orthostatic hypotension. Excessive alcohol intake and hot baths are associated with vasodilation.

 CN: Reduction of risk potential;  
CL: Create


**87. 1.** Atenolol is a beta-adrenergic antagonist indicated for management of hypertension. Sudden discontinuation of this drug is dangerous because it may exacerbate symptoms. The medication should not be discontinued without a physician's order. Blood pressure needs to be monitored more frequently than annually in a client who is newly diagnosed and treated for hypertension. Clients are not usually placed on a 2-g sodium diet for hypertension.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**88. 3.** Processed and cured meat products, such as cold cuts, ham, and hot dogs, are all high in both fat and sodium and should be avoided on a low-calorie, low-fat, low-salt diet. Dietary restrictions of all types are complex and difficult to implement with clients who are basically asymptomatic.

 CN: Basic care and comfort; CL: Apply


**89. 4.** Possible dizziness from orthostatic hypotension when rising from a crouched or bent position increases the client's risk of being injured by the equipment. The nurse should assess the client's blood pressure in all three positions (lying, sitting, and standing) at all routine visits. The client may experience muscle aches, or thirst from working in a warm, dry room, but these are not as potentially dangerous as orthostatic hypotension. The client should not be experiencing lethargy.

 CN: Reduction of risk potential; CL: Analyze

**90. 4.** Tailoring or individualizing a program to the client's lifestyle has been shown to be an effective strategy for changing health behaviors. Providing a written program, explaining the program to the client's spouse, and reassuring the client that he or she can do the program may be helpful but are not as likely to promote adherence as individualizing the program.

 CN: Psychosocial adaptation; CL: Synthesize


**91. 3.** A plan to reduce or stop smoking begins with establishing the client's personal daily smoking pattern and activities associated with smoking. It is important that the client understands the associated health and environmental risks, but this knowledge has not been shown to help clients change their smoking behavior.

 CN: Psychosocial adaptation; CL: Synthesize


**92. 3.** American Heart Association standards define hypertension as a consistent systolic blood pressure level greater than 140 mm Hg and a consistent diastolic blood pressure level greater than 90 mm Hg.

 CN: Reduction of risk potential; CL: Analyze

**93. 1.** Propranolol is a beta-adrenergic blocking agent. Actions of propranolol include reducing heart rate, decreasing myocardial contractility, and slowing conduction. Propranolol does not increase norepinephrine secretion, cause vasodilation, or block conversion of angiotensin I to angiotensin II.

 CN: Pharmacological and parenteral therapies; CL: Apply

**94. 3.** Compliance is the most critical element of hypertension therapy. In most cases, hypertensive clients require lifelong treatment and their hypertension cannot be managed successfully without drug therapy. Stress management is an important component of hypertension therapy, but the priority goal is related to compliance. It is not necessary for the client to change jobs or retire, but rather to learn to manage stress if the job is stressful. Losing weight may be necessary and will contribute to lower blood pressure, but the client must first accept the need for a lifelong management plan to control the hypertension.

 CN: Psychosocial adaptation; CL: Synthesize


**95. 1.** Renal disease, including renal insufficiency and failure, is a complication of hypertension. Effective treatment of hypertension assists in preventing this complication. Valvular heart disease, endocarditis, and peptic ulcer disease are not complications of hypertension.

 CN: Reduction of risk potential; CL: Synthesize

**96. 1.** Hypertension is referred to as the silent killer for adults, because until the adult has significant damage to other systems, the hypertension may go undetected. CVAs can be related to long-term hypertension. Liver or pulmonary disease is not generally associated with hypertension. Myocardial infarction is generally related to coronary artery disease.

 CN: Reduction of risk potential; CL: Create

**97. 2.** The client may be asymptomatic and the underlying cause should be assessed. Drugs that block the AV node should be avoided, such as beta blockers (Atenolol), calcium channel blockers, digoxin, and amiodarone. Symptomatic clients are treated with atropine and transcutaneous pacing. There is no indication for a fluid bolus, cardioversion, or arterial line.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

## The Client with a Permanent Pacemaker

**98. 1, 5.** The nurse must teach the client how to take and record his pulse daily. The client should be instructed to avoid lifting the operative-side arm above shoulder level for 1 week postinsertion. It takes up to 2 months for the incision site to heal and full range of motion to return. The client should avoid heavy lifting until approved by the physician. The pacemaker metal casing does not set off airport security alarms, so there are no travel restrictions. Prolonged immobilization is not required. Microwave ovens are safe to use and do not alter pacemaker function.

 CN: Reduction of risk potential;  
CL: Create

**99. 1.** Transcutaneous pacemaker therapy provides an adequate heart rate to a client in an emergency situation. Defibrillation and a lidocaine infusion are not indicated for the treatment of third-degree heart block. Transcutaneous pacing is used temporarily until a transvenous or permanent pacemaker can be inserted.

 CN: Physiological adaptation;  
CL: Synthesize

**100. 2.** Maintaining cardiac conduction stability to prevent arrhythmias is a priority immediately after artificial pacemaker implantation. The client should have continuous electrocardiographic monitoring until proper pacemaker functioning is verified. Skin integrity, while important, is not an immediate concern. The pacemaker is used to increase heart rate and cardiac output, not decrease it. The client should limit activity for the first 24 to 48 hours after pacemaker insertion. The client should also restrict movement of the affected extremity for 24 hours.

 CN: Reduction of risk potential;  
CL: Synthesize

**101. 3.** Education is a major component of the discharge plan for a client with an artificial pacemaker. The client with a permanent pacemaker needs to be able to state specific information about safety precautions, such as to refrain from lifting more than 3 lb or stretching and bending and to count the pulse once per week, that are necessary to maintain proper pacemaker function. The client will not necessarily be placed on a low cholesterol diet. The client should resume activities as he is able, and does not need to remain on bed rest. The client should know signs and symptoms of MI, but is not at risk because of the pacemaker.


 CN: Basic care and comfort; CL: Evaluate

## The Client Requiring Cardiopulmonary Resuscitation

**102. 3.** Transcutaneous pads should be placed on the client with third degree heart block. For a client who is symptomatic, transcutaneous pacing is the treatment of choice. The hemodynamic stability and pulse should be assessed prior to calling a code or initiating CPR. Defibrillation is performed for ventricular fibrillation or ventricular tachycardia with no pulse.

 CN: Management of care; CL: Synthesize

**103. 3.** The presence of a pulse determines the treatment for ventricular tachycardia. It is also important to assess the client's heart rate and level of consciousness. Cardioversion may be used to treat hemodynamically unstable tachycardias. Assessment of instability is required before cardioversion. It is not appropriate to begin CPR unless the pulse is absent. Defibrillation is used to treat ventricular fibrillation or pulseless ventricular tachycardia.

 CN: Physiological adaptation;  
CL: Synthesize


**104. 1, 3, 4.** A conducting agent is placed between the skin and the paddles to conduct the electrical current when discharged. The nurse must make sure to call "clear" before discharging the electrical current to prevent injury to others who may be helping with the client. Each paddle is placed directly on the conductive pads that are on the client's skin. Applying approximately 20 to 25 lb of pressure on each paddle is recommended to ensure good skin contact. The nurse must record the amount of electrical current delivered and the resulting rhythm.

 CN: Reduction of risk potential;  
CL: Synthesize

**105. 2.** Pupillary reaction is the best indication of whether oxygenated blood has been reaching the client's brain. Pupils that remain widely dilated and do not react to light probably indicate that serious brain damage has occurred. The pulse rate may be normal, mucous membranes may still be pink, and systolic blood pressure may be 80 mm Hg or higher, and serious brain damage may still have occurred.

 CN: Reduction of risk potential;  
CL: Evaluate

**106. 3.** Amiodarone is used for the treatment of premature ventricular contractions, ventricular tachycardia with a pulse, atrial fibrillation, and atrial flutter. Amiodarone is not used as initial therapy for a pulseless dysrhythmia.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**107. 2.** Because of its location near the xiphoid process, the liver is the organ most easily damaged from pressure exerted over the xiphoid process during CPR. The pressure on the victim's chest wall should be sufficient to compress the heart but not so great as to damage internal organs. Injury may result, however, even when CPR is performed properly.

 CN: Reduction of risk potential; CL: Apply

**108. 3.** An adult's sternum must be depressed 1.5 to 2 inches with each compression to ensure adequate heart compression.

 CN: Reduction of risk potential; CL: Apply

**109. 4.** If the chest wall is not rising with rescue breaths, the head should be repositioned first to ensure that the airway is adequately opened. An ambu bag allows for delivery of 100% oxygen. Compressions should be maintained at 100 per minute.

 CN: Physiological adaptation;  
CL: Synthesize

**110. 1.** The exhalation phase of ventilation is a passive activity that occurs during CPR as part of the normal relaxation of the victim's chest. No action by the rescuer is necessary.

 CN: Reduction of risk potential; CL: Apply


**111. 2.** After a person is without cardiopulmonary function for 4 to 6 minutes, permanent brain damage is almost certain. To prevent permanent brain damage, it is important to begin CPR promptly after a cardiopulmonary arrest.

 CN: Reduction of risk potential; CL: Apply

**112. 2.** The Heimlich maneuver should be administered only to a victim who cannot make *any* sounds due to airway obstruction. If the victim can whisper words or cough, some air exchange is occurring and the emergency medical system should be called instead of attempting the Heimlich maneuver. Cyanosis may accompany or follow choking; however, the Heimlich maneuver should only be initiated when the victim cannot speak.


 CN: Reduction of risk potential; CL: Apply

**113. 4.** The thrusts should be delivered below the xiphoid process, but above the umbilicus, to minimize the risk of internal injuries.

 CN: Reduction of risk potential; CL: Apply

**114. 2.** The priority action is to assess the client and determine whether the rhythm is life-threatening. More information, including vital signs, should be obtained and the physician should be quickly notified. A bolus of lidocaine may be ordered to treat this arrhythmia. This is not a code-type

situation unless the client has been determined to be in a life-threatening situation.

 CN: Physiological adaptation;  
CL: Synthesize

## Managing Care Quality and Safety

**115. 2.** The rapid response team should be called immediately to evaluate and treat the client. There is no indication at this time for manual ventilations or chest compressions. If the family is not interfering in client care, it can be reassuring to the family to see that all possible care is being provided.

 CN: Management of care; CL: Synthesize

**116. 4.** Unlicensed personnel are able to measure and record intake and output. The nurse is responsible for client teaching, physical assessments, and evaluating the information collected on the client.

 CN: Management of care; CL: Synthesize

**117. 2.** The client has gained 5 lb in 3 days with a steady increase in blood pressure. The client is exhibiting signs of heart failure and if the client is short of breath, this will be another sign. Asking how the client is feeling is too general and a more focused question will quickly determine the client's current health status. The scales should be calibrated periodically, but a 5 lb weight gain, along with increased blood pressure, is not likely due to problems with the scale. The weight gain is likely due to fluid retention, not drinking too much fluid.

 CN: Management of care; CL: Analyze

**118. 4.** The goals of managing clients outside of the hospital are for the clients to maintain health and prevent readmission, thus interventions, such as monitoring and teaching appear to have contributed to the low readmission rate in this group of clients. Although it is important that clients do not gain weight, view educational material and continue to take their medication, the primary indicator of effectiveness of the program is the lack of re-hospitalization.

 CN: Management of care; CL: Evaluate

**119. 3.** Using an individualized, printed checklist assures that all key information is reported; the checklist can then serve as a record to which nurses can refer later. Giving a verbal report leaves room for error in memory; using an audiotape or an electronic health record requires nurses to spend unnecessary time retrieving information.

 CN: Safety and infection control;  
CL: Evaluate



## TEST 2

# The Client with Vascular Disease

- The Client with Peripheral Vascular Disease
- The Client with Peripheral Vascular Disease Having an Amputation
- The Client with Buerger's Disease
- The Client with Vasospastic Disorder
- The Client with Thrombophlebitis and Embolus Formation
- The Client with an Aneurysm
- The Client with Stasis Ulcers
- The Client with Peripheral Arterial Occlusive Disease
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Peripheral Vascular Disease

**1.** The nurse is assessing a 48-year-old client with a history of smoking during a routine clinic visit. The client, who exercises regularly, reports having pain in the calf during exercise that disappears at rest. Which of the following findings requires further evaluation?

- 1. Heart rate 57 bpm.
- 2. SpO<sub>2</sub> of 94% on room air.
- 3. Blood pressure 134/82.
- 4. Ankle brachial index of 0.65.

**2.** A client with peripheral vascular disease has undergone a right femoral-popliteal bypass graft. The blood pressure has decreased from 124/80 to 94/62. What should the nurse assess **first**?

- 1. IV fluid solution.
- 2. Pedal pulses.
- 3. Nasal cannula flow rate.
- 4. Capillary refill.

**3.** An overweight client taking warfarin (Coumadin) has a nursing diagnosis of *Ineffective tissue perfusion* related to decreased arterial blood flow. What should the nurse instruct the client to do? Select all that apply.

- 1. Apply lanolin or petroleum jelly to intact skin.
- 2. Encourage a reduced-calorie, reduced-fat diet.
- 3. Inspect the involved areas daily for new ulcerations.
- 4. Instruct the client to limit activities of daily living (ADLs).
- 5. Use an electric razor to shave.

**4.** Peripheral blood flow is dependent on which of the following variables?

- 1. Blood viscosity and diameter of vessels.
- 2. Diameter and resistance of vessels.
- 3. Force of contraction of the heart and resistance of vessels.
- 4. Pressure differences in the arterial and venous systems and resistance.

**5.** Blood pressure in the systemic circulation is **highest** in the:

- 1. Arterioles.
- 2. Capillaries.
- 3. Aorta.
- 4. Venules.

**6.** A common abnormal laboratory result associated with the development of peripheral vascular disease (PVD) is:

- 1. High serum calcium level.
- 2. High serum lipid levels.
- 3. Low serum potassium level.
- 4. Low serum lipid levels.

**7.** The nurse is planning care for a client with a history of peripheral vascular disease who has symptoms of claudication. Nursing care should be directed to avoiding which of the following situations?

- 1. Oxygen demand by the muscle exceeds the supply.
- 2. Oxygen demand and supply of the working muscle are in balance.
- 3. Oxygen supply exceeds the demand of the working muscle.
- 4. Oxygen is absent.

**8.** Which of the following explains the influence of aging on the development of peripheral vascular disease?

- 1. Decreased resistance.
- 2. Increased resistance.
- 3. Decreased viscosity.
- 4. Increased viscosity.

**9.** The client admitted with peripheral vascular disease (PVD) asks the nurse why her legs hurt when she walks. The nurse bases a response on the knowledge that the main characteristic of PVD is:

- 1. Decreased blood flow.
- 2. Increased blood flow.
- 3. Slow blood flow.
- 4. Thrombus formation.

**10.** The nurse is planning care for a client who is diagnosed with peripheral vascular disease (PVD) and has a history of heart failure. The nurse should develop a plan of care that is based on the fact that the client may have a low tolerance for exercise related to:

- 1. Decreased blood flow.
- 2. Increased blood flow.
- 3. Decreased pain.
- 4. Increased blood viscosity.

**11.** When assessing the lower extremities of a client with peripheral vascular disease (PVD), the nurse notes bilateral ankle edema. The edema is related to:

- 1. Competent venous valves.
- 2. Decreased blood volume.
- 3. Increase in muscular activity.
- 4. Increased venous pressure.

**12.** The nurse is obtaining the pulse of a client who has had a femoral-popliteal bypass surgery 6 hours ago. Which assessment provides the most accurate information about the client's post-operative status?

1.



2.



3.



4.



**13.** The nurse is teaching a client about risk factors associated with atherosclerosis and how to reduce the risk. Which of the following is a risk factor that the client is not able to modify?

- 1. Diabetes.
- 2. Age.
- 3. Exercise level.
- 4. Dietary preferences.

**14.** The nurse is assessing the lower extremities of the client with peripheral vascular disease (PVD). During the assessment, the nurse should expect to find which of the following clinical manifestations of PVD?

- 1. Hairy legs.
- 2. Mottled skin.
- 3. Pink, cool skin.
- 4. Warm, moist skin.

**15.** The client has midcalf pain when walking a block or more. The client states that the discomfort is relieved with rest. The pain is expected when arterial occlusion reaches which of the following percentages?

- 1. 20%.
- 2. 40%.
- 3. 50%.
- 4. 100%.

**16.** The nurse is unable to palpate the client's left pedal pulses. Which of the following actions should the nurse take **next**?

- 1. Auscultate the pulses with a stethoscope.
- 2. Call the physician.
- 3. Use a Doppler ultrasound device.
- 4. Inspect the lower left extremity.

**17.** When using a Doppler instrument to assess peripheral pulses, the correct placement of the transducer is important because it is difficult to differentiate between:

- 1. Arterial and capillary blood flow.
- 2. Arterial and venous blood flow.
- 3. Arterial and arteriole blood flow.
- 4. Capillary and venous blood flow.

**18.** Which of the following lipid abnormalities is a risk factor for the development of atherosclerosis and peripheral vascular disease?

- 1. Low concentration of triglycerides.
- 2. High levels of high-density lipid (HDL) cholesterol.
- 3. High levels of low-density lipid (LDL) cholesterol.
- 4. Low levels of LDL cholesterol.

**19.** When assessing an individual with peripheral vascular disease, which clinical manifestation would indicate complete arterial obstruction in the lower left leg?

- 1. Aching pain in the left calf.
- 2. Burning pain in the left calf.
- 3. Numbness and tingling in the left leg.
- 4. Coldness of the left foot and ankle.

**20.** One goal of care for a client with PVD is to decrease anxiety, so as to decrease or prevent vasoconstriction of the:

- 1. Arteries.
- 2. Capillaries.
- 3. Lymphatics.
- 4. Veins.

**21.** A 70-year-old male with the diagnosis of claudication has been hospitalized for an evaluation of his increasingly impaired mobility and complaints of pain. The client tells the nurse that he can no longer walk a block without having severe pain in his left calf and foot. Based on these data, which nursing diagnosis would be **most** appropriate for this client?

- 1. *Activity intolerance* related to decreased blood supply and pain.
- 2. *Self-care deficit* related to increased leg pain.
- 3. *Ineffective coping* related to chronic pain.
- 4. *Impaired skin integrity* related to poor circulation.

**22.** A client with peripheral vascular disease returns to the surgical care unit after having femoral-popliteal bypass grafting. Indicate in which order the nurse should conduct assessment of this client.

1. Postoperative pain.

2. Peripheral pulses.

3. Urine output.

4. Incision site.

**23.** A client with a history of heart failure has bilateral +4 edema of her right ankle that extends up to midcalf. She is sitting out of bed and has her legs in a dependent position. Which of the following goals is the priority?

- 1. Decrease venous congestion.
- 2. Maintain normal respirations.
- 3. Maintain body temperature.
- 4. Prevent injury to lower extremities.

**24.** The nurse is assessing an older Caucasian male who has a history of peripheral vascular disease. The nurse observes that the man's left great toe is black. The discoloration is probably a result of:

- 1. Atrophy.
- 2. Contraction.
- 3. Gangrene.
- 4. Rubor.

**25.** The nurse uses a Doppler ultrasound device to assess the client's lower extremities. In addition, the nurse calculates the ankle-brachial index to estimate stenosis of the:

- 1. Arteries.
- 2. Aorta.
- 3. Carotid.
- 4. Veins.

**26.** A client is scheduled for an arteriogram. The nurse should explain to the client that the arteriogram will confirm the diagnosis of occlusive arterial disease by:

- 1. Showing the location of the obstruction and the collateral circulation.
- 2. Scanning the affected extremity and identifying the areas of volume changes.
- 3. Using ultrasound to estimate the velocity changes in the blood vessels.
- 4. Determining how long the client can walk.

**27.** A client is scheduled to have an arteriogram. During the arteriogram, the client reports having nausea, tingling, and dyspnea. The nurse's **immediate** action should be to:

- 1. Administer epinephrine.
- 2. Inform the physician.
- 3. Administer oxygen.
- 4. Inform the client that the procedure is almost over.

**28.** A client with peripheral vascular disease has chronic, severe pretibial and ankle edema bilaterally. Because the client is on complete bed rest and circulation is compromised, one goal is to maintain tissue integrity. Which of the following interventions will help achieve this outcome?

- 1. Administering pain medication.
- 2. Encouraging fluids.
- 3. Turning the client every 1 to 2 hours.
- 4. Maintaining hygiene.

**29.** A client who has been diagnosed with peripheral vascular disease (PVD) is being discharged. The client needs further instruction if she says she will:

- 1. Avoid heating pads.
- 2. Not cross her legs.
- 3. Wear leather shoes.
- 4. Use iodine on an injured site.

**30.** A client with peripheral vascular disease has bypass surgery. The **primary** goal of the plan of care after surgery is to:

- 1. Maintain circulation.
- 2. Prevent infection.
- 3. Relieve pain.
- 4. Provide education.

**31.** The nurse is instructing a client who is at risk for peripheral vascular disease how to use knee length elastic stockings (support hose). The teaching plan should include which of the following? Check all that apply.

- 1. Apply the elastic stockings in the morning.
- 2. Remove the stockings if swelling occurs.
- 3. Apply the stockings while in bed.
- 4. Once the stockings have been pulled over the calf, roll the remaining stocking down to make a cuff.
- 5. Keep the stockings in place for 48 hours and reapply using a clean pair of stockings.

**32.** A client is scheduled to undergo right axillary-to-axillary artery bypass surgery. Which of the following interventions is **most** important for the nurse to implement in the preoperative period?

- 1. Assess the temperature in the affected arm.
- 2. Monitor the radial pulse in the affected arm.
- 3. Protect the extremity from cold.
- 4. Avoid using the arm for a venipuncture.

### The Client with Peripheral Vascular Disease Having an Amputation

**33.** A client is admitted to the hospital with peripheral vascular disease (PVD) of the lower extremities. He is scheduled for an amputation of the left leg. The client says, "I've really tried to manage my condition well." Which of the following routines should the nurse evaluate as having been appropriate for him?

- 1. Resting with his legs elevated above the level of his heart.
- 2. Walking slowly but steadily for 30 minutes twice a day.
- 3. Minimizing activity.
- 4. Wearing antiembolism stockings at all times when out of bed.

**34.** While the nurse is providing preoperative teaching, the client says, "I hate the idea of being an invalid after they cut off my leg." The nurse's **most** therapeutic response should be:

- 1. "You'll still have one good leg to use."
- 2. "Tell me more about how you're feeling."
- 3. "Let's finish the preoperative teaching."
- 4. "You're fortunate to have a wife who can take care of you."

**35.** The client asks the nurse, “Why can’t the doctor tell me exactly how much of my leg they’re going to take off? Don’t you think I should know that?” The nurse responds, knowing that the final decision on the level of the amputation will depend **primarily** on:

- 1. The need to remove as much of the leg as possible.
- 2. The adequacy of the blood supply to the tissues.
- 3. The ease with which a prosthesis can be fitted.
- 4. The client’s ability to walk with a prosthesis.

**36.** A client has undergone an amputation of several toes and a femoral-popliteal bypass. The nurse should teach the client that after surgery which of the following leg positions is contraindicated for her while sitting in a chair?

- 1. Crossing the legs.
- 2. Elevating the legs.
- 3. Flexing the ankles.
- 4. Extending the knees.

**37.** The nurse is monitoring a client after an above-the-knee amputation and notes that blood has saturated through the distal part of the dressing. The nurse should immediately:

- 1. Apply a tourniquet.
- 2. Assess vital signs.
- 3. Call the physician.
- 4. Elevate the surgical extremity with a large pillow.

**38.** The client has had a below-the-knee amputation secondary to arterial occlusive disease. The nurse is instructing the client in stump care. Which of the following statements by the client indicates that she understands how to implement her plan of care?

- 1. “I should inspect the incision carefully when I change the dressing every other day.”
- 2. “I should wash the incision, dry it, and apply moisturizing lotion daily.”
- 3. “I should rewrap the stump as often as needed.”
- 4. “I should elevate the stump on pillows to decrease swelling.”

**39.** One goal in caring for a client with arterial occlusive disease is to promote vasodilation in the affected extremity. To achieve this goal, the nurse encourages the client to:

- 1. Avoid eating low-fat foods.
- 2. Elevate the legs above the heart.
- 3. Stop smoking.
- 4. Begin a jogging program.

**40.** The client complains of aching, weakness, and a cramping sensation in both of his lower extremities while walking. The nurse knows that exercise enhances blood circulation and utilization of oxygen by the tissues. To promote health and maintain the client’s level of activity, the nurse should suggest that the client try:

- 1. Cross-country skiing.
- 2. Jogging.
- 3. Golfing.
- 4. Riding a stationary bike.

**41.** The client with peripheral vascular disease has been prescribed diltiazem (Cardizem). The nurse should determine the effectiveness of this medication by assessing the client for:

- 1. Relief of anxiety.
- 2. Sedation.
- 3. Vasoconstriction.
- 4. Vasodilation.

**42.** A client is receiving Pentoxifylline (Trental) for intermittent claudication. The nurse should determine the effectiveness of the drug by asking the client:

- 1. If he has improved circulation in the legs.
- 2. If he can wiggle his toes.
- 3. If he is urinating more frequently.
- 4. If he is less dizzy.

**43.** A client with peripheral vascular disease and chronic obstructive pulmonary disease takes theophylline (Theo-Dur) 200 mg twice daily every day. The physician now prescribes pentoxifylline (Trental). To prevent problematic adverse effects, the nurse should monitor the client’s:

- 1. Digoxin level.
- 2. Partial thromboplastin time (PTT).
- 3. Serum cholesterol level.
- 4. Theophylline level.

**44.** A client with a history of coronary artery disease (CAD) has been diagnosed with peripheral vascular disease. The physician started the client on pentoxifylline (Trental) once daily. Approximately 1 hour after receiving the initial dose of pentoxifylline, the client complained of chest pain, which he stated he had not experienced before. Which of the following interventions represents the **most** appropriate nursing action?

- 1. Advise the client to rest.
- 2. Inform the physician.
- 3. Encourage the client to relax.
- 4. Document the episode in the chart.

**45.** A client with peripheral vascular disease is recovering from an aortofemoral-popliteal bypass graft. When developing a postoperative education plan, which question by the nurse will provide the **most** helpful information?

- 1. “How did you manage your health before admission?”
- 2. “How far could you walk without pain before surgery?”
- 3. “What is your home environment like?”
- 4. “Do you have problems with urine retention?”

**46.** The client with peripheral vascular disease and a history of hypertension is to be discharged on a low-fat, low-cholesterol, low-sodium diet. Which should be the nurse’s **first** step in planning the dietary instructions?

- 1. Determine the client’s knowledge level about cholesterol.
- 2. Ask the client to name foods high in fat, cholesterol, and salt.
- 3. Explain the importance of complying with the diet.
- 4. Assess the family’s food preferences.

### The Client with Buerger’s Disease

**47.** Which of the following clients is at **greatest** risk for Buerger’s disease?

- 1. A 29-year-old male with a 14-year history of cigarette smoking.
- 2. A 38-year-old female who is taking birth control pills.
- 3. A 54-year-old female with adult onset diabetes.
- 4. A 65-year-old male with atherosclerosis.

**48.** The **primary** goal for the client with Buerger’s disease is to prevent:

- 1. Embolus formation.
- 2. Fat embolus formation.
- 3. Thrombus formation.
- 4. Thrombophlebitis.

**49.** A client with Buerger’s disease smokes two packs of cigarettes a day. Smoking cessation is critical or the client may lose the affected extremity. When helping a client change behavior, it is important to know the client’s:

- 1. Ability to attend support groups.
- 2. Goals of the treatment.
- 3. Perception of the negative behavior.
- 4. Motivation.

**50.** A client with Buerger’s disease has established a goal to stop smoking. Which medication would be the **most** helpful in attaining this goal?

- 1. Zyban (Bupropion).
- 2. Nicotine (Nicotrol).
- 3. Nitroglycerin (Tridil).
- 4. Ibuprofen (Advil).

**51.** The nurse is assessing a client with Buerger’s disease. The nurse should determine if the client is experiencing:

- 1. Thickening of the intima and media of the artery.
- 2. Inflammation and fibrosis of arteries, veins, and nerves.
- 3. Vasospasm lasting several minutes.
- 4. Pain, pallor, and pulselessness.

### The Client with Vasospastic Disorder

**52.** When instructing a client who has been newly diagnosed with vasospastic disorder (Raynaud’s phenomenon) about management of care, the nurse should discuss which of the following topics?

- 1. Scheduling a sympathectomy procedure for the next visit.
- 2. Using a beta blocker medication.
- 3. Follow-up monitoring for development of connective tissue disease.
- 4. Benefit of an angioplasty to the affected extremities.

**53.** A client has been diagnosed with vasospastic disorder (Raynaud’s phenomenon) on the tip of the nose and fingertips. The physician has prescribed reserpine (Serpasil) to determine if the client will obtain relief. The client’s history reveals that he lives in Vermont and works outside in the logging industry. He smokes two packs of cigarettes per day. Which of the following components are an important part of the discharge plan for this client? Select all that apply.

- 1. Stopping smoking.
- 2. Wearing a face covering and gloves in the winter.
- 3. Placing fingertips in cool water to rewarm them.
- 4. Finding employment that can be done in a warm environment.
- 5. Reporting signs of orthostatic hypotension.

**54.** A nurse assesses a 40-year-old female client with vasospastic disorder (Raynaud's phenomenon) involving her right hand. The nurse notes the information in the progress notes, as shown below. From these findings, the nurse should formulate which **priority** nursing diagnosis?

Progress Notes		
Date	Time	Progress Notes
06/10/07	03:00 pm	The client has a palpable but faint right radial pulse. Capillary re-fill on all five digits less than 8 seconds. No observable swelling. The client is reporting numbness in the tips of all five digits. The skin is warm, dry, and red.  G. Fuentes, RN

- 1. *Acute pain* related to hyperemic stage.
- 2. *Disturbed sensory perception (tactile)* related to vasospastic process.
- 3. *Ineffective tissue perfusion (peripheral)* related to vasospastic process.
- 4. *Risk for impaired skin integrity* related to vasospastic process.

**55.** A nurse is assessing a group of clients. Which clients are at risk for vasospastic disorder (Raynaud's phenomenon)?

- 1. Young women.
- 2. Old women.
- 3. Old men.
- 4. Young men.

**56.** The client with vasospastic disorder (Raynaud's phenomenon) complains of cold and numbness in her fingers. The nurse assesses the client for effects of vasoconstriction. Which of the following is an early sign of vasoconstriction?

- 1. Cyanosis.
- 2. Gangrene.
- 3. Pallor.
- 4. Rubor.

**57.** During an initial assessment of a client diagnosed with vasospastic disorder (Raynaud's phenomenon), the nurse notes a sudden color change to white in the fingers. The nurse should **first** assess:

- 1. Appearance of cyanosis.
- 2. Radial pulse.
- 3. SpO<sub>2</sub> of the affected fingers.
- 4. Blood pressure.

**58.** The nurse should instruct a client who has been diagnosed with vasospastic disorder (Raynaud's phenomenon) to:

- 1. Immerse her hands in cold water during an episode.
- 2. Wear light garments when the temperature gets below 50° F (10° C).
- 3. Wear gloves when handling ice or frozen foods.
- 4. Live in a cold climate.

**59.** In order to prevent recurrent vasospastic episodes with Raynaud's phenomenon, the nurse should instruct the client to:

- 1. Keep the hands and feet elevated as much as possible.
- 2. Use a vibrating massage device on the hands.
- 3. Wear gloves when obtaining food from the refrigerator.
- 4. Increase coffee intake to 2 cups per day.

**60.** A client with Raynaud's phenomenon is prescribed diltiazem (Cardizem). An expected outcome is:

- 1. Decreased heart rate.
- 2. Conversion to normal sinus rhythm.
- 3. Reduced episodes of finger numbness.
- 4. Increased SpO<sub>2</sub>.

**61.** When giving discharge instructions to the client with vasospastic disorder (Raynaud's phenomenon), the nurse should explain that the expected outcome of taking a beta-adrenergic blocking medication is to control the symptoms by:

- 1. Decreasing the influence of the sympathetic nervous system on the tissues in the hands and feet.
- 2. Decreasing the pain by producing analgesia.
- 3. Increasing the blood supply to the affected area.
- 4. Increasing monoamine oxidase.

**62.** A client with vasospastic disorder (Raynaud's phenomenon) is scheduled for sympathectomy. This surgery is performed:

- 1. In the early stages of the disease to prevent further circulatory disturbances.
- 2. When the disease is controlled by medication.
- 3. When the client is unable to control stress-related vasospasm.
- 4. When all other treatment alternatives have failed.

## The Client with Thrombophlebitis and Embolus Formation

**63.** A client is being treated for deep vein thrombosis (DVT) in the left femoral artery. The physician has ordered 60 mg of enoxaparin (Lovenox) subcutaneously. Before administering the drug, the nurse checks the client's laboratory results, noted below.

Laboratory Results	
Test	Result
Prothrombin time	12.5 seconds
INR	2.0 seconds
Platelet count	50,000/ $\mu$ L

Based on these results, the nurse should:

- 1. Assess the client for bleeding.
- 2. Administer the medication.
- 3. Inform the physician.
- 4. Withhold the dose of Lovenox.

**64.** The nurse is caring for a client with acute arterial occlusion of the left lower extremity. To prevent further tissue damage, it is important for the nurse to observe for which of the following?

- 1. Blood pressure and heart rate changes.
- 2. Gradual or acute loss of sensory and motor function.
- 3. Metabolic acidosis.
- 4. Swelling in the left lower extremity.

**65.** A nurse is assigned to a client with venous thrombus. The nurse identifies a nursing diagnosis of *Impaired physical mobility* related to pain. Which should the nurse do **first**?

- 1. Elevate the legs.
- 2. Elevate the legs by using a pillow under the knees.
- 3. Encourage adequate fluid intake.
- 4. Massage the lower legs.

**66.** A 45-year-old client had a complete abdominal hysterectomy with bilateral salpingo-oophorectomy 2 days ago. The client's abdominal dressing is dry and intact. In addition, the client is taking liquids and voiding a sufficient quantity of straw-colored urine. While sitting up in the chair after her bath, the client complains of severe pain and numbness in her left leg. The nurse should respond immediately by:

- 1. Administering pain medication.
- 2. Assessing for edema in the left leg.
- 3. Assessing color and temperature of the left leg.
- 4. Encouraging the client to change her position.

**67.** A client is discharged after being hospitalized for thrombophlebitis. She will be driving home with her daughter, who lives 2 hours away. During the 2-hour ride, the nurse should advise the client to:

- 1. Perform arm circles while riding in the car.
- 2. Perform ankle pumps and foot range-of-motion exercises.
- 3. Elevate her legs while riding in the car.
- 4. Take an ambulance home.

**68.** A client is admitted from a nursing home with an acute onset of shortness of breath. A diagnosis of pulmonary embolism is made. One common cause of pulmonary embolism is:

- 1. Arteriosclerosis.
- 2. Aneurysm formation.
- 3. Deep vein thrombosis (DVT).
- 4. Varicose veins.

**69.** A client receives a thrombolytic agent. The expected outcome of this drug therapy includes:

- 1. Improved cerebral perfusion.
- 2. Decreased vascular permeability.
- 3. Dissolved emboli.
- 4. Prevention of further cerebral hemorrhage.

**70.** A client who weighs 187 lb has an order to receive enoxaparin (Lovenox) 1 mg/kg. This drug is available in a concentration of 30 mg/0.3 mL. What dose would the nurse administer in milliliters?

\_\_\_\_\_ mL.

**71.** A client is on complete bed rest. The nurse should assess the client for risk for developing which of the following complications?

- 1. Air embolus.
- 2. Fat embolus.
- 3. Stress fractures.
- 4. Thrombophlebitis.

**72.** A client is receiving an I.V. infusion of 5% dextrose in water (D<sub>5</sub>W). The skin around the I.V. insertion site is red, warm to touch, and painful. The nurse should **first**:

- 1. Administer acetaminophen (Tylenol).
- 2. Change the D<sub>5</sub>W to normal saline.
- 3. Discontinue the I.V.
- 4. Place a warm compress on the area.

**73.** The nurse is planning care for a client on complete bed rest. The plan of care should include all **except** which of the following:

- 1. Turning every 2 hours.
- 2. Passive and active range-of-motion exercises.
- 3. Use of thromboembolic disease support (TED) hose.
- 4. Maintaining the client in the supine position.



**74.** The client is admitted with left lower leg pain, a positive Homans' sign, and a temperature of 100.4° F (38° C). The nurse should assess the client further for signs of:

- 1. Aortic aneurysm.
- 2. Deep vein thrombosis (DVT) in the left leg.
- 3. I.V. drug abuse.
- 4. Intermittent claudication.

**75.** A client is admitted to the unit with a diagnosis of thrombophlebitis and deep vein thrombosis of the right leg. A loading dose of heparin has been given in the emergency room, and I.V. heparin will be continued for the next several days. The nurse should develop a plan of care for this client that will involve:

- 1. Administering aspirin as ordered.
- 2. Encouraging green leafy vegetables in the diet.
- 3. Monitoring the client's prothrombin time (PT).
- 4. Monitoring the client's activated partial thromboplastin time (aPTT) and International Normalized Ratio (INR).

**76.** A client who has undergone abdominal or pelvic surgery. In order to prevent deep vein thrombosis (DVT), the nurse should:

- 1. Restrict fluids.
- 2. Encourage deep breathing.
- 3. Assist the client to remain sedentary.
- 4. Use pneumatic compression stockings.

**77.** A client with deep vein thrombosis (DVT) has an edematous right lower extremity. The client lies on her right side frequently. Rubor is noted on the lateral aspect of the right ankle. From the data collected, the appropriate nursing diagnosis for this client would be:

- 1. *Activity intolerance* related to complaints of pain in lower right extremity.
- 2. *Ineffective health maintenance* related to lack of knowledge about DVT.
- 3. *Pain* related to edema.
- 4. *Risk for impaired skin integrity*.

**78.** The nurse interviews a 22-year-old female client who is scheduled for abdominal surgery the following week. The client is obese and uses estrogen-based oral contraceptives. This client is at high risk for development of:

- 1. Atherosclerosis.
- 2. Diabetes.
- 3. Vasospastic disorder (Raynaud's disease).
- 4. Thrombophlebitis.

**79.** The nurse observes that an older female has small to moderate, distended and tortuous veins running along the inner aspect of her lower legs. The nurse should:

- 1. Apply a half-leg pneumatic compression device.
- 2. Suggest the client contact her physician.
- 3. Assess the client for foot ulcers.
- 4. Encourage the client to avoid standing in one position for long periods of time.

**80.** Which of the following clients is at risk for varicose veins?

- 1. A client who has had a cerebrovascular accident.
- 2. A client who has had anemia.
- 3. A client who has had thrombophlebitis.
- 4. A client who has had transient ischemic attacks.

**81.** A client weighs 300 lb (136 kg) and has a history of deep vein thrombosis and thrombophlebitis. When reviewing a teaching plan with this client, the nurse knows that the client has understood the nurse's instructions when he states he will:

- 1. Avoid exercise.
- 2. Lose weight.
- 3. Perform leg lifts every 4 hours.
- 4. Wear support hose, using rubber bands to hold the stockings up.

**82.** Which instructions should the nurse include when developing a teaching plan for a client being discharged from the hospital on anticoagulant therapy after having deep vein thrombosis (DVT)? Select all that apply.

- 1. Checking urine for bright blood and a dark smoky color.
- 2. Daily walking as a good exercise.
- 3. Using garlic and ginger, which may decrease bleeding time.
- 4. Performing foot/leg exercises and walking around the airplane cabin on long flights.
- 5. Prevention as the best treatment for DVT.
- 6. Avoiding surface bumps because the skin is prone to injury.

**83.** A client has an emergency embolectomy for an embolus in the femoral artery. After the client returns from the recovery room, in **what order**, from first to last, should the nurse provide care?

1. Administer pain medication.

2. Draw blood for laboratory studies.

3. Regulate the I.V. infusion.

4. Monitor the pulses.

5. Inspect the dressing.


## The Client with an Aneurysm

**84.** The nurse is developing a discharge teaching plan for a client who underwent a repair of abdominal aortic aneurysm 4 days ago. The nurse reviews the client's chart for information about the client's history. Key findings are noted in the chart below.

### History And Physical

- 1) Smokes four cigars a month.
- 2) Vital signs: blood pressure, ranges from 150/76 mm Hg to 170/98 mm Hg; heart rate, 90 to 100 beats per minute; respirations, 12–18 per minute; temperature, 99.9° F (37.8° C).
- 3) +1 bilateral ankle edema.

Based on the data and expected outcomes, which should the nurse emphasize in the teaching plan?

- 1. Food intake.
- 2. Fluid volume.
- 3. Skin integrity.
- 4. Tissue perfusion.

**85.** A client is admitted with a 6.5-cm thoracic aneurysm. The nurse records findings from the initial assessment in the client's chart, as shown below.

### Vital Signs

Date	05/07/07	
Time	10:00 am	
Blood pressure	160/90 mm Hg	
Heart rate	74 bpm	
Respirations	20 per minute	
	G. Fuentes, RN	

At 10:30 a.m., the client complains of sharp mid-chest pain after having a bowel movement. What should the nurse do **first**?

- 1. Assess the client's vital signs.
- 2. Administer a bolus of lactated Ringer's solution.
- 3. Assess the client's neurologic status.
- 4. Contact the physician.

**86.** Nursing assessment of a 54-year-old client in the emergency department reveals severe back pain, Grey Turner's sign, nausea, blood pressure of 90/40, heart rate 128 beats per minute and respirations 28 per minute. The nurse should **first**:

- 1. Assess the urine output.
- 2. Place a large bore I.V.
- 3. Position onto the left side.
- 4. Insert a nasogastric tube.

**87.** A client had a repair of a thoracoabdominal aneurysm 2 days ago. Which of the following findings should the nurse consider unexpected and report to the physician immediately? The client has:

- 1. Abdominal pain at 5 on a scale of 0 to 10 for the last 2 days.
- 2. Heart rate of 100 beats per minute after ambulating 200 feet.
- 3. Urine output of 2,000 mL in 24 hours.
- 4. Weakness and numbness in the lower extremities.

**88.** A client is admitted to the emergency department complaining of severe abdominal pain. A radiograph reveals a large abdominal aortic aneurysm. The **primary** goal at this time is to:

- 1. Maintain circulation.
- 2. Manage pain.
- 3. Prepare the client for emergency surgery.
- 4. Teach postoperative breathing exercises.

**89.** Before surgery for a known aortic aneurysm, the client's pulse pressure begins to widen, suggesting increased aortic valvular insufficiency. If the branches of the aortic arch are involved, the nurse should assess the client for:

- 1. Loss of consciousness.
- 2. Anxiety.
- 3. Headache.
- 4. Disorientation.

**90.** A client has sudden, severe pain in his back and chest, accompanied by shortness of breath. The client describes the pain as a "tearing" sensation. The physician suspects the client is experiencing a dissecting aortic aneurysm. The code cart is brought into the room because one complication of a dissecting aneurysm is:

- 1. Cardiac tamponade.
- 2. Stroke.
- 3. Pulmonary edema.
- 4. Myocardial infarction.

**91.** Which of the following increases the risk of having a large abdominal aortic aneurysm rupture?

- 1. Anemia.
- 2. Dehydration.
- 3. High blood pressure.
- 4. Hyperglycemia.

**92.** The nurse is planning care for a client who has returned to the medical-surgical unit following repair of an aortic aneurysm. The nurse **first** should assess the client for:

- 1. Alteration in renal perfusion.
- 2. Electrolyte imbalance.
- 3. Ineffective coping.
- 4. Wound infection.

**93.** A client underwent surgery to repair an abdominal aortic aneurysm. The surgeon made an incision that extends from the xiphoid process to the pubis. At 12 noon 2 days after surgery, the client complains of abdominal distention. The nurse checks the progress notes in the medical record, as shown below.

Nurses Progress Notes		
Date	Time	Progress Notes
07/07/07	10:00 pm	The client is receiving D <sub>5</sub> W, 1,000 mL q 8 h. The NG tube is attached to low suction and draining well. The client has been NPO except ice chips. The client has had 10 mg morphine for pain at 6 a.m.  E. Levine, RN

What is **most** likely contributing to the client's abdominal distention?

- 1. Nasogastric (NG) tube.
- 2. Ice chips.
- 3. I.V. fluid intake.
- 4. Morphine.

**94.** A client is discharged after an aortic aneurysm repair with a synthetic graft to replace part of the aorta. The nurse should instruct the client to notify the physician before having:

- 1. Blood drawn.
- 2. An I.V. line inserted.
- 3. Major dental work.
- 4. An X-ray examination.

**95.** A client with deep vein thrombosis has been receiving warfarin (Coumadin) for 2 months. The client reports bleeding gums, increased bruising, and dark stools. These symptoms indicate that the medication:

- 1. Does not need to be changed.
- 2. Needs to be decreased.
- 3. Needs to be increased.
- 4. Is not being taken as prescribed.

## The Client with Stasis Ulcers

**96.** A well-nourished client is admitted with a stasis ulcer. The nurse assesses the ulcer and finds excavation of the skin surface as a result of sloughing of inflammatory necrotic tissue. The physician has ordered the ulcer to be flushed with a fibrinolytic agent. Which of the following goals are appropriate for this client? Select all that apply.

- 1. Increase oxygen to the tissues.
- 2. Prevent direct trauma to the ulcer.
- 3. Improve nutrition.
- 4. Prevent infection.
- 5. Reduce pain.

**97.** A client has had a stasis ulcer of the left ankle with 2+ pitting edema for 2 years. The client is taking chlorothiazide (Diuril). The expected outcome of this drug is:

- 1. Improved capillary circulation.
- 2. Decreased blood pressure.
- 3. Wound healing.
- 4. Absence of infection.

**98.** The nurse assesses a client with a 5 × 2 stasis ulcer just above the left malleolus. The wound is open with irregular, reddened, swollen edges and there is a moderate amount of yellowish tan drainage coming from the wound. The client verbalizes pressure-type pain and rates the discomfort at 7 on a scale of 0 to 10. To maintain tissue integrity, the **primary** nursing goal should focus on:

- 1. Administering prescribed analgesics.
- 2. Applying lanolin lotions to the left ankle stasis ulcer.
- 3. Encouraging the client to sit up in a chair four times per day.
- 4. Providing an over-the-bed cradle to protect the left ankle from the pressure of bed linens.

**99.** The nurse is discharging a client with a chronic right ankle stasis ulcer. Before discharge, the nurse realizes that the client needs further teaching about wound care when he indicates that he:

- 1. Has made an appointment with a physical therapist.
- 2. Will apply a home herb mixture to his wound to promote healing.
- 3. Will need to be client with the healing process.
- 4. Will eat a balanced diet.

### The Client with Peripheral Arterial Occlusive Disease

**100.** The nurse is caring for a client who has just had an ankle-brachial index (ABI) test. The left arm blood pressure was 160/80 mm Hg and a palpable systolic blood pressure of the left lower extremity was 130/60 mm Hg. These findings suggest that the client has:

- 1. Mild peripheral artery disease.
- 2. Moderate peripheral artery disease.
- 3. No apparent occlusion in the left lower extremity.
- 4. Severe peripheral artery disease.

**101.** A client is admitted for a revascularization procedure for arteriosclerosis in his left iliac artery. To promote circulation in the extremities, the nurse should:

- 1. Position the client on a firm mattress.
- 2. Keep the involved extremity warm with blankets.
- 3. Position the left leg at or below the body's horizontal plane.
- 4. Encourage the client to raise and lower his leg four times every hour.

**102.** A sedentary, obese, middle-aged client is recovering from a right iliac blood clot. The nurse should develop a discharge plan with the client that will focus on participating in which of the following activities? Select all that apply.

- 1. Aerobic activity.
- 2. Strength training.
- 3. Weight control.
- 4. Stress management.

**103.** The nurse is assessing the pulse in a client with aortic iliac disease. On the illustration below, indicate the pulse site that will give the nurse the most useful data.



### Managing Care Quality and Safety

**104.** A client with a history of hypertension and peripheral vascular disease underwent an aorto-bifemoral bypass graft. Preoperative medications included pentoxifylline (Trental); metoprolol (Toprol XL); and furosemide (Lasix). On postoperative day 1, the 12 noon vital signs are: Temperature 37.2 °C; heart rate 132 beats per minute; respiratory rate 20; blood pressure 126/78. Urine output is 50 to 70 mL/hour. The hemoglobin and hematocrit are stable. Using the SBAR (Situation-Background-Assessment-Recommendation) technique for communication, the nurse recommends that the primary care provider:

- 1. Continues the pentoxifylline.
- 2. Increases the I.V. fluids.
- 3. Restarts the metoprolol.
- 4. Resumes the furosemide.

**105.** The nurse is planning care for a client who had surgery for abdominal aortic aneurysm repair 2 days ago. The pain medication and the use of relaxation and imagery techniques are not relieving the client's pain and the client refuses to get out of bed to ambulate as ordered. The nurse contacts the physician, explains the situation, and provides information about drug dose, frequency of administration, the client's vital signs, and the client's score on the pain scale. The nurse requests an order for a different, or stronger, pain medication. The physician tells the nurse that the current order for pain medication is sufficient for this client and that the client will feel better in several days. The nurse should **next**:

- 1. Explain to the physician that the current pain medication and other strategies are not helping the client and it is making it difficult for the client to ambulate as ordered.
- 2. Ask the hospitalist to write an order for a stronger pain medication.
- 3. Wait until the next shift and ask the nurse on that shift to contact the physician.
- 4. Report the incident to the team leader.

**106.** The nurse is obtaining a blood sample for a PTT test ordered for a client who is taking heparin. It is 5 a.m. When drawing the blood, the nurse should do which of the following? Select all that apply.

- 1. Awake the client.
- 2. Check the armband for client identification number and compare with the order.
- 3. Label the sample vial in front of the client.
- 4. Verify the room number with the room assignment.
- 5. Ask the client to state his/her name.

**107.** A client has acute arterial occlusion. The physician has ordered I.V. heparin. **Before** starting the medication, the nurse should:

- 1. Review the blood coagulation laboratory values.
- 2. Test the client's stools for occult blood.
- 3. Count the client's apical pulse for 1 minute.
- 4. Check the 24-hour urine output record.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Peripheral Vascular Disease

**1. 4.** An Ankle Brachial Index of 0.65 suggests moderate arterial vascular disease in a client who is experiencing intermittent claudication. A Doppler ultrasound is indicated for further evaluation. The bradycardic heart rate is acceptable in an athletic client with a normal blood pressure. The SpO<sub>2</sub> is acceptable; the client has a smoking history.

🔑 CN: Physiological adaptation;  
CL: Analyze

**2. 2.** With each set of vital signs, the nurse should assess the dorsalis pedis and posterior tibial pulses. The nurse needs to ensure adequate perfusion to the lower extremity with the drop in blood pressure. I.V. fluids, nasal cannula setting, and capillary refill are important to assess, however, priority is to determine the cause of drop in blood pressure and that adequate perfusion through the new graft is maintained.

🔑 CN: Reduction of risk potential;  
CL: Analyze

**3. 1, 2, 3, 5.** Maintaining skin integrity is important in preventing chronic ulcers and infections. The client should be taught to routinely inspect the skin on a daily basis. The client should reduce weight to promote circulation; a diet lower in calories and fat is appropriate. Because the client is receiving Coumadin, the client is at risk for bleeding from cuts. To decrease the risk of cuts, the nurse should suggest that the client use an electric razor. The client with decreased arterial blood flow should be encouraged to participate in ADLs. In fact, the client should be encouraged to consult an exercise physiologist for an exercise program that enhances the aerobic capacity of the body.

🔑 CN: Health promotion and maintenance;  
CL: Synthesize

**4. 4.** Blood flows in a unidirectional manner, and the blood flow involves the differences in pressure between the arterial and venous systems.

The two variables influencing blood flow within this closed system are the pressure differences and the resistance to blood flow throughout the system. The greater the resistance, the greater the driving force needed, which results in an increase in the force of the contraction of the heart. Blood viscosity is important, and diameter influences resistance, but flow is dependent on pressure differences and resistance. The force of the contraction of the heart and resistance of vessels influence flow, but it is the pressure differences that control blood flow.

🔑 CN: Health promotion and maintenance;  
CL: Apply

**5. 3.** Blood pressure is the highest in the aorta as the blood is being ejected out of the left ventricle into the aorta. The pressure declines as the blood flows through the arteries, capillaries, arterioles, veins, capillaries, and venules. The force of the contraction of the heart and resistance of vessels influence flow; however, it is the pressure differences that control blood flow.

🔑 CN: Health promotion and maintenance;  
CL: Apply

**6. 2.** High serum lipid levels are associated with an increased incidence of PVD. High serum calcium level, low serum potassium level, and low serum lipid levels have no relation to PVD.

🔑 CN: Reduction of risk potential;  
CL: Apply

**7. 1.** *Claudication* is the term used to describe the discomfort a person experiences when oxygen demand in the leg muscles is greater than the supply. The pain is a result of tissue hypoxia in the working muscle. Symptoms include aching, cramping, and weakness.

🔑 CN: Physiological adaptation;  
CL: Synthesize


**8. 2.** As people age, the accumulation of collagen in the intima of the blood vessels results in the vessels' becoming stiff and less flexible. Consequently, there is an increased resistance within the aging adult's circulatory system.

🔑 CN: Health promotion and maintenance;  
CL: Apply

**9. 1.** Decreased blood flow is a common characteristic of all PVD. When the demand for oxygen to the working muscles becomes greater than the supply, pain is the outcome. Slow blood flow throughout the circulatory system may suggest pump failure. Thrombus formation can result from stasis or damage to the intima of the vessels.

🔑 CN: Reduction of risk potential;  
CL: Apply

**10. 1.** A client with PVD and heart failure will experience decreased blood flow. In this situation, low exercise tolerance (oxygen demand becomes greater than the oxygen supply) may be related to less blood being ejected from the left ventricle into the systemic circulation. Decreased blood supply to the tissues results in pain. Increased blood viscosity may be a component, but it is of much less importance than the disease processes.

 CN: Reduction of risk potential;  
CL: Synthesize

**11. 4.** In PVD, decreased blood flow can result in increased venous pressure. The increase in venous pressure results in an increase in capillary hydrostatic pressure, which causes a net filtration of fluid out of the capillaries into the interstitial space, resulting in edema. Valves often become incompetent with PVD. Blood volume is not decreased in this condition. Decreased muscular action would contribute to the formation of edema in the lower extremities.

 CN: Reduction of risk potential;  
CL: Analyze


**12. 4.**



The presence of a strong dorsalis pedis pulse indicates that there is circulation to the extremity distal to the surgery indicating that the graft between the femoral and popliteal artery is allowing blood to circulate effectively. Answer 1 shows the nurse obtaining the radial pulse; answer 2 shows the femoral pulse, which is proximal to the surgery site and will not indicate circulation distal to the surgery site. Answer 3 shows the nurse obtaining an apical pulse.

 CN: Reduction of risk potential;  
CL: Analyze

**13. 2.** Age is a nonmodifiable risk factor for atherosclerosis. The nurse instructs the client to manage modifiable risk factors such as comorbid diseases (e.g., diabetes), activity level, and diet. Controlling serum blood glucose levels, engaging in regular aerobic activity, and choosing a diet low in saturated fats can reduce the risk of developing atherosclerosis.

 CN: Health promotion and maintenance;  
CL: Apply

**14. 2.** Reduction of blood flow to a specific area results in decreased oxygen and nutrients. As a result, the skin may appear mottled. Loss of hair and cool, dry skin are other signs that the nurse may observe in a client with PVD of the lower extremities.

 CN: Health promotion and maintenance;  
CL: Analyze


**15. 3.** Generally, a 50% to 75% occlusion in the arterial lumen causes symptoms associated with intermittent claudication. When the demand for oxygen becomes greater than the supply in the working muscle, the client experience pain (aching, cramping). When the individual sits down and rests, the demand and supply of oxygen become balanced and the discomfort dissipates. Occlusion of 100% would result in ischemia and necrosis of tissue distal to the artery and would require immediate surgical intervention.

 CN: Reduction of risk potential;  
CL: Analyze

**16. 3.** When pedal pulses are not palpable, the nurse should obtain a Doppler ultrasound device. Auscultation is not likely to be helpful if the pulse isn't palpable. Inspection of the lower extremity can be done simultaneously when palpating, but the nurse should first try to locate a pulse by Doppler. Calling the physician may be necessary if there is a change in the client's condition.

 CN: Physiological adaptation;  
CL: Synthesize


**17. 2.** The sound produced by the Doppler instrument reflects all of the vascular structures in the path of the sound beam; therefore, it may be hard to differentiate between arterial and venous blood flow. Capillary and arteriole blood flow cannot be auscultated with a Doppler instrument.

 CN: Physiological adaptation; CL: Apply

**18. 3.** An increased LDL cholesterol concentration has been documented as a risk factor for the development of atherosclerosis. LDL cholesterol is not broken down in the liver but is deposited into the intima of the blood vessels. Low triglyceride levels are desirable. High HDL and low LDL levels are beneficial and are known to be protective for the cardiovascular system.

 CN: Reduction of risk potential; CL: Apply

**19. 4.** Coldness in the left foot and ankle is consistent with complete arterial obstruction. Other expected findings would include paralysis and pallor. Aching pain, a burning sensation, or numbness and tingling are earlier signs of tissue hypoxia and ischemia and are commonly associated within incomplete obstruction.

 CN: Physiological adaptation;  
CL: Analyze

**20. 1.** Anxiety stimulates the sympathetic nervous system, which results in the secretion of epinephrine, angiotensin, and serum proteins that cause vasoconstriction in the arteries of the peripheral circulatory system. As a result, peripheral vascular resistance is increased. This vasoconstriction may increase pain in the areas where PVD is the greatest. The lymphatic system does not affect the blood supply of tissues.

 CN: Physiological adaptation; CL: Apply

**21. 1.** Activity intolerance related to decreased blood supply and pain is a common problem with clients experiencing claudication. The goal should be to educate the client to maintain his level of activity and incorporate frequent rest periods to prevent episodes of decreased blood supply. The data do not suggest that the client cannot perform self-care activities, is not coping with his chronic pain, or that his skin integrity is impaired. It should be appropriate to incorporate the nursing diagnosis of *Risk for impaired skin integrity* into the client's plan of care.

 CN: Health promotion and maintenance; CL: Analyze

**22.**

2. Peripheral pulses.

4. Incision site.

3. Urine output.

1. Postoperative pain.


Because assessment of the presence and quality of the pedal pulses in the affected extremity is essential after surgery to make sure that the bypass graft is functioning, this step should be done first. The nurse should next ensure that the dressing is intact, and then that the client has adequate urine output. Lastly, the nurse should determine the client's level of pain.

 CN: Physiological adaptation; CL: Synthesize

**23. 1.** Decreasing venous congestion in the extremities is a desired outcome for clients with heart failure. The nurse should elevate the client's legs above the level of the heart to achieve this goal. The client is not demonstrating difficulty breathing or being cold. The nurse should prevent injury to the swollen extremity; however, this is not the priority.

 CN: Health promotion and maintenance; CL: Synthesize

**24. 3.** The term *gangrene* refers to blackened, decomposing tissue that is devoid of circulation. Chronic ischemia and death of the tissue can lead to gangrene in the affected extremity. Injury, edema, and decreased circulation lead to infection, gangrene, and tissue death. Atrophy is the shrinking of tissue, and contraction is joint stiffening secondary to disuse. The term *rubor* denotes a reddish color of the skin.

 CN: Physiological adaptation; CL: Analyze


**25. 1.** The ankle-brachial index is based on the ratio of the ankle systolic blood pressure to arm systolic blood pressure. It allows one to quantify the degree of arterial stenosis.

 CN: Reduction of risk potential; CL: Analyze


**26. 1.** An arteriogram involves injecting a radiopaque contrast agent directly into the vascular system to visualize the vessels. It usually involves computed tomographic scanning. The velocity of the blood flow can be estimated by duplex ultrasound. The client's ankle-brachial index is determined, and then the client is requested to walk. The normal response is little or no drop in ankle systolic pressure after exercise.

 CN: Reduction of risk potential; CL: Apply

**27. 2.** Clients may have an immediate or a delayed reaction to the radiopaque dye. The physician should be notified immediately because the symptoms suggest an allergic reaction. Treatment may involve administering oxygen and epinephrine. Explaining that the procedure is over does not address the current symptoms.

 CN: Physiological adaptation; CL: Synthesize

**28. 3.** The client is at greater risk for skin breakdown in the lower extremities related to the edema and to remaining in one position, which increases capillary pressure. Turning the client every 1 to 2 hours promotes vasodilation and prevents vascular compression. Administering pain medication will not have an effect on skin integrity. Encouraging fluids is not a direct intervention for maintaining skin integrity, although being well hydrated is a goal for most clients. Maintaining hygiene does influence skin integrity but is secondary in this situation.


 CN: Physiological adaptation; CL: Synthesize

**29. 4.** The client should avoid using iodine or over-the-counter medications. Iodine is a highly toxic solution. An individual who has known PVD should be seen by a physician for treatment to avoid infection. The client with PVD should avoid heating pads and crossing the legs, and should wear leather

shoes. A heating pad can cause injury, which, because of the decreased blood supply, can be difficult to heal. Crossing the legs can further impede blood flow. Leather shoes provide better protection.

 CN: Health promotion and maintenance;  
CL: Evaluate

**30. 1.** Maintaining circulation in the affected extremity after surgery is the focus of care. The graft can become occluded, and the client must be assessed frequently to determine whether the graft is patent. Preventing infection and relieving pain are important but are secondary to maintaining graft patency. Education should have taken place in the preoperative phase and then continued during the recovery phase.

 CN: Physiological adaptation;  
CL: Synthesize

**31. 1, 3.** Elastic stockings (support hose) are used to promote circulation by preventing pooling of blood in the feet and legs. The stockings should be applied in the morning before the client gets out of bed. The stockings should be applied smoothly and to avoid wrinkles, but the top should not be rolled down to avoid constriction of circulation. The stockings should be removed every 8 hours and the client should elevate the legs for 15 minutes and reapply the stockings. Clean stockings should be applied daily or as needed.

 CN: Health promotion and maintenance;  
CL: Create

**32. 4.** If surgery is scheduled, the nurse should avoid venipunctures in the affected extremity. The goal should be to prevent unnecessary trauma and possible infection in the affected arm. Disruptions in skin integrity and even minor skin irritations can cause the surgery to be canceled. The nurse can continue to monitor the temperature and radial pulse in the affected arm; however, doing so is not the priority. Keeping the client warm is important but is not the priority at this time.


 CN: Reduction of risk potential;  
CL: Analyze

### The Client with Peripheral Vascular Disease Having an Amputation


**33. 2.** Slow, steady walking is a recommended activity for clients with peripheral vascular disease because it stimulates the development of collateral circulation. The client with PVD should not remain inactive. Elevating the legs above the heart or wearing antiembolism stockings is a strategy for alleviating venous congestion and may worsen peripheral arterial disease.

 CN: Basic care and comfort; CL: Evaluate

**34. 2.** Encouraging the client who is undergoing amputation to verbalize feelings is the most therapeutic nursing intervention. By eliciting concerns, the nurse may be able to provide information to help the client cope. The nurse should avoid value-laden responses, such as “You’ll still have one good leg,” that may make the client feel guilty or hostile and block further communication. The nurse should not ignore the client’s expressed concerns, nor should the nurse reinforce the client’s concern about invalidism and dependency or assume that his wife is willing to care for him.

 CN: Psychosocial adaptation;  
CL: Synthesize

**35. 2.** The level of amputation commonly cannot be accurately determined until surgery, when the surgeon can directly assess the adequacy of the circulation of the residual limb. A longer residual limb facilitates prosthesis fitting and will make it easier for the client to walk. However, although these aspects will be considered in the final decision, they are not the primary factors influencing the decision.

 CN: Physiological adaptation;  
CL: Synthesize


**36. 1.** Leg crossing is contraindicated because it causes adduction of the hips and decreases the flow of blood into the lower extremities. This may result in increased pressure in the graft in the affected leg. Elevating the legs, flexing the ankles, and extending the knees are not necessarily contraindicated.

 CN: Reduction of risk potential;  
CL: Synthesize

**37. 2.** The client should be evaluated for hemodynamic stability and extent of bleeding prior to calling the physician. Direct pressure can be used prior to applying a tourniquet if there is significant bleeding. To avoid flexion contractures, which can delay rehabilitation, elevation of the surgical limb is contraindicated.

 CN: Reduction of risk potential;  
CL: Synthesize

**38. 3.** The purpose of wrapping the stump is to shape the residual limb to accept a prosthesis and bear weight. The compression bandaging should be worn at all times for many weeks after surgery and should be reapplied as needed to keep it free of wrinkles and snug. The dressing should be changed daily to allow for inspection of the stump incision. No lotions should be applied to the stump unless specifically ordered by the physician. The stump should not be elevated on pillows because this will contribute to the formation of flexion contractures. Contractures will prevent the client from wearing a prosthesis and ambulating.

 CN: Physiological adaptation;  
CL: Evaluate




**39. 3.** Nicotine causes vasospasm and impedes blood flow. Stopping smoking is the most significant lifestyle change the client can make. The client should eat low-fat foods as part of a balanced diet. The legs should not be elevated above the heart because this will impede arterial flow. The legs should be in a slightly dependent position. Jogging is not necessary and probably is not possible for many clients with arterial occlusive disease. A rehabilitation program that includes daily walking is suggested.

 CN: Health promotion and maintenance;  
CL: Synthesize


**40. 4.** In this case, the exercise prescription needs to be individualized because walking causes discomfort. To maintain the level of activity and decrease venous congestion, riding a stationary bike is another appropriate exercise behavior. Use of a stationary bike provides a non-weight-bearing exercise modality, which allows a longer duration of activity. Jogging and cross-country skiing are weight-bearing activities. In addition, cross-country skiing involves a cold environment, and maintaining warmth is essential in promoting arterial blood flow and preventing vasoconstriction. Golfing is a good activity, but it is not typically considered an exercise that causes aerobic changes in the body.

 CN: Health promotion and maintenance;  
CL: Synthesize

**41. 4.** Diltiazem is a calcium channel blocker that blocks the influx of calcium into the cell. In this situation, the primary use of diltiazem is to promote vasodilation and prevent spasms of the arteries. As a result of the vasodilation, blood, oxygen, and nutrients can reach the muscle and tissues. Diltiazem is not an antianxiety agent and does not promote sedation. It also does not cause vasoconstriction, which would be contraindicated for the client with PVD.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**42. 1.** Although pentoxifylline's (Trental) precise mechanism of action is unknown, its therapeutic effect is to increase blood flow, and the client should have improved circulation in the legs. The client does not have nerve impairment, and should be able to wiggle his toes. Urination is not improved by taking pentoxifylline. Dizziness is a side effect of the drug, not an intended outcome.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**43. 4.** Pentoxifylline can potentiate the effects of theophylline and increase the risk of theophylline toxicity. Therefore, the nurse should monitor the client's theophylline level. Pentoxifylline does not interact with digoxin. Pentoxifylline can interact

with heparin, and the client's PTT would need to be monitored closely if the client were taking heparin. It does not affect cholesterol levels.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**44. 2.** Angina is an adverse reaction to pentoxifylline, which should be used cautiously in clients with CAD. The nurse should report the client's symptoms to the physician, who may order nitroglycerin and possibly discontinue the pentoxifylline. The client should rest until the chest pain subsides, and documentation is essential when a client experiences an adverse reaction with medications that have been prescribed; however, the nurse's top priority is to call the physician, report the problem, and obtain an order for nitroglycerin. The client's complaints should never be dismissed.

 CN: Physiological adaptation;  
CL: Synthesize

**45. 1.** Assessing the individual's health behavior before surgery will help the nurse and client develop strategies to manage the postoperative course. Asking open-ended questions will illicit the most helpful information. The client's ability to walk after surgery will be improved after surgery. The nurse can ask direct questions after obtaining general information.

 CN: Health promotion and maintenance;  
CL: Create

**46. 4.** Before beginning dietary interventions, the nurse must assess the client's pattern of food intake, life style, food preferences, and ethnic, cultural, and financial influences.

 CN: Basic care and comfort;  
CL: Synthesize

## The Client with Buerger's Disease

**47. 1.** Thromboangiitis obliterans (Buerger's disease) is a nonatherosclerotic, inflammatory vasoocclusive disorder. The disorder occurs predominantly in younger men less than 40 years of age and there is a very strong relationship with tobacco use. Diagnosis is based on age of onset, history of tobacco use, symptoms, and exclusion of diabetes mellitus.


 CN: Reduction of risk potential;  
CL: Analyze

**48. 3.** Because of the inflammation, a common complication of Buerger's disease is thrombus formation and potential occlusion of the vessel. Inflammation of the immediate and small arteries and veins is involved in the disease process. Embolus is a potential risk if a thrombus has developed.


Fat embolus is associated with fractures of the bones. Thrombophlebitis occurs after thrombus formation.

 CN: Health promotion and maintenance;  
CL: Synthesize

**49. 3.** When helping a client change detrimental health behavior, it is critical to learn how the client perceives the situation or problem. The client is more likely to change detrimental health behaviors if he realizes that there is a problem and that these behaviors lead to the problem. While understanding the client's ability to attend group meetings, his goals for treatment, and his motivation may help facilitate change, the nurse should first understand the client's perception of the problem and then determine what strategies might work from his perspective.

 CN: Health promotion and maintenance;  
CL: Analyze

**50. 1.** Zyban, a non-nicotine medication, is used to promote smoking cessation. All types of nicotine should be avoided to prevent vasoconstriction. Nitroglycerin, used for angina, and ibuprofen, an anti-inflammatory medication, have no role in smoking cessation.

 CN: Pharmacological and parenteral therapies; CL: Apply

**51. 2.** Buerger's disease is characterized by inflammation and fibrosis of arteries, veins, and nerves. White blood cells infiltrate the area and become fibrotic, which results in occlusion of the vessels. Signs and symptoms include slowly developing claudication, cyanosis, coldness, and pain at rest. Thickening of the intima and media of the artery is characteristic of atherosclerosis. Vasospasm lasting several minutes is characteristic of Raynaud's disease. Pain, pallor, and pulselessness are symptoms of acute occlusion of an artery by an embolus or other cause (e.g., compartment syndrome).


 CN: Health promotion and maintenance;  
CL: Analyze

### The Client with Vasospastic Disorder


**52. 3.** Clients with Raynaud's phenomenon should receive routine follow-up to monitor symptoms and to assess for the development of connective tissue or autoimmune diseases associated with Raynaud's. Beta blockers are not considered first-line drug therapy. A sympathectomy is considered only in advanced cases. There is no benefit to an angioplasty, which is used for atherosclerotic vascular disease.

 CN: Health promotion and maintenance;  
CL: Create


**53. 1, 2.** Vasospastic disorder (Raynaud's disease) is a form of intermittent arteriolar vasoconstriction that results in coldness, pain, and pallor of the fingertips, toes, or tip of the nose, and a rebound circulation with redness and pain. The nurse should instruct the client to stop smoking because nicotine is a vasoconstrictor. An adverse effect of reserpine is orthostatic hypotension. The client should report dizziness and low blood pressure as it may be necessary to consider stopping the drug. The client should prevent vasoconstriction by covering affected parts when in cold environments. The nurse can teach the client to rewarm exposed extremities by using warm water or placing them next to the body, such as under the axilla. It is not realistic to ask this client to change jobs at this time.

 CN: Health promotion and maintenance;  
CL: Create

**54. 2.** The client complains of numbness in her fingertips, thus *Disturbed sensory perception (tactile)* is the priority nursing diagnosis. The client does not complain of acute pain. The other data suggest that the circulation is adequate at this time, so neither *Ineffective tissue perfusion* nor *Risk for impaired skin integrity* is the priority nursing diagnosis.

 CN: Physiological adaptation;  
CL: Analyze


**55. 1.** Vasospastic disorder (Raynaud's disease) is more common in young women and is associated with collagen diseases such as rheumatoid arthritis and lupus.

 CN: Physiological adaptation;  
CL: Analyze

**56. 3.** Initially the vasoconstriction effect produces pallor or a whitish coloring, followed by cyanosis (bluish) and finally rubor (red). Gangrene is the end result of complete arterial occlusion; the skin is blackened and without a blood supply.

 CN: Reduction of risk potential;  
CL: Analyze

**57. 2.** Decreased perfusion from vasospasm induces color changes in the extremity. The degree of decreased perfusion should be assessed by taking the radial pulse. Color changes progressively to blue with cyanosis and then red when reperfusion occurs. The SpO<sub>2</sub> requires adequate perfusion for accuracy. A blood pressure will cause further constriction and reduction of perfusion in the extremity.


 CN: Physiological adaptation;  
CL: Analyze

**58. 3.** Extreme changes in temperature can precipitate a vasospastic episode and should be avoided by clients with vasospastic disorder


(Raynaud's disease). The client should be encouraged to wear gloves when handling frozen foods or ice. The client should immerse the involved extremity in warm water during an episode to promote vasodilation and relaxation of the small arteries that are in spasm. The client can help prevent vasospasm brought on by temperature changes by wearing warm clothes. Living in a cold climate will exacerbate the symptoms.

 CN: Health promotion and maintenance;  
CL: Synthesize


**59. 3.** Loose warm clothing should be worn to protect from the cold. Wearing gloves when handling cold objects will help prevent vasospasms. Vibrating equipment and typing contribute to vasospasm. Tobacco and caffeine should be avoided. Elevation will decrease arterial perfusion during vasospasms.

 CN: Health promotion and maintenance;  
CL: Synthesize

**60. 3.** Calcium channel blockers are first-line drug therapy for the treatment of vasospasms with Raynaud's phenomenon when other therapies are ineffective. Cardizem relaxes smooth muscles and improves peripheral perfusion, therefore reducing finger numbness. Cardizem decreases heart rate and is used to treat atrial fibrillation, but these are not associated with Raynaud's. When vasospasms are prevented, an accurate SpO<sub>2</sub> can be measured in the affected extremity, however SpO<sub>2</sub> is a measurement of systemic oxygenation not influenced by Cardizem.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**61. 1.** Beta-adrenergic medications block the beta-adrenergic receptors. Therefore, the expected outcome of the medication is to decrease the influence of the sympathetic nervous system on the blood vessels in the hands. Beta-adrenergic blockers have no analgesic effects. Increasing blood supply to the affected area is an indirect effect of beta-adrenergic blockers. They do not increase monoamine oxidase, which does not play a role in Raynaud's disease.

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 4.** Sympathectomy is scheduled only after other treatment alternatives have been explored and have failed. Medication and stress management are beneficial strategies to prevent advancement of the disease process. If the disease is controlled by medication, there is no reason for surgery.


 CN: Physiological adaptation; CL: Apply

## The Client with Thrombophlebitis and Embolus Formation


**63. 4.** Based on the laboratory findings, prothrombin time and INR are at acceptable anticoagulation levels for the treatment of DVT. However, the platelets are below the acceptable level. Clients taking enoxaparin are at risk for thrombocytopenia. Because of the low platelet level, the nurse should withhold the enoxaparin, assess the client for bleeding, and then contact the physician.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**64. 2.** Acute arterial occlusion is a sudden interruption of blood flow. The interruption can be the result of complete or partial obstruction. Acute pain, loss of sensory and motor function, and a pale, mottled, numb extremity are the most dramatic and observable changes that indicate a life-threatening interruption of tissue perfusion. Blood pressure and heart rate changes may be associated with the acute pain episode. Metabolic acidosis is a complication of irreversible ischemia. Swelling may result but may also indicate venous stasis or arterial insufficiency.

 CN: Physiological adaptation;  
CL: Analyze

**65. 1.** Venous stasis can increase pain. Therefore, proper positioning in bed or when sitting up in a chair can help promote venous drainage, reduce swelling, and reduce the amount of pain the client might experience. Placing a pillow under the knees causes flexion of the joint, resulting in a dependent position of the lower leg and causing a decrease in blood flow. Fluids are encouraged to maintain normal fluid and electrolyte balance but do little to relieve pain. Therapeutic massage to the legs is discouraged because of the danger of breaking up the clot.

 CN: Basic care and comfort;  
CL: Synthesize

**66. 3.** The client is likely suffering from an embolus as a result of abdominal surgery. The nurse should inspect the left leg for color and temperature changes associated with tissue perfusion. Administering pain medication without gathering more information about the pain can mask important signs and symptoms. Although assessing for edema is important, it is not critical to this situation. Encouraging the client to change her position does not adequately address the need for gathering more data.

 CN: Reduction of risk potential;  
CL: Synthesize


**67. 2.** Performing active ankle and foot range-of-motion exercises periodically during the ride home will promote muscular contraction and provide support to the venous system. It is the muscular action that facilitates return of the blood from the lower extremities, especially when in the dependent position. Arm circle exercises will not promote circulation in the leg. It is not necessary for the client to elevate her legs as long as she does not occlude blood flow to her legs and does her leg exercises. It is not necessary to take an ambulance because the client is able to sit in the car safely.

 CN: Reduction of risk potential;  
CL: Synthesize

**68. 3.** DVT is commonly associated with venous stasis in the legs when there is a lack of the skeletal muscle pump that enhances venous return to the heart. When a client is confined to bed rest, venous compression occurs because of the position of the lower extremities. This increased pressure causes damage to the intima lining of the veins and causes platelets to adhere to the damaged site. DVT increases the risk that a displaced plaque will become a pulmonary embolus. Arteriosclerosis is hardening of the arteries; aneurysm is the abnormal dilation of a vessel; and varicose veins are swollen, tortuous veins. These are not generally considered causes of pulmonary embolism.

 CN: Physiological adaptation; CL: Apply

**69. 3.** Thrombolytic agents are used for clients with a history of thrombus formation, cerebrovascular accidents, and chronic atrial fibrillation. The thrombolytic agents act by dissolving emboli. Thrombolytic agents do not directly improve perfusion or increase vascular permeability, nor do they prevent cerebral hemorrhage.

 CN: Pharmacological and parenteral therapies; CL: Apply

#### **70. 0.85 mL**

First convert pounds (lb) to kilograms (kg) by using the formula:

$$1 \text{ kg} = 2.2 \text{ lb} [187 \text{ lb} \div 2.2 = 85 \text{ kg}].$$

The physician's order is for the client to receive enoxaparin (Lovenox) 1 mg/kg. Therefore, the client is to receive 85 mg. The desired dose in milliliters then can be calculated by using the formula of desired dose (D) divided by dose or strength of dose on hand (H) times volume (V).

$$85 \text{ (mg)} \times 0.3 \text{ mL} = 25.5 \text{ mg/mL}$$

$$25.5 \text{ mg} \div 30 = 0.85 \text{ mL.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**71. 4.** Thrombophlebitis is an inflammation of a vein. The underlying etiology involves stasis of blood, increased blood coagulability, and vessel wall injury. The symptoms of thrombophlebitis are pain, swelling, and deep muscle tenderness. Air embolus is a result of air entering the vascular system. Fat embolus is associated with the presence of intracellular fat globules in the lung parenchyma and peripheral circulation after long-bone fractures. Stress fractures are associated with the musculoskeletal system.

 CN: Health promotion and maintenance;  
CL: Analyze

**72. 3.** The first action should be to discontinue the I.V. The nurse should restart the I.V. elsewhere and then apply a warm compress to the affected area. The nurse should administer acetaminophen or an anti-inflammatory agent only if ordered by the physician. The type of infusion cannot be changed without a physician's order, and such a change would not help in this case.

 CN: Reduction of risk potential;  
CL: Synthesize


**73. 4.** Three factors contribute to the formation of venous thrombus and thrombophlebitis: damage to the inner lining of the vein (prolonged pressure), hypercoagulability of the blood, and venous stasis. Bed rest and immobilization are associated with decreased blood flow and venous pooling in the lower extremities. Keeping the client in the supine position would not be appropriate. Turning the client every 1 to 2 hours, passive and active range-of-motion exercises, and use of TED hose help prevent venous stasis in the lower extremities.

 CN: Reduction of risk potential;  
CL: Create

**74. 2.** The client demonstrates classic symptoms of DVT, and the nurse should continue to assess the client. Signs and symptoms of an aortic aneurysm include abdominal pain and a pulsating abdominal mass. Clients with drug abuse demonstrate confusion and decreased levels of consciousness. Claudication is an intermittent pain in the leg.

 CN: Psychosocial adaptation; CL: Analyze


**75. 4.** Heparin dosage is usually determined by the physician based on the client's aPTT and INR laboratory values. Therefore, the nurse monitors these values to prevent complications. Administering aspirin when the client is on heparin is contraindicated. Green leafy vegetables are high in vitamin K and therefore are not recommended for clients receiving heparin. Monitoring of the client's PT is done when the client is receiving warfarin sodium (Coumadin).

 CN: Pharmacological and parenteral therapies; CL: Create

**76. 4.** The use of pneumatic compression stockings is an intervention used to prevent DVT. Other strategies include early ambulation, leg exercises if the client is confined to bed, adequate fluid intake, and administering anticoagulant medication as ordered. Deep breathing would be encouraged post-operatively, but it does not prevent DVT.

 CN: Health promotion and maintenance;  
CL: Synthesize

**77. 4.** *Risk for impaired skin integrity* is the primary nursing diagnosis. With rubor or hyperemia, there is increased blood flow to the area, raising filtration pressure. As a result, capillary permeability is altered, causing damage to capillary walls. The increased permeability, obstruction of lymphatic drainage, elevation of venous pressure, and decrease in plasma protein osmotic force result in edema. The data do not support the nursing diagnoses of *Activity intolerance*, *Ineffective health maintenance*, or *Pain*.

 CN: Physiological adaptation;  
CL: Analyze

**78. 4.** The data suggest an increased risk of thrombophlebitis. The risk factors in this situation include abdominal surgery, obesity, and use of estrogen-based oral contraceptives. Risk factors for atherosclerosis include genetics, older age, and a high-cholesterol diet. Risk factors for diabetes include genetics and obesity. Risk factors for vasospastic disorders include cold climate, age (16 to 40), and immunologic disorders.

 CN: Reduction of risk potential;  
CL: Analyze

**79. 4.** The client has varicose veins which are evident by the tortuous, distended veins where blood has pooled. To prevent pooling of the blood, the client should not stand in one place for long periods of time. It is not necessary to use compression devices, but the client could wear support hose if she stands for long periods of time. The client can consider cosmetic surgery to remove the distended veins, but there is not indication that the client should contact the physician at this point in time. The nurse can inspect the client's feet, but the client is not at risk for ulcers at this time..

 CN: Health promotion and maintenance;  
CL: Synthesize

**80. 3.** Secondary varicosities can result from previous thrombophlebitis of the deep femoral veins, with subsequent valvular incompetence. Cerebrovascular accident, anemia, and transient ischemic attacks are not associated with an increased risk of varicose veins.

 CN: Health promotion and maintenance;  
CL: Analyze

**81. 2.** The client is at risk for development of varicose veins. Therefore, prevention is key in the treatment plan. Maintaining ideal body weight is the goal. In order to achieve this, the client should consume a balanced diet and participate in a regular exercise program. Depending on the individual, leg lifts may or may not be an appropriate activity. Performing leg lifts provides muscular activity and should be done more often than every 4 hours. Wearing support hose is helpful. However, the client should not use rubber bands to hold the stockings up.

 CN: Reduction of risk potential;  
CL: Evaluate

**82. 1, 2, 4, 5, 6.** Clients with resolving DVT being sent home on anticoagulant therapy need instructions about assessing and preventing bleeding episodes and preventing a recurrence of DVT. Blood in the urine (hematuria) is often one of the first symptoms of anticoagulant overdose. Fresh blood in the urine is red; however, blood in the urine may also be a dark smoky color. Daily ambulation is an excellent activity to keep the venous blood circulating and thus to prevent blood clots from forming in the lower extremities. Garlic and ginger increase the bleeding time and should not be used when a client is on anticoagulant therapy. Clients who have had previous DVTs should avoid activities that cause stagnation and pooling of venous blood. Prolonged sitting coupled with change of air pressure without foot or leg exercises or ambulation in the cabin are activities that prevent venous return. Instructing the client about prevention measures is important because clients with DVT are at high risk for pulmonary emboli (PE), which can be fatal. The client can be taught risk factors for DVT and PE. In addition, recommendations for prevention of these events also are standard protocol in practice and should be shared with the client for home care purposes. Older adults should be monitored closely for bleeding because the skin becomes thinner and the capillaries become more fragile with the aging process.

 CN: Health promotion and maintenance;  
CL: Create

**83.**

4. Monitor the pulses.

5. Inspect the dressing.

3. Regulate the I.V. infusion.

1. Administer pain medication.


2. Draw blood for laboratory studies.

The nurse should first monitor the popliteal and pedal pulses in the affected extremity after arterial embolectomy. Monitoring peripheral pulses below the site of occlusion checks the arterial circulation in the involved extremity. The nurse should next inspect the dressing to be sure that the client is not bleeding at the surgical site. The nurse should next regulate the I.V. infusion to prevent fluid overload. Then the nurse should assess pain and administer pain medications as ordered. Last, the nurse can obtain blood for laboratory studies.


 CN: Physiological adaptation;  
CL: Synthesize

### The Client with an Aneurysm


**84. 4.** The underlying pathophysiology in this client is atherosclerosis. The findings from the assessment indicate the risk factors of smoking and high blood pressure. Therefore, tissue perfusion is a priority for health promoting education. The data do not support education that focuses on food or fluid intake. Although edema is a potential problem and could contribute to poor skin integrity, the edema will likely be resolved by the aneurysm repair.

 CN: Physiological adaptation;  
CL: Synthesize

**85. 1.** The size of the thoracic aneurysm is rather large, so the nurse should anticipate rupture. A sudden incidence of pain may indicate leakage or rupture. The blood pressure and heart rate will provide useful information in assessing for hypovolemic shock. The nurse needs more data before initiating other interventions. After assessment of vital signs, neurologic status, and pain, the nurse can then contact the physician. Administering lactated Ringer's solution would require a physician's order.


 CN: Physiological adaptation;  
CL: Synthesize

**86. 2.** The symptoms suggest an abdominal aortic aneurysm that is leaking or rupturing. An I.V. should be inserted for immediate volume replacement. With hypovolemia, the urine output will be diminished. Repositioning may potentiate the problem. A nasogastric tube may be considered with severe nausea and vomiting to decompress the stomach.


 CN: Physiological adaptation;  
CL: Synthesize

**87. 4.** One of the complications of a thoracoabdominal aneurysm repair is spinal cord injury. Therefore, it is important for the nurse to assess for signs and symptoms of neurologic changes at and below the site where the aneurysm was repaired. The client is expected to have moderate pain following surgery.

An elevated heart rate is expected after physical exertion. It is important to monitor urine output following aneurysm surgery, but a urine output of 2,000 mL in 24 hours is adequate following surgery.

 CN: Safety and infection control;  
CL: Synthesize

**88. 3.** The primary goal is to prepare the client for emergency surgery. The goal would be to prevent rupture of the aneurysm and potential death. Circulation is maintained, unless the aneurysm ruptures. When the client is prepared for surgery, the nurse should place the client in a recumbent position to promote circulation, teach the client about postoperative breathing exercises, and administer pain medication if ordered.

 CN: Physiological adaptation;  
CL: Synthesize

**89. 1.** If the aortic arch is involved, there will be a decrease in the blood flow to the cerebrum. Therefore, loss of consciousness will be observed. A sudden loss of consciousness is a primary symptom of rupture and no blood flow to the brain. Anxiety is not a sign of aortic valvular insufficiency. The end result of decreased cerebral blood flow is loss of consciousness, not headache or disorientation.

 CN: Reduction of risk potential;  
CL: Analyze


**90. 1.** Cardiac tamponade is a life-threatening complication of a dissecting thoracic aneurysm. The sudden, painful “tearing” sensation is typically associated with the sudden release of blood, and the client may experience cardiac arrest. Stroke, pulmonary edema, and myocardial infarction are not common complications of a dissecting aneurysm.

 CN: Physiological adaptation; CL: Apply

**91. 3.** In the preoperative phase, the goal is to prevent rupture. The client is placed in a semi-Fowler's position and in a quiet environment. The systolic blood pressure is maintained at the lowest level the client can tolerate. Anemia, dehydration, and hyperglycemia do not put the client at risk for rupture.

 CN: Health promotion and maintenance;  
CL: Analyze


**92. 1.** Following surgical repair of an aortic aneurysm, there is a potential for an alteration in renal perfusion, manifested by decreased urine output. The altered renal perfusion may be related to renal artery embolism, prolonged hypotension, or prolonged aortic cross-clamping during surgery. Electrolyte imbalance, ineffective coping, and wound infection may occur after any surgery and do not present imminent risk for this client.

 CN: Physiological adaptation;  
CL: Analyze


**93. 4.** The client is experiencing paralytic ileus. One of the adverse effects of morphine used to manage pain is decreased GI motility. Bowel manipulation and immobility also contribute to a postoperative ileus. Insertion of an NG tube generally prevents a postoperative ileus. The ice chips and I.V. fluids will not affect the ileus.

 CN: Basic care and comfort; CL: Analyze

**94. 3.** The client with a synthetic graft may need to be treated with prophylactic antibiotics before undergoing major dental work. This reduces the danger of systemic infection caused by bacteria from the oral cavity. Venous access for drawing blood, I.V. line insertion, and X-rays do not contribute to the risk of infection.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**95. 2.** These symptoms suggest that the client is receiving too much Coumadin. Coumadin hinders the hepatic synthesis of vitamin K–dependent clotting factors and prolongs the clotting time. Because many factors influence the effectiveness of Coumadin, the dosage is monitored closely. Signs and symptoms of blood loss include bleeding gums, petechiae, bruises, dark stools, and dark urine.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

### The Client with Stasis Ulcers

**96. 1, 2, 4, 5.** The underlying pathophysiology in stasis ulcers of the skin surface is a result of inadequate oxygen and other nutrients to the tissues because of edema and decreased circulation. The nurse should first initiate care that will increase oxygen and improve tissue integrity. It is also important to prevent trauma to the tissues and prevent infections, which result from decreased microcirculation that limits the body's response to infection. Stasis ulcers are painful. The nurse can administer prescribed analgesics 30 minutes before changing the dressing. There is no indication that the client's overall nutrition needs to be improved.

 CN: Physiological adaptation; CL: Create


**97. 1.** The result of chronic venous stasis is swelling and edema and superficial varicose veins. Diuretics will help reduce the swelling, thus improving capillary circulation. Although diuretics may decrease blood pressure, that is not the intended outcome of this drug. The nurse should teach the client to prevent infection and monitor wound healing, but these are not the primary outcomes of chlorothiazide.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**98. 4.** Providing an over-the-bed cradle will decrease the amount of pressure that the linens exert upon the lower extremity and prevent further tissue breakdown. Administering prescribed analgesics would be an intervention for reducing the pain. Applying lanolin lotions to the left ankle ulcer will not promote healing. Encouraging the client to sit up in a chair four times per day is an intervention to promote activity. The nurse would elevate the involved extremity while the client is sitting up to reduce venous stasis and capillary pressure.


 CN: Health promotion and maintenance; CL: Synthesize

**99. 2.** The nurse should first determine what the client means when he says he will apply an herb mixture to his ulcer. The nurse should then encourage the client to consult the physician because home remedies may be beneficial or may interfere with the medical treatment plan. In many cultures, home remedies are commonly used and may be helpful. The nurse must be sensitive to these traditions and cultural beliefs. The other statements demonstrate that the client understands the plan of care for his ulcer.


 CN: Health promotion and maintenance; CL: Evaluate

### The Client with Peripheral Arterial Occlusive Disease

**100. 1.** The ABI test is a noninvasive test that compares the systolic blood pressure in the arm with that of the ankle. It may be done before or after exercise. The client's highest brachial systolic pressure is divided by the left ankle systolic blood pressure to get 0.81. This score is between 0.71 and 0.90, which suggests mild peripheral artery disease. Moderate peripheral artery disease would yield a score of 0.41 to 0.70. Severe peripheral artery disease would result in a score of 0.00 to 0.40.

 CN: Physiological adaptation; CL: Analyze

**101. 3.** Keeping the involved extremity at or below the body's horizontal plane will facilitate tissue perfusion and prevent tissue damage. The nurse should avoid placing the affected extremity on a hard surface, such as a firm mattress, to avoid pressure ulcers. In addition, the involved extremity should be free from heavy overlying bed linens. The nurse should handle the involved extremity in a gentle fashion to prevent friction or pressure. Raising the leg would cause occlusion to the iliac artery, which is contrary to the goal to promote arterial circulation.

 CN: Physiological adaptation; CL: Synthesize

**102. 1, 3.** Discharge teaching begins when the client enters the hospital. One of the risk factors for clot formation is a sedentary lifestyle, and the client should engage in daily aerobic activity, such as biking or swimming (non-weight-bearing). The client is also overweight and should plan to control his weight through dietary counseling or attending weight management programs in the community. Strength training is beneficial by increasing strength and lean body mass, but not helpful in preventing vascular disease. Stress management is not a focus based on the client's needs at this time.

 CN: Health promotion and maintenance;  
CL: Create

**103.** The nurse should assess the femoral artery. Weak or absent femoral pulses are symptomatic of aortoiliac disease.

 CN: Physiological adaptation;  
CL: Analyze



## Managing Care Quality and Safety

**104. 3.** The client is experiencing a rebound tachycardia from abrupt withdrawal of the beta blocker. The beta blocker should be restarted due to the tachycardia, history of hypertension, and the desire to reduce the risk of postoperative myocardial morbidity. The bypass surgery should correct the claudication and need for pentoxifylline. The furosemide and increase in fluids are not indicated since the client's urine output and blood pressure are satisfactory and there is no indication of bleeding. The potassium should also be assessed prior to starting the furosemide.

 CN: Management of care; CL: Synthesize


**105. 1.** The nurse is the client's advocate in planning for pain relief. When presented with a communications conflict, the nurse should first restate the concern, providing as much information as needed. If the physician still does not offer an acceptable solution for pain management the nurse can then discuss the situation with the hospitalist on the team and report the incident to the team leader. Waiting until the next shift to handle the problem does not contribute to the goal of managing the client's pain.

 CN: Safety and infection control;  
CL: Synthesize

**106. 1, 2, 3, 5.** When obtaining blood samples, the nurse must use two acceptable sources of identification (the client states his/her name; the nurse verifies the client's name and identification number of the armband); verifying a room number is not acceptable as client's can be easily reassigned to other rooms. The client must be awake to state his/her name. Blood samples must be labeled in front of the client.

 CN: Safety and infection control;  
CL: Synthesize

**107. 1.** Before starting a heparin infusion, it is essential for the nurse to know the client's baseline blood coagulation values (hematocrit, hemoglobin, and red blood cell and platelet counts). In addition, the partial thromboplastin time should be monitored closely during the process. The client's stools would be tested only if internal bleeding is suspected. Although monitoring vital signs such as apical pulse is important in assessing potential signs and symptoms of hemorrhage or potential adverse reactions to the medication, vital signs are not the most important data to collect before administering the heparin. Intake and output are not important assessments for heparin administration unless the client has fluid and volume problems or kidney disease.

 CN: Safety and infection control;  
CL: Synthesize



TEST  
3

## The Client with Hematologic Health Problems

- The Client with Red Blood Cell Disorders
- The Client with Platelet Disorders
- The Client with White Blood Cell Disorders
- The Client with Lymphoma
- The Client Who Is in Shock
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Red Blood Cell Disorders

1. The nurse is assisting with a bone marrow aspiration and biopsy. In which order, from first to last, should the nurse complete the following tasks?

1. Position the client in a side-lying position.

2. Clean the skin with an antiseptic solution.

3. Verify the client has signed an informed consent.

4. Apply ice to the biopsy site.

2. A client with iron deficiency anemia is refusing to take the prescribed oral iron medication because the medication is causing nausea. The nurse should do which of the following? Select all that apply.

- 1. Suggest that the client use ginger when taking the medication.
- 2. Ask the client what she thinks is causing the nausea.
- 3. Tell the client to use stool softeners to minimize constipation.
- 4. Offer to administer the medication by an intramuscular injection.
- 5. Suggest that the client take the iron with orange juice.

3. A client had a mastectomy followed by chemotherapy 6 months ago. She reports that she is now “unable to concentrate at her card game” and “it seems harder and harder to finish her errands because of exhaustion.” Based on this information, the nurse should suggest that the client do which of the following?

- 1. Take frequent naps.
- 2. Limit activities.
- 3. Increase fluid intake.
- 4. Avoid contact with others.

4. A client is to have a transfusion of packed red blood cells from a designated donor. The client asks if any diseases can be transmitted by this donor. The nurse should inform the client that which of the following diseases can be transmitted by a designated donor? Select all that apply.

- 1. Epstein-Barr virus.
- 2. Human immunodeficiency virus (HIV).
- 3. Cytomegalovirus (CMV).
- 4. Hepatitis A.
- 5. Malaria.

5. A client has been admitted with active rectal bleeding. He has been typed and cross-matched for 2 units of packed red blood cells (RBCs). Within 10 minutes of admission the client faints when getting up to go to the bedside commode. The nurse notifies the health care provider, who orders a unit of blood immediately. The nurse should expect which type of packed RBCs will be used for immediate transfusion?

- 1. A negative.
- 2. B negative.
- 3. AB negative.
- 4. O negative.

**6.** The nurse is preparing to teach a client with microcytic hypochromic anemia about the diet to follow after discharge. Which of the following foods should be included in the diet?

- 1. Eggs.
- 2. Lettuce.
- 3. Citrus fruits.
- 4. Cheese.

**7.** The nurse should instruct the client to eat which of the following foods to obtain the best supply of vitamin B<sub>12</sub>?

- 1. Whole grains.
- 2. Green leafy vegetables.
- 3. Meats and dairy products.
- 4. Broccoli and brussels sprouts.

**8.** The nurse has just admitted a 35-year-old female client who has a serum vitamin B<sub>12</sub> concentration of 800 pg/mL. Which of the following laboratory findings should cue the nurse to focus the client history assessment on specific drug or alcohol use?

- 1. Total bilirubin, 0.3 mg/dL.
- 2. Serum creatinine, 0.5 mg/dL.
- 3. Hemoglobin, 16 g/dL.
- 4. Folate, 1.5 ng/mL.

**9.** Which of the following lab values should the nurse report to the health care provider when the client has anemia?

- 1. Schilling test result, elevated.
- 2. Intrinsic factor, absent.
- 3. Sedimentation rate, 16 mm per hour.
- 4. Red blood cells (RBCs) within normal range.

**10.** The nurse devises a teaching plan for the client with aplastic anemia. Which of the following is the **most** important concept to teach for health promotion and maintenance?

- 1. Eat animal protein and dark green, leafy vegetables every day.
- 2. Avoid exposure to others with acute infections.
- 3. Practice yoga and meditation to decrease stress and anxiety.
- 4. Get 8 hours of sleep at night and take naps during the day.

**11.** A client comes to the health clinic 3 years after undergoing a resection of the terminal ileum and tells the nurse that he has weakness, shortness of breath, and a sore tongue. Which client statement indicates a need for intervention and client teaching?

- 1. "I have been drinking plenty of fluids."
- 2. "I have been gargling with warm salt water for my sore tongue."
- 3. "I have three to four loose stools per day."
- 4. "I take a vitamin B<sub>12</sub> tablet every day."

**12.** A client who follows a vegetarian diet was referred to a dietitian for nutritional counseling for anemia. Which client outcome indicates that the client does **not** understand nutritional counseling? The client:

- 1. Adds dried fruit to cereal and baked goods.
- 2. Cooks tomato-based foods in iron pots.
- 3. Drinks coffee or tea with meals.
- 4. Adds vitamin C to all meals.

**13.** A client was admitted to the hospital with iron deficiency anemia and blood-streaked emesis. Which question is **most** appropriate for the nurse to ask in determining the extent of the client's activity intolerance?

- 1. "What daily activities were you able to do 6 months ago compared with the present?"
- 2. "How long have you had this problem?"
- 3. "Have you been able to keep up with all your usual activities?"
- 4. "Are you more tired now than you used to be?"

**14.** A physician orders vitamin B<sub>12</sub> for a client with pernicious anemia. Which site is appropriate for the nurse to administer vitamin B<sub>12</sub>? Select all that apply.

- 1. Median cutaneous.
- 2. Greater femur trochanter.
- 3. Acromion muscle.
- 4. Ventrogluteal.
- 5. Upper back.
- 6. Dorsogluteal.

**15.** Which position would **most** help to decrease a client's discomfort when the client's spouse injects vitamin B<sub>12</sub> using the ventrogluteal site?

- 1. Lying on the side with legs extended.
- 2. Lying on the abdomen with toes pointed inward.
- 3. Leaning over the edge of a low table with hips flexed.
- 4. Standing upright with the feet one shoulder-width apart.

**16.** A client is admitted from the emergency department after falling down a flight of stairs at home. Her vital signs are stable and her history states that she had a gastric stapling 2 years ago and takes neomycin for acne. The client jokes about how she is clumsy lately and trips over things. The nurse should ask the client which of the following questions? Select all that apply.

- 1. "Are you experiencing numbness in your extremities?"
- 2. "How much vitamin B<sub>12</sub> are you getting?"
- 3. "Are you feeling depressed?"
- 4. "Do you feel safe at home?"
- 5. "Are you getting sufficient iron in your diet?"

**17.** A client returned home from an overseas tour of duty and tells the nurse he is always tired. He has a temperature of 99.5° F (37.5° C). His skin is dark bronze, and his urine has a dark color. His hemoglobin level is 9 g/dL; his hematocrit is 49, and red blood cells are 2.75 million/ $\mu$ L. What should the nurse do **first**?

- 1. Initiate an intake and output record.
- 2. Place the client on bed rest.
- 3. Place the client on contact isolation.
- 4. Keep the client out of sunlight.

**18.** When a client is receiving a cephalosporin, the nurse must monitor the client for which of the following?

- 1. Drug-induced hemolytic anemia.
- 2. Purpura.
- 3. Infectious emboli.
- 4. Ecchymosis.

**19.** A client is to have a Schilling test? The nurse should:

- 1. Administer methylcellulose (Citrucel).
- 2. Start a 24- to 48-hour urine specimen collection.
- 3. Maintain nothing-by-mouth (NPO) status.
- 4. Start a 72-hour stool specimen collection.

**20.** A client from a Mediterranean country is admitted with thalassemia, jaundice, splenomegaly, and hepatomegaly. Which of the following should be the **primary** focus of nursing care for this client?

- 1. Providing activities of daily living on the time schedule of the client's homeland.
- 2. Offering foods that the client enjoys in order to increase the intake of calories.
- 3. Decreasing cardiac demands by promoting rest.
- 4. Listening to concerns about the hospitalization.

**21.** A client with pernicious anemia asks why she must take vitamin B<sub>12</sub> injections for the rest of her life. Which is the nurse's **best** response?

- 1. "The reason for your vitamin deficiency is an inability to absorb the vitamin because the stomach is not producing sufficient acid."
- 2. "The reason for your vitamin deficiency is an inability to absorb the vitamin because the stomach is not producing sufficient intrinsic factor."
- 3. "The reason for your vitamin deficiency is an excessive excretion of the vitamin because of kidney dysfunction."
- 4. "The reason for your vitamin deficiency is an increased requirement for the vitamin because of rapid red blood cell production."

**22.** An African-American woman had experienced severe palpitations, weakness, and shortness of breath after taking bacitracin (Bactrim). As a part of the discharge planning, the nurse should evaluate the client's knowledge about:

- 1. Increased folic acid needs.
- 2. Congenital enzyme deficiency.
- 3. Restricted activity in hot weather.
- 4. Need for blood transfusions.

**23.** The nurse is assessing a client's activity tolerance by having the client walk on a treadmill for 5 minutes. Which of the following indicates an abnormal response?

- 1. Pulse rate increased by 20 beats per minute (bpm) immediately after the activity.
- 2. Respiratory rate decreased by 5 breaths/minute.
- 3. Diastolic blood pressure increased by 7 mm Hg.
- 4. Pulse rate within 6 bpm of resting pulse after 3 minutes of rest.

**24.** When comparing the hematocrit levels of a postoperative client, the nurse notes that the hematocrit decreased from 36% to 34% on the third day even though the RBC count and hemoglobin value remained stable at 4.5 million/ $\mu$ L and 11.9 g/dL, respectively. The nurse should **next**:

- 1. Check the dressing and drains for frank bleeding.
- 2. Call the physician.
- 3. Continue to monitor vital signs.
- 4. Start oxygen at 2 L/minute per nasal cannula.

**25.** The nurse is administering packed red blood cells (PRBCs) to a client. The nurse should **first**:

- 1. Discontinue the I.V. catheter if a blood transfusion reaction occurs.
- 2. Administer the PRBCs through a percutaneously inserted central catheter line with a 20-gauge needle.
- 3. Flush PRBCs with 5% dextrose and 0.45% normal saline solution.
- 4. Stay with the client during the first 15 minutes of infusion.

**26.** The nurse should instruct a young female adult with sickle cell anemia to do which of the following? **Select all that apply.**

- 1. Drink plenty of fluids when outside in hot weather.
- 2. Avoid travel to cities where the oxygen level is lower.
- 3. Be aware that since she is homozygous for HbS, she carries the sickle cell trait.
- 4. Know that pregnancy with sickle cell disease increases the risk of a crisis.
- 5. Avoid flying on commercial airlines.

**27.** The nurse is teaching a client and his family about the client's new diagnosis of hemochromatosis. Which of the following details should the nurse include?

- 1. Hemochromatosis is an autoimmune disorder that affects the HFE gene.
- 2. Individuals who are heterozygous for hemochromatosis rarely develop the disease.
- 3. Individuals who are homozygous for hemochromatosis are carriers of hemochromatosis.
- 4. Men are at greater risk for hemochromatosis.

**28.** A client is having a blood transfusion reaction. The nurse must do the following in what order of priority from first to last?

1. Notify the attending physician and blood bank.

2. Complete the appropriate Transfusion Reaction Form(s).

3. Stop the transfusion.

4. Keep the I.V. open with normal saline infusion.





**29.** Which safety measures would be **most** important to implement when caring for a client who is receiving 2 units of packed red blood cells (PRBCs)? Select all that apply.

- 1. Verify that the ABO and Rh of the 2 units are the same.
- 2. Infuse a unit of PRBCs in less than 4 hours.
- 3. Stop the transfusion if a reaction occurs, but keep the line open.
- 4. Take vital signs every 15 minutes while the unit is transfusing.
- 5. Inspect the blood bag for leaks, abnormal color, and clots.
- 6. Use a 22-gauge catheter for optimal flow of a blood transfusion.

**30.** A client who had received 25 mL of packed red blood cells (PRBCs) has low back pain and pruritus. After stopping the infusion, the nurse should take what action **next**?

- 1. Administer prescribed antihistamine and aspirin.
- 2. Collect blood and urine samples and send to the lab.
- 3. Administer prescribed diuretics.
- 4. Administer prescribed vasopressors.

**31.** A client is to receive epoetin (Epogen) injections. What laboratory value should the nurse assess before giving the injection?

- 1. Hematocrit.
- 2. Partial thromboplastin time.
- 3. Hemoglobin concentration.
- 4. Prothrombin time.

**32.** When beginning I.V. erythropoietin (Epogen, Procrit) therapy, the nurse should do which of the following? Select all that apply.

- 1. Checking the hemoglobin levels before administering subsequent doses.
- 2. Shaking the vial thoroughly to mix the concentrated white, milky solution.
- 3. Keeping the multidose vial refrigerated between scheduled twice-a-day doses.
- 4. Administering the medication through the I.V. line without other medications.
- 5. Adjusting the initial doses according to the client's changes in blood pressure.
- 6. Educating the client to avoid driving and performing hazardous activity during the initial treatment.

**33.** A client states that she is afraid of receiving vitamin B<sub>12</sub> injections because of potential toxic reactions. Which is the nurse's **best** response to relieve these fears?

- 1. "Vitamin B<sub>12</sub> will cause ringing in the ears before a toxic level is reached."
- 2. "Vitamin B<sub>12</sub> may cause a very mild rash initially."
- 3. "Vitamin B<sub>12</sub> cause mild nausea but nothing toxic."
- 4. "Vitamin B<sub>12</sub> is generally free of toxicity because it is water-soluble."

**34.** A client with microcytic anemia is having trouble selecting food from the hospital menu. Which food is **best** for the nurse to suggest for satisfying the client's nutritional needs?

- 1. Egg yolks.
- 2. Brown rice.
- 3. Vegetables.
- 4. Tea.

**35.** A client with macrocytic anemia has a burn on her foot and states that she had been watching television while lying on a heating pad. Which action should be the nurse's **first** response?

- 1. Assess for potential abuse.
- 2. Check for diminished sensations.
- 3. Document the findings.
- 4. Clean and dress the area.

**36.** Which of the following is a late symptom of polycythemia vera?

- 1. Headache.
- 2. Dizziness.
- 3. Pruritus.
- 4. Shortness of breath.

**37.** The nurse is teaching a client with polycythemia vera about potential complications from this disease. Which manifestations should the nurse include in the client's teaching plan? Select all that apply.

- 1. Hearing loss.
- 2. Visual disturbance.
- 3. Headache.
- 4. Orthopnea.
- 5. Gout.
- 6. Weight loss.

**38.** When a client is diagnosed with aplastic anemia, the nurse should assess the client for changes in which of the following physiologic functions?

- 1. Bleeding tendencies.
- 2. Intake and output.
- 3. Peripheral sensation.
- 4. Bowel function.

### The Client with Platelet Disorders

**39.** A health care provider orders 0.5 mg of protamine sulfate for a client who is showing signs of bleeding after receiving a 100-unit dose of heparin. The nurse should expect the effects of the protamine sulfate to be noted in which of the following time frames?

- 1. 5 minutes.
- 2. 10 minutes.
- 3. 20 minutes.
- 4. 30 minutes.

**40.** The nurse is to administer subcutaneous heparin to an older adult. What facts should the nurse keep in mind when administering this dose? Select all that apply.

- 1. It should be administered in the anterior area of the iliac crest.
- 2. The onset is immediate.
- 3. Use a 27G, 5/8" needle.
- 4. Cephalosporin potentiates the effects of heparin.
- 5. Double check the dose with another nurse.

**41.** A client has a platelet count of 31,000/ $\mu$ L. The nurse should instruct the client to:

- 1. Pad sharp surfaces to avoid minor trauma when walking.
- 2. Assess for spontaneous petechiae in the extremities.
- 3. Keep the room darkened.
- 4. Check for blood in the urine.

**42.** A client with a history of systemic lupus erythematosus was admitted with a severe viral respiratory tract infection and diffuse petechiae. Based on these data, it is **most** important that the nurse further evaluate the client's recent:

- 1. Quality and quantity of food intake.
- 2. Type and amount of fluid intake.
- 3. Weakness, fatigue, and ability to get around.
- 4. Length and amount of menstrual flow.

**43.** When a client with thrombocytopenia has of a severe headache, the nurse interprets that this may indicate which of the following?

- 1. Stress of the disease.
- 2. Cerebral bleeding.
- 3. Migraine headache.
- 4. Sinus congestion.

**44.** The nurse evaluates that the client correctly understands how to report signs and symptoms of bleeding when the client makes which of the following statements?

- 1. "Petechiae are large, red skin bruises."
- 2. "Ecchymoses are large, purple skin bruises."
- 3. "Purpura is an open cut on the skin."
- 4. "Abrasions are small pinpoint red dots on the skin."

**45.** The client states she does not understand what causes idiopathic thrombocytopenic purpura (ITP). The nurse provides which of the following explanations?

- 1. It is believed that the platelets are coated with antibodies and the spleen sees them as foreign bodies.
- 2. It is believed that the liver identifies the platelets as foreign bodies.
- 3. It is now believed that the syndrome is related to an underactive immune system.
- 4. The cause is unknown.

**46.** The nurse should instruct the client with a platelet count of less than 150,000/ $\mu$ L to avoid which of the following activities?

- 1. Ambulation.
- 2. Valsalva's maneuver.
- 3. Visiting with children.
- 4. Semi-Fowler's position.

**47.** A client who is taking Bufferin Arthritis Strength caplets develops prolonged bleeding from a superficial skin injury on the forearm. The nurse should tell the client to do which of the following **first**?

- 1. Place the forearm under a running stream of lukewarm water.
- 2. Pat the injury with a dry washcloth.
- 3. Wrap the entire forearm from the wrist to the elbow.
- 4. Apply an ice pack for 20 minutes.

**48.** A client's bone marrow report reveals normal stem cells and precursors of platelets (megakaryocytes) in the presence of decreased circulating platelets. The nurse recognizes a knowledge deficit when the client makes which of the following statements?

- 1. "I need to stop flossing and throw away my hard toothbrush."
- 2. "I am glad that my report turned out normal."
- 3. "Now I know why I have all these bruises."
- 4. "I shouldn't jump off that last step anymore."

**49.** The nurse should assess a client with thrombocytopenia who has developed a hemorrhage for which of the following?

- 1. Tachycardia.
- 2. Bradycardia.
- 3. Decreased  $\text{Paco}_2$ .
- 4. Narrowed pulse pressure.

**50.** The client with idiopathic thrombocytopenic purpura (ITP) asks the nurse why she has to take steroids. Which is the nurse's **best** response?

- 1. Steroids destroy the antibodies and prolong the life of platelets.
- 2. Steroids neutralize the antigens and prolong the life of platelets.
- 3. Steroids increase phagocytosis and increase the life of platelets.
- 4. Steroids alter the spleen's recognition of platelets and increase the life of platelets.

**51.** A client is to be discharged on prednisone. Which of the following statements indicates that the client understands important concepts about the medication therapy?

- 1. "I need to take the medicine in divided doses at morning and bedtime."
- 2. "I am to take 40 mg of prednisone for 2 months and then stop."
- 3. "I need to wear or carry identification that I am taking prednisone."
- 4. "Prednisone will give me extra protection from colds and flu."

**52.** When teaching the client older than age 50 who is receiving long-term prednisone therapy, the nurse should recommend?

- 1. Take the prednisone with food.
- 2. Take over-the-counter drugs as needed.
- 3. Exercise three to four times a week.
- 4. Eat foods that are low in potassium.

**53.** The nurse is preparing a teaching plan about increased exercise for a female client who is receiving long-term corticosteroid therapy. What type of exercise is **most** appropriate for this client?

- 1. Floor exercises.
- 2. Stretching.
- 3. Running.
- 4. Walking.

**54.** The nurse is teaching a client with a history of acquired thrombocytopenia about how to prevent and control hemorrhage. Which statement indicates that the client needs further instruction?

- 1. "I can apply direct pressure over small cuts for at least 5 to 10 minutes to stop a venous bleed."
- 2. "I can count the number of tissues saturated to detect blood loss during a nosebleed."
- 3. "I can take hormones to decrease blood loss during menses."
- 4. "I can count the number of sanitary napkins to detect excess blood loss during menses."

**55.** A client has been on long-term prednisone therapy. The nurse should instruct the client to consume a diet high in which of the following? Select all that apply.

- 1. Carbohydrate.
- 2. Protein.
- 3. Trans fat.
- 4. Potassium.
- 5. Calcium.
- 6. Vitamin D.

**56.** Platelets should **not** be administered under which of the following conditions?

- 1. The platelet bag is cold.
- 2. The platelets are 2 days old.
- 3. The platelet bag is at room temperature.
- 4. The platelets are 12 hours old.

**57.** The nurse is preparing to administer platelets. The nurse should:

- 1. Check the ABO compatibility.
- 2. Administer the platelets slowly.
- 3. Gently rotate the bag.
- 4. Use a whole blood tubing set.

**58.** Which of the following indicates that a client has achieved the goal of correctly demonstrating deep breathing for an upcoming splenectomy? The client:

- 1. Breathes in through the nose and out through the mouth.
- 2. Breathes in through the mouth and out through the nose.
- 3. Uses diaphragmatic breathing in the lying, sitting, and standing positions.
- 4. Takes a deep breath in through the nose, holds it for 5 seconds, and blows out through pursed lips.

**59.** A client is scheduled for an elective splenectomy. Immediately before the client goes to surgery, the nurse should determine that the client has:

- 1. Voided completely.
- 2. Signed the consent.
- 3. Vital signs recorded.
- 4. Name band on wrist.

**60.** When receiving a client from the postanesthesia care unit after a splenectomy, which should the nurse assess after obtaining vital signs?

- 1. Nasogastric drainage.
- 2. Urinary catheter.
- 3. Dressing.
- 4. Need for pain medication.

**61.** The client's family asks why the client who had a splenectomy has a nasogastric (NG) tube. An NG tube is used to:

- 1. Move the stomach away from where the spleen was removed.
- 2. Irrigate the operative site.
- 3. Decrease abdominal distention.
- 4. Assess for the gastric pH as peristalsis returns.

**62.** A client who had a splenectomy is being discharged. Of the following discharge instructions, which is **most** specific to the client's surgical procedure?

- 1. Do not drive.
- 2. Alternate rest and activity.
- 3. Make an appointment for the staples to be removed.
- 4. Report early signs of infection.

**63.** What is the earliest clinical manifestation in a client with acute disseminated intravascular coagulation (DIC)?

- 1. Severe shortness of breath.
- 2. Bleeding without history or cause.
- 3. Orthopnea.
- 4. Hematuria.

**64.** Which of the following is contraindicated for a client diagnosed with disseminated intravascular coagulation (DIC)?

- 1. Treating the underlying cause.
- 2. Administering heparin.
- 3. Administering warfarin sodium (Coumadin).
- 4. Replacing depleted blood products.

**65.** A client with disseminated intravascular coagulation develops clinical manifestations of microvascular thrombosis. The nurse should assess the client for:

- 1. Hemoptysis.
- 2. Focal ischemia.
- 3. Petechiae.
- 4. Hematuria.

**66.** Which of the following is an assessment finding associated with internal bleeding with disseminated intravascular coagulation?

- 1. Bradycardia.
- 2. Hypertension.
- 3. Increasing abdominal girth.
- 4. Petechiae.

### The Client with White Blood Cell Disorders

**67.** A 10-year-old client is diagnosed with infectious mononucleosis. Her white blood cell (WBC) count is 19,000/ $\mu$ L. She has a streptococcal throat infection and her spleen is enlarged. She has aching muscles. Which of the following instructions should the nurse include in discharge planning with the client and her parents? Select all that apply.

- 1. Stay on bed rest until the temperature is normal.
- 2. Gargle with warm saline while the throat is irritated.
- 3. Increase intake of fluids until the infection subsides.
- 4. Take aspirin as long as the fever and myalgia persist.
- 5. Avoid contact sports while the spleen is enlarged.

**68.** The nurse notes that the daily white blood cell (WBC) count in a client with aplastic anemia has dropped overnight from 3,900 to 2,900/ $\mu$ L. Which is the appropriate nursing intervention?

- 1. Continue monitoring the client.
- 2. Call the laboratory to verify the report.
- 3. Document the finding.
- 4. Call the physician and place the client in reverse isolation.

**69.** A client who had an exploratory laparotomy 3 days ago has a white blood cell (WBC) differential with a shift to the left. The nurse instructs unlicensed personnel to report which clinical manifestation?

- 1. Swelling around the incision.
- 2. Redness around the incision.
- 3. Elevated temperature.
- 4. Purulent wound drainage.

**70.** The nurse is developing a care plan for a client with leukemia. The plan should include which of the following? Select all that apply.

- 1. Monitor temperature and report elevation.
- 2. Recognize signs and symptoms of infection.
- 3. Avoid crowds.
- 4. Maintain integrity of skin and mucous membranes.
- 5. Take a baby aspirin each day.

**71.** A client with neutropenia has an absolute neutrophil count of 900. What is the client's risk of infection?

- 1. Normal risk.
- 2. Moderate risk.
- 3. High risk.
- 4. Extremely high risk.

**72.** Which factor besides the degree of neutropenia does the nurse assess in determining the client's risk of infection?

- 1. Length of time neutropenia has existed.
- 2. Health status before neutropenia.
- 3. Body build and weight.
- 4. Resistance to infection in childhood.

**73.** Which nursing action is important in preventing cross-contamination?

- 1. Change gloves immediately after use.
- 2. Stand 2 feet from the client.
- 3. Speak minimally when in the room.
- 4. Wear long-sleeved shirts.

**74.** The nurse should teach the neutropenic client and the family to avoid which of the following?

- 1. Using suppositories or enemas.
- 2. Using a high-efficiency particulate air (HEPA) filter mask.
- 3. Performing perianal care after every bowel movement.
- 4. Performing oral care after every meal.

**75.** The nurse should remind family members who are visiting a client with granulocytopenia to:

- 1. Visit only if they do not have a cold.
- 2. Wash their hands.
- 3. Leave the children at home.
- 4. Avoid kissing the client on the lips.

**76.** The nurse should remind the unlicensed personnel that which of the following is the **most** important goal in the care of the neutropenic client in isolation?

- 1. Listening to the client's feelings of concern.
- 2. Completing the client's care in a nonhurried manner.
- 3. Completing all of the client's care at one time.
- 4. Instructing the client to dispose of tissue after blowing the nose.

**77.** A nurse is obtaining consent for a bone marrow aspiration. What should the nurse do? Select all that apply.

- 1. Witness the client signing the consent form.
- 2. Evaluate that the client understands the procedure.
- 3. Explain the risks of the procedure to the client.
- 4. Verify that the client is signing the consent form of his own free will.
- 5. Determine that the client understands post-procedure care.

**78.** A client is about to undergo bone marrow aspiration of the sternum. Which of the following statements should the nurse include to provide information to the client about what the client will feel during the procedure?

- 1. "You may feel a warm solution being wiped over your entire front from your neck down to your navel and out to your shoulders."
- 2. "You will not feel the local anesthetic being applied because it will be sprayed on."
- 3. "You will feel a pulling type of discomfort for a few seconds."
- 4. "After the needle is removed, you will feel a bandage being applied around your chest."

**79.** Twenty-four hours after a bone marrow aspiration, the nurse evaluates which of the following as an appropriate client outcome?

- 1. The client maintains bed rest.
- 2. There is redness and swelling at the aspiration site.
- 3. The client requests morphine sulfate for pain.
- 4. There is no bleeding at the aspiration site.

**80.** A client states, "I don't want any more tests. Who cares what kind of leukemia I have? I just want to be treated now." Which is the nurse's **best** response?

- 1. "I'm sure you are frustrated and want to be well now."
- 2. "Your treatment can be more effective if it is based on more specific information about your disease."
- 3. "Now, you know the tests are necessary and that you are just upset right now."
- 4. "I understand how you feel."

**81.** During the induction stage for treatment of leukemia, the nurse should remove which items that the family has brought into the room?

- 1. A Bible.
- 2. A picture.
- 3. A sachet of lavender.
- 4. A hairbrush.

**82.** The nurse identifies deficient knowledge when the client undergoing induction therapy for leukemia makes which of the following statements?

- 1. "I will have to pace my activities with rest periods."
- 2. "I can't wait to get home to my cat!"
- 3. "I will use warm saline gargle instead of brushing my teeth."
- 4. "I must report a temperature of 100° F."



**83.** A 60-year-old client with acute myeloid leukemia (AML) states that he overheard one of the other clients say that AML had a very poor prognosis. The client explains to the nurse that he had understood his doctor to say that he had a relatively good prognosis. Which is the nurse's **best** response?

- 1. "You must have misunderstood. Whom did you hear that from?"
- 2. "AML does have a very poor prognosis for poorly differentiated cells."
- 3. "AML is the most common nonlymphocytic leukemia."
- 4. "Your doctor stated your prognosis based on the differentiation of your cells."

**84.** The goal of nursing care for a client with acute myeloid leukemia (AML) is to prevent:

- 1. Cardiac arrhythmias.
- 2. Liver failure.
- 3. Renal failure.
- 4. Hemorrhage.

**85.** The nurse is assessing a client with chronic myeloid leukemia (CML). The nurse should assess the client for:

- 1. Lymphadenopathy.
- 2. Hyperplasia of the gum.
- 3. Bone pain from expansion of marrow.
- 4. Shortness of breath..

**86.** Which of the following individuals are at risk for acquiring acute lymphocytic leukemia (ALL)? The client who is:

- 1. 4 to 12 years.
- 2. 20 to 30 years.
- 3. 40 to 50 years.
- 4. 60 to 70 years.

**87.** The client with acute lymphocytic leukemia (ALL) is at risk for infection. What should the nurse do?

- 1. Place the client in a private room.
- 2. Have the client wear a mask.
- 3. Have staff wear gowns and gloves.
- 4. Restrict visitors.

**88.** In assessing a client in the early stage of chronic lymphocytic leukemia (CLL), the nurse should determine if the client has:

- 1. Enlarged, painless lymph nodes.
- 2. Headache.
- 3. Hyperplasia of the gums.
- 4. Unintentional weight loss.

**89.** The nurse is planning care with a client with acute leukemia who has mucositis. The nurse should advise the client that after every meal and every four hours while awake the client should use:

- 1. Lemon-glycerin swabs.
- 2. A commercial mouthwash.
- 3. A saline or baking soda solution.
- 4. A commercial toothpaste and brush

**90.** The client with acute leukemia and the health care team establish mutual client outcomes of improved tidal volume and activity tolerance. Which measure would be **least** likely to promote outcome achievement?

- 1. Ambulating in the hallway.
- 2. Sitting up in a chair.
- 3. Lying in bed and taking deep breaths.
- 4. Using a stationary bicycle in the room.

**91.** The nurse is evaluating the client's learning about combination chemotherapy. Which of the following statements by the client about reasons for using combination chemotherapy indicates the need for **further** explanation?

- 1. "Combination chemotherapy is used to interrupt cell growth cycle at different points."
- 2. "Combination chemotherapy is used to destroy cancer cells and treat side effects simultaneously."
- 3. "Combination chemotherapy is used to decrease resistance."
- 4. "Combination chemotherapy is used to minimize the toxicity from using high doses of a single agent."

**92.** In providing care to the client with leukemia who has developed thrombocytopenia, the nurse assesses the most common sites for bleeding. Which of the following is **not** a common site?

- 1. Biliary system.
- 2. Gastrointestinal tract.
- 3. Brain and meninges.
- 4. Pulmonary system.

**93.** The nurse's **best** explanation for why the severely neutropenic client is placed in reverse isolation is that reverse isolation helps prevent the spread of organisms:

- 1. To the client from sources outside the client's environment.
- 2. From the client to health care personnel, visitors, and other clients.
- 3. By using special techniques to dispose of contaminated materials.
- 4. By using special techniques to handle the client's linens and personal items.

## The Client with Lymphoma

**94.** Which of the following clinical manifestations does the nurse **most** likely observe in a client with Hodgkin's disease?

- 1. Difficulty swallowing.
- 2. Painless, enlarged cervical lymph nodes.
- 3. Difficulty breathing.
- 4. A feeling of fullness over the liver.

**95.** A client with a suspected diagnosis of Hodgkin's disease is to have a lymph node biopsy. Which action is correct for handling the lymph node biopsy specimen for histologic examination for this client?

- 1. Maintain sterile technique.
- 2. Use a mask, gloves, and a gown when assisting with the procedure.
- 3. Place the specimen in a container and send it to the laboratory when someone is available to take it.
- 4. Call for a laboratory technician to assist the physician.

**96.** The client with Hodgkin's disease undergoes an excisional cervical lymph node biopsy under local anesthesia. After the procedure, which does the nurse assess **first**?

- 1. Vital signs.
- 2. The incision.
- 3. The airway.
- 4. Neurologic signs.

**97.** The nurse explains to the client that a biopsy of the enlarged lymph node is important because, if Hodgkin's disease is present, the histologic examination will reveal which of the following?

- 1. Tay-Sachs cells.
- 2. Sarcoidosis cells.
- 3. Reed-Sternberg cells.
- 4. Duchenne's cells.

**98.** When assessing the client with Hodgkin's disease, the nurse should observe the client for which of the following findings?

- 1. Herpes zoster infections.
- 2. Discolored teeth.
- 3. Hemorrhage.
- 4. Hypercellular immunity.

**99.** The client with Hodgkin's disease develops B symptoms. These manifestations indicate which of the following?

- 1. The client has a low-grade fever (temperature lower than 100° F [37.8° C]).
- 2. The client has a weight loss of 5% or less of body weight.
- 3. The client has night sweats.
- 4. The client probably has not progressed to an advanced stage.

**100.** The nurse is developing a discharge plan about home care with a client who has lymphoma. The nurse should emphasize which of the following?

- 1. Use analgesics as needed.
- 2. Take a shower with perfumed shower gel.
- 3. Wear a mask when outside of the home.
- 4. Take an antipyretic every morning.

**101.** The client asks the nurse to explain what it means that his Hodgkin's disease is diagnosed at stage 1A. Which of the following describes the involvement of the disease?

- 1. Involvement of a single lymph node.
- 2. Involvement of two or more lymph nodes on the same side of the diaphragm.
- 3. Involvement of lymph node regions on both sides of the diaphragm.
- 4. Diffuse disease of one or more extralymphatic organs.

**102.** A client is undergoing a bone marrow aspiration and biopsy. What is the **best** way for the nurse to help the client handle her stress?

- 1. Allow the client's family to stay with her as long as possible.
- 2. Stay with the client and hold her hand without speaking.
- 3. Encourage the client to take slow, deep breaths to relax.
- 4. Allow the client time to express her feelings.

**103.** The nurse explains to the client with Hodgkin's disease that a bone marrow biopsy will be taken after the aspiration. What should the nurse explain about the biopsy?

- 1. "Your biopsy will be performed before the aspiration because enough tissue may be obtained so that you won't have to go through the aspiration."
- 2. "You will feel a pressure sensation when the biopsy is taken but should not feel actual pain; if you do, tell the doctor so that you can be given extra numbing medicine."
- 3. "You may hear a crunch as the needle passes through the bone, but when the biopsy is taken, you will feel a suction-type pain that will last for just a moment."
- 4. "You will be shaved and cleaned with an antiseptic agent, after which the doctor will inject a needle without making an incision to aspirate out the bone marrow."

**104.** A client with advanced Hodgkin's disease is admitted to hospice because death is imminent. The goal of nursing care is to help relieve the client's:

- 1. Fear of pain.
- 2. Fear of further therapy.
- 3. Feelings of isolation.
- 4. Feelings of social inadequacy.

**105.** The client is a survivor of non-Hodgkin's lymphoma. Which of the following statements indicates the client needs additional information?

- 1. "Regular screening is very important for me."
- 2. "The survivor rate is directly proportional to the incidence of second malignancy."
- 3. "The survivor rate is indirectly proportional to the incidence of second malignancy."
- 4. "It is important for survivors to know the stage of the disease and their current treatment plan."

### The Client Who Is in Shock

**106.** Which of the following is the **most** important goal of nursing care for a client who is in shock?

- 1. Manage fluid overload.
- 2. Manage increased cardiac output.
- 3. Manage inadequate tissue perfusion.
- 4. Manage vasoconstriction of vascular beds.

**107.** Which of the following nursing assessment findings indicates hypovolemic shock in a client who has had a 15% blood loss?

- 1. Pulse rate less than 60 bpm.
- 2. Respiratory rate of 4 breaths/minute.
- 3. Pupils unequally dilated.
- 4. Systolic blood pressure less than 90 mm Hg.

**108.** Which of the following findings is the **best** indication that fluid replacement for the client in hypovolemic shock is adequate?

- 1. Urine output greater than 30 mL/hour.
- 2. Systolic blood pressure greater than 110 mm Hg.
- 3. Diastolic blood pressure greater than 90 mm Hg.
- 4. Respiratory rate of 20 breaths/minute.

**109.** Which of the following is a risk factor for hypovolemic shock?

- 1. Hemorrhage.
- 2. Antigen-antibody reaction.
- 3. Gram-negative bacteria.
- 4. Vasodilation.

**110.** Which is a priority assessment for the client in shock who is receiving an I.V. infusion of packed red blood cells and normal saline solution?

- 1. Fluid balance.
- 2. Anaphylactic reaction.
- 3. Pain.
- 4. Altered level of consciousness.

**111.** The client who does not respond adequately to fluid replacement has an order for an I.V. infusion of dopamine hydrochloride at 5 µg/kg/minute. To determine that the drug is having the desired effect, the nurse should assess the client for:

- 1. Increased renal and mesenteric blood flow.
- 2. Increased cardiac output.
- 3. Vasoconstriction.
- 4. Reduced preload and afterload.

**112.** A client is receiving dopamine hydrochloride for treatment of shock. The nurse should:

- 1. Administer pain medication concurrently.
- 2. Monitor blood pressure continuously.
- 3. Evaluate arterial blood gases at least every 2 hours.
- 4. Monitor for signs of infection.

**113.** A male client who has been taking warfarin (Coumadin) has been admitted with severe acute rectal bleeding and the following laboratory results: International Normalized Ratio (INR), 8; hemoglobin, 11 g/dL; and hematocrit, 33%. Which of the following physician orders should the nurse expect to implement initially? Select all that apply.

- 1. Administer I.V. dextrose 5% in 0.45% normal saline solution.
- 2. Schedule client for a sigmoidoscopy in the morning.
- 3. Give 1 unit fresh frozen plasma (FFP).
- 4. Administer vitamin K (AquaMEPHYTON) 2.5 mg P.O.
- 5. Begin giving polyethylene glycol-electrolyte solution (GoLYTELY) in preparation for sigmoidoscopy.
- 6. Administer Fleet enema.

**114.** The nurse in the preoperative holding area keeps a client with gastric bleeding in a dimly lit environment with one family member present. What is the **primary** rationale for these nursing interventions?

- 1. To stabilize fluid and electrolyte balance.
- 2. To minimize oxygen consumption.
- 3. To increase client and family comfort.
- 4. To prevent infection.

**115.** When assessing a client for early septic shock, the nurse observes for which of the following?

- 1. Cool, clammy skin.
- 2. Warm, flushed skin.
- 3. Decreased systolic blood pressure.
- 4. Hemorrhage.

**116.** A client with toxic shock has been receiving ceftriaxone sodium (Rocephin), 1 g every 12 hours. In addition to culture and sensitivity studies, which other laboratory findings does the nurse monitor?

- 1. Serum creatinine.
- 2. Spinal fluid analysis.
- 3. Arterial blood gases.
- 4. Serum osmolality.

**117.** Which nursing intervention is **most** important in preventing septic shock?

- 1. Administering I.V. fluid replacement therapy as ordered.
- 2. Obtaining vital signs every 4 hours for all clients.
- 3. Monitoring red blood cell counts for elevation.
- 4. Maintaining asepsis of indwelling urinary catheters.

**118.** Which of the following is an indication of a complication of septic shock?

- 1. Anaphylaxis.
- 2. Acute respiratory distress syndrome (ARDS).
- 3. Chronic obstructive pulmonary disease (COPD).
- 4. Mitral valve prolapse.

## Managing Care Quality and Safety

**119.** A nurse has two clients that have an order to receive a blood transfusion of packed red blood cells at the same time. The first client's blood pressure dropped from the preoperative value of 120/80 mm Hg to a postoperative value of 100/50. The second client is 58 years old and is hospitalized because he developed dehydration and anemia following pneumonia. After checking the patency of their I.V. lines and vital signs, which should the nurse do **next**?

- 1. Call for both clients' blood transfusions at the same time.
- 2. Ask another nurse to verify the compatibility of both units at the same time.
- 3. Call for and hang the first client's blood transfusion.
- 4. Ask another nurse to call for and hang the blood for the second client.

**120.** When a blood transfusion is terminated following a reaction, the nurse must do which of the following? Select all that apply.

- 1. Send freshly-collected urine samples to the laboratory.
- 2. Return the remainder of the blood component unit to the blood bank.
- 3. Return the intravenous administration set to the blood bank.
- 4. Alert Risk Management about the incident.
- 5. Report the incident to the Infection Control Manager.

**121.** The nurse is administering a medication to a client with myeloid leukemia and does not know the use, dose, or side effects. To obtain the most up-to-date information about this drug, the nurse should:

- 1. Check the Physician's Drug Reference (PDR) at the nurses' station.
- 2. Obtain a pharmacology textbook from the hospital library.
- 3. Consult the drug guide provided by the hospital on the nurses' PDA.
- 4. Review information at the drug manufacturer's website.

**122.** The charge nurse on a hematology/oncology unit is reviewing the policy for using abbreviations with the staff. The charge nurse should emphasize which of the following about why dangerous abbreviations need to be eliminated? Select all that apply.

- 1. To ensure efficient and accurate communication.
- 2. To prevent medication errors.
- 3. To ensure client safety.
- 4. To make it easier for clients to understand the medication orders.
- 5. To make data entry into a computerized health record easier.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Red Blood Cell Disorders

1.

3. Verify the client has signed an informed consent.

1. Position the client in a side-lying position.

2. Clean the skin with an antiseptic solution.

4. Apply ice to the biopsy site.


First, the nurse must verify that the client has voluntarily signed a consent form before the procedure begins, and check that the client understands the procedure. The nurse then positions the client in a side-lying, or *lateral decubitus*, position with the affected side up. Then the nurse should clean the skin site and surrounding area with an antiseptic solution such as Betadine before the health care provider numbs the site and collects the specimen. When the procedure is finished, the nurse must apply ice to the biopsy site to reduce pain.

🔑 CN: Management of care; CL: Synthesize

2. 1, 2, 5. Nausea and vomiting are common adverse effects of oral iron preparations. The nurse should first ask the client why she does not want to take the oral medication, and then suggest ways to decrease the nausea and vomiting. Ginger may help minimize the nausea and the client can try this remedy and evaluate its effectiveness. Iron should be taken on an empty stomach but can be taken with orange juice. The client can evaluate if this helps the nausea. Stool softeners should not be used in clients with iron deficiency anemia. Instead, constipation can be prevented by following a high-fiber diet. Administering iron intramuscularly is done only if other approaches are not effective.

🔑 CN: Health promotion and maintenance; CL: Synthesize


**3. 1.** This client is likely experiencing fatigue and should increase her periods of rest. The fatigue may be caused by anemia from depletion of red blood cells due to the chemotherapy. Asking the client to limit her activities may cause the client to become withdrawn. The information given does not support limiting activity. Increasing fluid intake will not reduce the fatigue. The information does not indicate that the client is immunosuppressed and should avoid contact with others.

 CN: Physiological adaptation;  
CL: Synthesize


**4. 1, 2, 3.** Using designated donors does not decrease the risk of contracting infectious diseases, such as the Epstein-Barr virus, HIV, or CMV. Hepatitis A is transmitted by the oral-fecal route, not the blood route; however, hepatitis B and C can be contracted from a designated donor. Malaria is transmitted by mosquitoes.

 CN: Safety and infection control;  
CL: Apply


**5. 4.** A routine serology study to confirm compatibility between a blood donor and recipient takes about 1 hour. In an emergency, O negative RBCs can be safely administered to most clients, which is why a person with O-negative blood is called a *universal donor*. The other types of RBCs may cause an adverse reaction.

 CN: Safety and infection control;  
CL: Apply

**6. 1.** One of the microcytic, hypochromic anemias is iron deficiency anemia. A rich source of iron is needed in the diet, and eggs are high in iron. Other foods high in iron include organ and muscle (dark) meats; shellfish, shrimp, and tuna; enriched, whole-grain, and fortified cereals and breads; legumes, nuts, dried fruits, and beans; oatmeal; and sweet potatoes. Dark green, leafy vegetables and citrus fruits are good sources of vitamin C. Cheese is a good source of calcium.


 CN: Reduction of risk potential;  
CL: Apply

**7. 3.** Good sources of vitamin B<sub>12</sub> include meats and dairy products. Whole grains are a good source of thiamine. Green, leafy vegetables are good sources of niacin, folate, and carotenoids (precursors of vitamin A). Broccoli and brussels sprouts are good sources of ascorbic acid (vitamin C).


 CN: Reduction of risk potential;  
CL: Apply

**8. 4.** The normal range of folic acid is 1.8 to 9 ng/mL, and the normal range of vitamin B<sub>12</sub> (cyanocobalamin) is 200 to 900 pg/mL. A low folic

acid level in the presence of a normal vitamin B<sub>12</sub> level is indicative of a primary folic acid deficiency anemia. Factors that affect the absorption of folic acid are drugs such as methotrexate, oral contraceptives, antiseizure drugs, and alcohol. The total bilirubin, serum creatinine, and hemoglobin values are within normal limits.

 CN: Physiological adaptation;  
CL: Analyze

**9. 2.** The defining characteristic of pernicious anemia, a megaloblastic anemia, is lack of the intrinsic factor which results from atrophy of the stomach wall. Without the intrinsic factor, vitamin B<sub>12</sub> cannot be absorbed in the small intestine and folic acid needs vitamin B<sub>12</sub> for deoxyribonucleic acid synthesis of RBCs. The gastric analysis is done to determine the primary cause of the anemia. An elevated excretion of the injected radioactive vitamin B<sub>12</sub>, which is protocol for the first and second stage of the Schilling test, indicates that the client has the intrinsic factor and can absorb vitamin B<sub>12</sub> in the intestinal tract. A sedimentation rate of 16 mm/hour is normal for both men and women and is a nonspecific test to detect the presence of inflammation; it is not specific to anemias. An RBC value within the normal range does not indicate an anemia.


 CN: Physiological adaptation;  
CL: Synthesize

**10. 2.** Clients with aplastic anemia are severely immunocompromised and at risk for infection and possible death related to bone marrow suppression and pancytopenia. Strict aseptic technique and reverse isolation are important measures to prevent infection. Although diet, reduced stress, and rest are valued in supporting health, the potentially fatal consequence of an acute infection places it as a priority for teaching the client about health maintenance. Animal meat and dark green leafy vegetables, good sources of vitamin B<sub>12</sub> and folic acid, should be included in the daily diet. Yoga and meditation are good complementary therapies to reduce stress. Eight hours of rest and naps are good for spacing and pacing activity and rest.


 CN: Reduction of risk potential;  
CL: Synthesize

**11. 4.** Vitamin B<sub>12</sub> combines with intrinsic factor in the stomach and is then carried to the ileum, where it is absorbed into the bloodstream. In this situation, vitamin B<sub>12</sub> cannot be absorbed regardless of the amount of oral intake of sources of vitamin B<sub>12</sub>, such as animal protein or vitamin B<sub>12</sub> tablets. Vitamin B<sub>12</sub> needs to be injected every month because the ileum has been surgically removed. Replacement of fluids and electrolytes is important when the client has continuous multiple loose

stools on a daily basis. Warm salt water is used to soothe sore mucous membranes. Crohn's disease and a small-bowel resection may cause several loose stools a day.

 CN: Physiological adaptation;  
CL: Analyze


**12. 3.** Coffee and tea increase gastrointestinal motility and inhibit the absorption of nonheme iron. Clients are instructed to add dried fruits to dishes at every meal because dried fruits are a nonheme or nonanimal iron source. Cooking in iron cookware, especially acid-based foods such as tomatoes, adds iron to the diet. Clients are instructed to add a rich supply of vitamin C to every meal because the absorption of iron is increased when food with vitamin C or ascorbic acid is consumed.

 CN: Reduction of risk potential;  
CL: Evaluate

**13. 1.** It is difficult to determine activity intolerance without objectively comparing activities from one time frame to another. Because iron deficiency anemia can occur gradually and individual endurance varies, the nurse can best assess the client's activity tolerance by asking the client to compare activities 6 months ago and at present. Asking a client how long a problem has existed is a very open-ended question that allows for too much subjectivity for any definition of the client's activity tolerance. Also, the client may not even identify that a "problem" exists. Asking the client whether he is staying abreast of usual activities addresses whether the tasks were completed, not the tolerance of the client while the tasks were being completed or the resulting condition of the client after the tasks were completed. Asking the client if he is more tired now than usual does not address his activity tolerance. Tiredness is a subjective evaluation and again can be distorted by factors such as the gradual onset of the anemia or the endurance of the individual.

 CN: Reduction of risk potential;  
CL: Analyze

**14. 4, 6.** A client with pernicious anemia has lost the ability to absorb vitamin B<sub>12</sub> either because of the lack of an acidic gastric environment or the lack of the intrinsic factor. Vitamin B<sub>12</sub> must be administered by a deep intramuscular route. The ventrogluteal and dorsogluteal locations are the most acceptable sites for a deep intramuscular injection. The other sites are not acceptable.

 CN: Pharmacological and parenteral therapies; CL: Apply

**15. 2.** To promote comfort when injecting at the ventrogluteal site, the position of choice is with the client lying on the abdomen with toes pointed inward. This positioning promotes muscle


relaxation, which decreases the discomfort of making an injection into a tense muscle. Lying on the side with legs extended will not provide the greatest muscle relaxation. Leaning over the edge of a table with the hips flexed and standing upright with the feet apart will increase muscular tension.

 CN: Physiological adaptation; CL: Apply

**16. 1, 2, 3, 4.** The nurse should ask the client about symptoms related to pernicious anemia because she had her stomach stapled 2 years ago and shows no history of supplemental vitamin B<sub>12</sub>. Numbness and tingling relate to a loss of intrinsic factor from the gastric stapling. Intrinsic factor is necessary for absorption of vitamin B<sub>12</sub>. The nurse should suspect pernicious anemia if the client is not taking supplemental vitamin B<sub>12</sub>. Other signs and symptoms of pernicious anemia include cognitive problems and depression. The nurse also should ask about the client's support at home in case the fall was not an accident. Pernicious anemia is not related to dietary intake of iron.

 CN: Reduction of risk potential;  
CL: Analyze

**17. 1.** The nurse should prepare to start an intake and output record because the client is exhibiting clinical manifestations of anemia with jaundice and is demonstrating a fluid imbalance. The client does not need to be on bed rest at this point. The client is not contagious and does not need to be placed in contact isolation. The changes in the color of the skin and urine are related to the jaundice and will not be affected by sunlight.


 CN: Physiological adaptation;  
CL: Synthesize

**18. 1.** Drug-induced hemolytic anemia is acquired, antibody-mediated, RBC destruction precipitated by medications, such as cephalosporins, sulfa drugs, rifampin, methyl dopa, procainamide, quinidine, and thiazides. Purpura is a condition with various manifestations characterized by hemorrhages into the skin, mucous membranes, internal organs, and other tissues. Infectious emboli are clumps of bacteria present in blood or lymph. Ecchymoses are skin discolorations due to extravasations of blood into the skin or mucous membranes.


 CN: Reduction of risk potential;  
CL: Analyze

**19. 2.** Urinary vitamin B<sub>12</sub> levels are measured after the ingestion of radioactive vitamin B<sub>12</sub>. A 24- to 48-hour urine specimen is collected after administration of an oral dose of radioactively tagged vitamin B<sub>12</sub> and an injection of nonradioactive vitamin B<sub>12</sub>. In a healthy state of absorption, excess vitamin B<sub>12</sub> is excreted in the urine; in a malabsorptive state


or when the intrinsic factor is missing, vitamin B<sub>12</sub> is excreted in the feces. Citrucel is a bulk-forming agent. Laxatives interfere with the absorption of vitamin B<sub>12</sub>. The client is NPO 8 to 12 hours before the test but is not NPO during the test. A stool collection is not a part of the Schilling test. If stool contaminates the urine collection, the results will be altered.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**20. 3.** This client has clinical manifestations of thalassemia major, a disease found in descendants from the Mediterranean Sea area whose mother and father both possess a gene for thalassemia (i.e., the client is homozygous for the gene). The severe hemolytic anemia causes sequestration of red blood cells in the spleen and liver which leads to engorgement of the organs and chronic bone marrow hyperplasia. Rest will decrease the demands on the heart due to the diminished hemoglobin level, a physiologic concern. The nurse should follow the time schedule of the area in which the client is now living. The nurse can help the client order preferred foods and listen to concerns, but the main priority is to decrease oxygen demands.

 CN: Physiological adaptation;  
CL: Synthesize


**21. 2.** Most clients with pernicious anemia have deficient production of intrinsic factor in the stomach. Intrinsic factor attaches to the vitamin in the stomach and forms a complex that allows the vitamin to be absorbed in the small intestine. The stomach is producing enough acid, there is not an excessive excretion of the vitamin, and there is not a rapid production of red blood cells in this condition.

 CN: Physiological adaptation;  
CL: Synthesize


**22. 2.** This client presented with the typical signs of glucose-6-phosphate dehydrogenase (G6PD)–deficiency anemia. Ten percent of African Americans inherit an X-linked recessive disorder of the G6PD enzyme in the red blood cell (RBC). When cells with decreased levels of G6PD are exposed to certain drugs, such as sulfonamides, acetylsalicylic acid, thiazide diuretics, and vitamin K, the RBC may hemolyze and anemia and jaundice may occur. The reaction is self-limited as soon as the causative agent is withheld. No further treatment is necessary except counseling to prevent acute incidence by avoiding exposure to specific drugs. There is no need for increased folic acid, restricted activity in hot weather, or blood transfusions.

 CN: Physiological adaptation;  
CL: Evaluate


**23. 2.** The normal physiologic response to activity is an increased metabolic rate over the resting basal rate. The decrease in respiratory rate indicates that the client is not strong enough to complete the mechanical cycle of respiration needed for gas exchange. The postactivity pulse is expected to increase immediately after activity but by no more than 50 bpm if it is strenuous activity. The diastolic blood pressure is expected to rise but by no more than 15 mm Hg. The pulse returns to within 6 bpm of the resting pulse after 3 minutes of rest.

 CN: Physiological adaptation;  
CL: Evaluate

**24. 3.** The nurse should continue to monitor the client because this value reflects a normal physiologic response. The physician does not need to be called, and oxygen does not need to be started based on these laboratory findings. Immediately after surgery, the client's hematocrit reflects a falsely high value related to the body's compensatory response to the stress of sudden loss of fluids and blood. Activation of the intrinsic pathway and the renin-angiotensin cycle via antidiuretic hormone produces vasoconstriction and retention of fluid for the first 1 to 2 days postoperatively. By the second to third day, this response decreases and the client's hematocrit level is more reflective of the amount of RBCs in the plasma. Fresh bleeding is a less likely occurrence on the third postoperative day but is not impossible; however, the nurse should have expected to see a decrease in the RBC count and hemoglobin value accompanying the hematocrit.

 CN: Physiological adaptation;  
CL: Synthesize

**25. 4.** The most likely time for a blood transfusion reaction to occur is during the first 15 minutes or first 50 mL of the infusion. If a blood transfusion reaction does occur, it is imperative to keep an established I.V. line so that medication can be administered to prevent or treat cardiovascular collapse in case of anaphylaxis. PRBCs should be administered through a 19-gauge or larger needle; a peripherally inserted central catheter line is not recommended, in order to avoid a slow flow. RBCs will hemolyze in dextrose or lactated Ringer's solution and should be infused with only normal saline solution.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**26. 1, 2, 4.** The nurse should teach the client to drink plenty of fluids when outside in hot weather to avoid becoming dehydrated. The client should avoid high altitudes, such as mountains, where the oxygen levels are low and may precipitate a sickle cell crisis. The nurse should alert young women

with sickle cell anemia that pregnancy increases the risk of a crisis. People who are homozygous for HbS have sickle cell anemia; the heterozygous form is the sickle cell carrier trait. A client with sickle cell anemia may fly on commercial airlines; the airplane is pressurized for an adequate oxygen level.

 CN: Health promotion and maintenance;  
CL: Synthesize

**27. 2.** The nurse should teach the client and family that individuals who are heterozygous for hemochromatosis rarely develop the disease. The nurse should teach that men and women are equally at risk for hemochromatosis, but men are diagnosed earlier because women do not usually have manifestations until menopause. Hemochromatosis is the most common genetic disorder in the United States. Individuals who are homozygous for hemochromatosis received a defective gene from each parent. Those with homozygous genes may develop the disease.

 CN: Health promotion and maintenance;  
CL: Synthesize

### 28.

3. Stop the transfusion.

4. Keep the I.V. open with normal saline infusion.

1. Notify the attending physician and blood bank.

2. Complete the appropriate Transfusion Reaction Form(s).

When the client is having a blood transfusion reaction, the nurse should first stop the transfusion and then keep the I.V. open with normal saline infusion. Next, the nurse should notify the physician and blood bank, then complete the required form(s) regarding the transfusion reaction.

 CN: Physiological adaptation;  
CL: Synthesize

**29. 2, 3, 5.** The American Association of Blood Banks recommends that two qualified people, such as two registered nurses or a physician and a registered nurse, compare the name and number on the identification bracelet with the tag on the blood bag. Verifying that the two units are the same is not a recommendation. Rather, the verification is always with the client, not with bags of blood. A unit of blood should infuse in 4 hours or less to avoid the risk of septicemia since no preservatives are used. When a blood transfusion reaction occurs, the blood transfusion should be stopped immediately, but the I.V. line should be kept open so that emergency medications and fluids can be administered.

The unit of PRBCs should be inspected for contamination by looking for leaks, abnormal color, clots, and excessive air bubbles. When a unit of PRBCs is being transfused, vital signs are assessed before the transfusion begins, after the first 15 minutes, and then every hour until 1 hour after the transfusion has been completed. When PRBCs are being administered, a 20-gauge or larger needle is needed to avoid destroying the RBCs passing through the lumen and to allow for maximal flow rate.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**30. 2.** ABO- and Rh-incompatible blood causes an antigen-antibody reaction that produces hemolysis or agglutination of red blood cells (RBCs). At the first indication of any sign/symptom of reaction, the blood transfusion is stopped. Blood and urine samples are obtained from the client and sent to the lab along with the remaining untransfused blood. Hemoglobin in the urine and blood samples taken at the time of the reaction provides evidence of a hemolytic blood transfusion reaction. Antihistamine, aspirin, diuretics, and vasopressors may be administered with different types of transfusion reactions.

 CN: Reduction of risk potential;  
CL: Synthesize

**31. 1.** Epoetin (Epoen) is a recombinant DNA form of erythropoietin, which stimulates the production of RBCs and therefore causes the hematocrit to rise. The elevation in hematocrit causes an elevation in the blood pressure; therefore, the blood pressure is a vital sign that should be checked. The partial thromboplastin time, hemoglobin level, and prothrombin time are not monitored for this drug.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**32. 4, 5, 6.** Erythropoietin is administered to decrease the need for blood transfusions by stimulating RBC production. The medication should be administered through the I.V. line without other medications to avoid a reaction. The hematocrit, a simple measurement of the percent of RBCs in the total blood volume, is used to monitor this therapy. When initiating I.V. erythropoietin therapy, the nurse should monitor the hematocrit level so that it rises no more than four points in any 2-week period. In addition, the initial doses of erythropoietin are adjusted according to the client's changes in blood pressure. The nurse should tell the client to avoid driving and performing hazardous activity during the initial treatment due to possible dizziness and headaches secondary to the adverse effect of hypertension. The hematocrit, not the hemoglobin level, is used for monitoring the effectiveness of therapy. The vial of erythropoietin should not be shaken




because it may be biologically inactive. The solution should not be used if it is discolored. The nurse should not reenter the vial once it has been entered; it is a one-time use vial. All remaining erythropoietin should be discarded since it does not contain preservatives.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**33. 4.** Vitamin B<sub>12</sub> is a water-soluble vitamin. When water-soluble vitamins are taken in excess of the body's needs, they are filtered through the kidneys and excreted. Vitamin B<sub>12</sub> is considered to be nontoxic. Adverse reactions that have occurred are believed to be related to impurities or to the preservative in B<sub>12</sub> preparations. Ringing in the ears, rash, and nausea are not considered to be related to vitamin B<sub>12</sub> administration.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**34. 2.** Brown rice is a source of iron from plant sources (nonheme iron). Other sources of nonheme iron are whole-grain cereals and breads, dark green vegetables, legumes, nuts, dried fruits (apricots, raisins, dates), oatmeal, and sweet potatoes. Egg yolks have iron but it is not as well absorbed as iron from other sources. Vegetables are a good source of vitamins that may facilitate iron absorption. Tea contains tannin, which combines with nonheme iron, preventing its absorption.

 CN: Physiological adaptation; CL: Apply


**35. 2.** Macrocytic anemias can result from deficiencies in vitamin B<sub>12</sub> or ascorbic acid. Only vitamin B<sub>12</sub> deficiency causes diminished sensations of peripheral nerve endings. The nurse should assess for peripheral neuropathy and instruct the client in self-care activities for her diminished sensation to heat and pain (e.g., using a heating pad at a lower heat setting, making frequent checks to protect against skin trauma). The burn could be related to abuse, but this conclusion would require more supporting data. The findings should be documented, but the nurse would want to address the client's sensations first. The decision of how to treat the burn should be determined by the physician.

 CN: Reduction of risk potential;  
CL: Synthesize


**36. 3.** Pruritus is a late symptom that results from abnormal histamine metabolism. Headache and dizziness are early symptoms from engorged veins. Shortness of breath is an early symptom from congested mucous membranes and ineffective gas exchange.

 CN: Physiological adaptation;  
CL: Analyze

**37. 2, 3, 4, 5.** Polycythemia vera, a condition in which too many RBCs are produced in the blood serum, can lead to an increase in the hematocrit and hypervolemia, hyperviscosity, and hypertension. Subsequently, the client can experience dizziness, tinnitus, visual disturbances, headaches, or a feeling of fullness in the head. The client may also experience cardiovascular symptoms such as heart failure (shortness of breath and orthopnea) and increased clotting time or symptoms of an increased uric acid level such as painful, swollen joints (usually the big toe). Hearing loss and weight loss are not manifestations associated with polycythemia vera.


 CN: Reduction of risk potential;  
CL: Create

**38. 1.** Aplastic anemia decreases the bone marrow production of RBCs, white blood cells, and platelets. The client is at risk for bruising and bleeding tendencies. A change in the client's intake and output is important, but assessment for the potential for bleeding takes priority. Change in the peripheral nervous system is a priority problem specific to clients with vitamin B<sub>12</sub> deficiency. Change in bowel function is not associated with aplastic anemia.

 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Platelet Disorders

**39. 3.** A dose of 0.5 mg of protamine sulfate reverses a 100-unit dose of heparin within 20 minutes. The nurse should administer protamine sulfate by I.V. push slowly to avoid adverse effects, such as hypotension, dyspnea, bradycardia, and anaphylaxis.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**40. 1, 3, 4, 5.** Older adults may have little subcutaneous tissue, so the area around the anterior iliac crest is a suitable site for these clients. The nurse should use a 27G, 5/8" needle. Cephalosporin and penicillin potentiate the effects of heparin. Two nurses should check the dose because a dose error could cause hemorrhage. The onset of heparin is not immediate when given subcutaneously.

 CN: Pharmacological and parenteral therapies; CL: Apply

**41. 1.** A client with a platelet count of 30,000 to 50,000/ $\mu$ L is susceptible to bruising with minor trauma. Padding areas that the client might bump, scratch, or hit may help prevent minor trauma. A platelet count of 15,000 to 30,000/ $\mu$ L may result in spontaneous petechiae and bruising, especially on the extremities. Safety measures to pad surfaces

would still be used, but the focus would be on assessing for new spontaneous petechiae. Keeping the room dark does not help the client with a low platelet count. When the count is lower than 20,000/ $\mu\text{L}$ , the client is at risk for spontaneous bleeding from the mucous membranes (oral, nasal, urinary, and rectal) and intracranial bleeding.

 CN: Reduction of risk potential;  
CL: Synthesize

**42. 4.** A recent viral infection in a female client between the ages of 20 and 30 with a history of systemic lupus erythematosus and an insidious onset of diffuse petechiae are hallmarks of idiopathic thrombocytopenic purpura. It is important to ask whether the client's recent menses have been lengthened or are heavier. Determining her ability to clot can help determine her risk of increased bleeding tendency until a platelet count is drawn. Petechiae are not caused by poor nutrition. Because of poor food and fluid intake or weakness and fatigue, the client may have gotten bruises from falling or bumping into things, but not petechiae.

 CN: Reduction of risk potential;  
CL: Analyze

**43. 2.** When the platelet count is very low, RBCs leak out of the blood vessels and into the tissue. If the blood pressure is elevated and the platelet count falls to less than 15,000/ $\mu\text{L}$ , internal bleeding in the brain can occur. A severe headache occurs from meningeal irritation when blood leaks out of the cerebral vasculature. When a client has thrombocytopenia, the nurse should always assess for cerebral bleeding by checking vital signs and performing neurologic checks. Headaches can be caused by stress, migraines, and sinus congestion. However, the concern here is the risk of internal bleeding into the brain.

 CN: Health promotion and maintenance;  
CL: Analyze

**44. 2.** Large, purplish skin lesions caused by hemorrhage are called ecchymoses. Small, flat, red pinpoint lesions are petechiae. Numerous petechiae result in a reddish, bruised appearance called purpura. An abrasion is a wound caused by scraping.

 CN: Health promotion and maintenance;  
CL: Evaluate


**45. 1.** Previously the cause was unknown, but recent research suggests that idiopathic thrombocytopenic purpura occurs when antibody-coated platelets are identified as foreign bodies and destroyed by macrophages in the spleen. It is not an idiosyncratic response and is not related to a depressed immune system.

 CN: Health promotion and maintenance;  
CL: Apply

**46. 2.** When the platelet count is less than 150,000/ $\mu\text{L}$ , prolonged bleeding can occur from trauma, injury, or straining such as with Valsalva's maneuver. Clients should avoid any activity that causes straining to evacuate the bowel. Clients can ambulate, but pointed or sharp surfaces should be padded. Clients can visit with their families but should avoid any scratches, bumps, or scrapes. Clients can sit in a semi-Fowler's position but should change positions to promote circulation and check for petechiae.

 CN: Health promotion and maintenance;  
CL: Synthesize


**47. 4.** Bufferin contains aspirin, which is an anti-coagulant; bleeding time can be prolonged. Intermittent use of ice packs to the site may stop the bleeding; ice causes blood vessels to vasoconstrict. Use of lukewarm water, patting the injury, and wrapping the entire forearm do not promote vasoconstriction to stop bleeding.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**48. 2.** The client who states that the test results are normal has only heard that the bone marrow is functioning. The etiology is in the destruction of circulating platelets. Further tests must be completed to determine the cause (e.g., a coating of the platelets with antibodies that are seen as foreign bodies). The bone marrow result does rule out other potential diagnoses such as anemia, leukemia, or myeloproliferative disorders that involve bone marrow depression. The client needs to stop flossing and throw away his hard toothbrush, which can lead to bleeding of the gums. The destruction of the circulating platelets accounts for the easy bruising and the need to protect oneself from further bruising. The client should not jump or increase exertion of joints, which may lead to bleeding in the joints and joint pain.

 CN: Reduction of risk potential;  
CL: Evaluate


**49. 1.** The nurse observes tachycardia in the hemorrhaging client because the heart beats faster to compensate for decreased circulating volume and decreased numbers of oxygen-carrying RBCs. The degree of cardiopulmonary distress and anemia will be related to the amount of hemorrhage that occurred and the period of time over which it occurred. Bradycardia is a late symptom of hemorrhage; it occurs after the client is no longer able to compensate and is debilitating further into shock. If bradycardia is left untreated, the client will die from cardiovascular collapse. Decreased  $\text{Paco}_2$  is a late symptom of hemorrhage, after transport of oxygen to the tissue has been affected. A narrowed pulse pressure is not an early sign of hemorrhage.

 CN: Physiological adaptation;  
CL: Analyze


**50. 4.** ITP is treated with steroids to suppress the splenic macrophages from phagocytizing the antibody-coated platelets, which are recognized as foreign bodies, so that the platelets live longer. The steroids also suppress the binding of the autoimmune antibody to the platelet surface. Steroids do not destroy the antibodies on the platelets, neutralize antigens, or increase phagocytosis.

 CN: Pharmacological and parenteral therapies; CL: Apply


**51. 3.** The client needs to wear or carry information containing the name of the drug, dosage, physician and contact information, and emergency instructions because additional corticosteroid drug therapy would be needed during emergency situations. Prednisone should be taken in the morning because it can cause insomnia and because exogenous corticosteroid suppression of the adrenal cortex is less when it is administered in the morning. Prednisone must never be stopped suddenly. It must be tapered off to allow for the adrenal cortex to recover from drug-induced atrophy so that it can resume its function. Prednisone suppresses the immune response and masks infections. It does not provide extra protection against infection.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**52. 1.** Nausea, vomiting, and peptic ulcers are gastrointestinal adverse effects of prednisone, so it is recommended that clients take the prednisone with food. In some instances, the client may be advised to take a prescribed antacid prophylactically. The client should never take over-the-counter drugs without notifying the physician who prescribed the prednisone. The client should ask the physician about the amount and kind of exercise because of the need to establish baseline physical values before starting an exercise program and because of the increased potential for comorbidity with increasing age. The client should eat foods that are high in potassium to prevent hypokalemia.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**53. 4.** The best exercise for females who are on long-term corticosteroid therapy is a low-impact, weight-bearing exercise such as walking or weight lifting. Floor exercises do not provide for the weight bearing. Stretching is appropriate but does not offer sufficient weight bearing. Running provides for weight bearing but is hard on the joints and may cause bleeding.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**54. 2.** The client needs further teaching if she thinks that the number of tissues saturated represents all of the blood lost during a nosebleed. During a nosebleed, a significant amount of blood can be swallowed and go undetected. It is important that clients with severe thrombocytopenia do not take a nosebleed lightly. Clients with thrombocytopenia can apply pressure for 5 to 10 minutes over a small, superficial cut. Clients with thrombocytopenia can take hormones to suppress menses and control menstrual blood loss. Clients can also count the number of saturated sanitary napkins to approximate blood loss during menses. Some authorities estimate that a completely soaked sanitary napkin holds 50 mL.

 CN: Reduction of risk potential; CL: Evaluate


**55. 2, 4, 5, 6.** Adverse effects of prednisone are weight gain, retention of sodium and fluids with hypertension and cushingoid features, a low serum albumin level, suppressed inflammatory processes with masked symptoms, and osteoporosis. A diet high in protein, potassium, calcium, and vitamin D is recommended. Carbohydrate would elevate glucose and further compromise a client's immune status. Trans fat does not counteract the adverse effects of steroids such as prednisone.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**56. 1.** Platelets cannot survive cold temperatures. The platelets should be stored at room temperature and last for no more than 5 days.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**57. 3.** The bag containing platelets needs to be gently rotated to prevent clumping. ABO compatibility is not a necessary requirement, but human leukocyte antigen (HLA) matching of lymphocytes may be completed to avoid development of anti-HLA antibodies when multiple platelet transfusions are necessary. Platelets should be administered as fast as can be tolerated by the client to avoid aggregation. Most institutions use tubing especially for platelets instead of tubing for blood and blood products.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**58. 4.** The correct technique for deep breathing postoperatively to avoid atelectasis and pneumonia is to take in a deep breath through the nose, hold it for 5 seconds, then blow it out through pursed lips. The goal is to fully expand and empty the lungs for pulmonary hygiene.

 CN: Reduction of risk potential; CL: Evaluate


**59. 3.** An elective surgical procedure is scheduled in advance so that all preparations can be completed ahead of time. The vital signs are the final check that must be completed before the client leaves the room so that continuity of care and assessment is provided for. The first assessment that will be completed in the preoperative holding area or operating room will be the client's vital signs. The client should have emptied the bladder before receiving preoperative medications so that the bladder is empty when it is time for transport into the operating room. The client should have signed the consent before the transport time so that if there were any questions or concerns there was time to meet with the surgeon. Also, the consent form must be signed before any sedative medications are given. The client's name band should be placed as soon as the client arrives in the perioperative setting, and it remains in place through discharge.

 CN: Physiological adaptation;  
CL: Analyze

**60. 3.** After a splenectomy, the client is at high risk for hypovolemia and hemorrhage. The dressing should be checked often; if drainage is present, a circle should be drawn around the drainage and the time noted to help determine how fast bleeding is occurring. The nasogastric tube should be connected, but this can wait until the dressing has been checked. A urinary catheter is not needed. The last pain medication administration and the client's current pain level should be communicated in the exchange report. Checking for hemorrhage is a greater priority than assessing pain level.

 CN: Physiological adaptation;  
CL: Analyze


**61. 3.** A splenectomy may involve manipulation of the upper abdominal organs, such as diaphragm, stomach, liver, spleen, and small intestines. Manipulation of these organs and resulting inflammation lead to a slowed peristalsis. An NG tube is placed to decrease abdominal distention in the immediate postoperative phase. The stomach does not need to be manipulated away from the spleen postoperatively, nor would an NG tube accomplish this. The NG tube drains gastric contents and air in the stomach; it is not in the operative site, and therefore cannot be used to irrigate it. The gastric juices are not checked as an indicator that peristalsis has returned; instead, bowel sounds are auscultated in all four quadrants to indicate the return of peristalsis.

 CN: Physiological adaptation;  
CL: Apply


**62. 4.** Clients who have had a splenectomy are especially prone to infection. The reduction of immunoglobulin M leaves the client especially at risk for immunologic deficiency infections. All clients who have had major abdominal surgery usually receive discharge instructions not to drive because the stomach muscles are not strong enough to brake hard or quickly after the abdominal muscles have been separated. All clients need to pace activity and rest when going home after major surgery. Rest and sleep allow the growth hormone to repair the tissue, and activity allows the energy and strength to build endurance and muscle strength. An appointment is usually made to see the surgeon in the office 1 week after discharge for follow-up and to remove sutures or staples if this has not already been done.

 CN: Reduction of risk potential;  
CL: Synthesize


**63. 2.** There is no well-defined sequence for acute DIC other than that the client starts bleeding without a history or cause and does not stop bleeding. Later signs may include severe shortness of breath, hypotension, pallor, petechiae, hematoma, orthopnea, hematuria, vision changes, and joint pain.

 CN: Physiological adaptation;  
CL: Analyze


**64. 3.** DIC has not been found to respond to oral anticoagulants such as warfarin sodium (Coumadin). Treatments for DIC are controversial but include treating the underlying cause, administering heparin, and replacing depleted blood products.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**65. 2.** Clinical manifestations of microvascular thrombosis are those that represent a blockage of blood flow and oxygenation to the tissue that results in eventual death of the organ. Examples of microvascular thrombosis include acute respiratory distress syndrome, focal ischemia, superficial gangrene, oliguria, azotemia, cortical necrosis, acute ulceration, delirium, and coma. Hemoptysis, petechiae, and hematuria are signs of hemorrhage.

 CN: Physiological adaptation;  
CL: Analyze

**66. 3.** As blood collects in the peritoneal cavity, it causes dilation and distention, which is reflected in increased abdominal girth. The client would be tachycardic and hypotensive. Petechiae reflect bleeding in the skin.

 CN: Physiological adaptation;  
CL: Analyze

## The Client with White Blood Cell Disorders


**67. 1, 2, 3, 5.** The nurse should teach this client to stay on bed rest if she has a fever, gargle with warm saline, and increase her oral fluids to prevent dehydration from the elevated temperature. The client with an enlarged spleen should avoid contact sports due to the increased risk of injury due to the enlargement. The nurse should tell the client to avoid aspirin if she has a fever because of the risk of Reye's syndrome. Instead, nonsteroidal anti-inflammatory drugs should be used to treat fever and myalgia.

 CN: Basic care and comfort; CL: Create


**68. 4.** The client will need an order to be placed in reverse (protective) isolation because his normal defenses are ineffective and place him at risk for infection (leukopenia, less than 5,000 cells/ $\mu$ L). The faster the decrease in WBCs, the greater the bone marrow suppression, and the more susceptible the client is to infection from not only pathogenic but nonpathogenic organisms. The client will continue to be monitored, the laboratory may be called, and the report will be placed on the chart, but protection of the client must be instituted immediately.

 CN: Physiological adaptation;  
CL: Synthesize


**69. 3.** A shift to the left means that more immature than mature WBCs are at the site of inflammation or infection. Immature WBCs are less effective at phagocytosis and do not produce classic signs of inflammation, such as pus, redness, swelling, or heat. Fever is the only sign; therefore, it is a significant sign of infection in a client with immature or depressed WBCs.

 CN: Physiological adaptation;  
CL: Analyze


**70. 1, 2, 3, 4.** Nursing care of a client with leukemia includes managing and preventing infection, maintaining integrity of skin and mucous membranes, instituting measures to prevent bleeding, and monitoring for bleeding. Aspirin is an anticoagulant; bleeding tendencies, such as petechiae, ecchymosis, epistaxis, gingival bleeding, and retinal hemorrhages are likely due to thrombocytopenia.

 CN: Reduction of risk potential;  
CL: Create


**71. 2.** A client is at moderate risk when the ANC is less than 1,000. The ANC decreases proportionately to the increased risk for infection. The client is at normal risk for infection if the ANC is 1,500 or greater. The client is at high risk for infection if the ANC is less than 500. An ANC of 100 or less is life-threatening.

 CN: Physiological adaptation;  
CL: Analyze


**72. 1.** The one factor that may be more important than the degree of neutropenia in determining the risk for infection is the duration of the neutropenia.

 CN: Physiological adaptation;  
CL: Analyze


**73. 1.** Bedside rails, call bells, drug-administration controls operated by the client, and other surface areas are frequently touched by caregivers with used gloves. Changing gloves immediately after use protects the client from contamination by organisms. Cross-contamination is a break in technique of serious consequence to the severely compromised client. Standing 2 feet from the client, speaking minimally, and wearing long-sleeved shirts are not required in standard interventions for risk of infection.

 CN: Safety and infection control;  
CL: Synthesize

**74. 1.** The neutropenic client is at risk for infection, especially bacterial infection of the respiratory and gastrointestinal tracts. Breaks in the mucous membranes, such as those that could be caused by the insertion of a suppository or enema tube, would be a break in the first line of the body's defense and a direct port of entry for infection. The client with neutropenia is encouraged to wear a HEPA filter mask and to use an incentive spirometer for pulmonary hygiene. The client needs to know the importance of completing meticulous total body hygiene daily, including perianal care after every bowel movement, to decrease the flora at normal body orifices. The client also needs to know the importance of performing oral care after every meal and every 4 hours while the client is awake to decrease the bacterial buildup in the oropharynx.

 CN: Health promotion and maintenance;  
CL: Synthesize

**75. 2.** The Centers for Disease Control and Prevention advises that washing hands before, during, and after care has a significant effect in reducing infections. It is advisable to avoid introducing a cold or children's germs and to avoid kissing on the lips, but the primary prevention technique is hand washing.

 CN: Health promotion and maintenance;  
CL: Synthesize

**76. 4.** The most common source of infection and microbial colonization in neutropenic clients is their own nonpathogenic normal flora. Attention to personal hygiene, such as oral, pulmonary, urinary, and rectal care, is essential. It is important to acknowledge the client's concerns and fears and to provide organized, nonhurried, caring care, but it is more important to teach the client how to prevent an infection that could be life-threatening.

 CN: Health promotion and maintenance;  
CL: Synthesize


**77. 1, 2, 4, 5.** The nurse can serve as a witness for consent for procedures. The nurse also ascertains whether the client has an understanding that is consistent with the procedure listed on the form, determines that the client is signing the consent of his own free will, and determines that the client understands postprocedure care. The nurse's role does not include explaining the risks of the procedure. That responsibility belongs to the person who is to perform the procedure, such as the physician.

 CN: Management of care; CL: Synthesize


**78. 3.** As the bone marrow is being aspirated, the client will feel a suction or pulling type of sensation or discomfort that lasts a few seconds. A systemic premedication may be given to decrease this discomfort. A small area over the sternum is cleaned with an antiseptic. It is unnecessary to paint the entire anterior chest. The local anesthetic is injected through the subcutaneous tissue to numb the tissue for the larger-bore needle that is used for aspiration and biopsy. After the needle is removed, pressure is held over the aspiration site for 5 to 10 minutes to achieve hemostasis. A small dressing is applied; a large pressure dressing, such as an Ace bandage, would restrict the expansion of the lungs and is not used.

 CN: Psychosocial adaptation; CL: Apply

**79. 4.** After a bone marrow aspiration, the puncture site should be checked every 10 to 15 minutes for bleeding. For a short period after the procedure, bed rest may be ordered. Signs of infection, such as redness and swelling, are not anticipated at the aspiration site. A mild analgesic may be ordered. If the client continues to need the morphine for longer than 24 hours, the nurse should suspect that internal bleeding or increased pressure at the puncture site may be the cause of the pain and should consult the physician.

 CN: Physiological adaptation;  
CL: Evaluate


**80. 2.** The nurse is an advocate for the client with leukemia who can be empowered with knowledge of the treatment. Immunologic, cytogenetic, morphologic, histochemical, and other means are used to identify cell subtypes and stages of leukemia cell development for very specific and optimal treatment. The nurse should not label the client's feeling, such as frustration or emotional; only the client can identify her own feelings. Chastising the client is not helpful. It disavows the client's emotional state and responses to her diagnosis and involved treatment. Unless nurses have had leukemia, they cannot possibly know how the client feels even though they may be trying to offer her empathy.

 CN: Psychosocial adaptation;  
CL: Synthesize


**81. 3.** The induction phase of chemotherapy is an aggressive treatment to kill leukemia cells. The client is severely immunocompromised and severely at risk for infection. Flowers, herbs, and plants should be avoided during this time. The client's Bible, pictures, and other personal belongings can be cleaned before being brought into the room to prevent client contact with pathogenic and non-pathogenic organisms.

 CN: Safety and infection control;  
CL: Synthesize

**82. 2.** The nurse identifies that the client does not understand that contact with animals must be avoided because they carry infection and the induction therapy will destroy the client's WBCs. The induction therapy will cause anemia, and the client will experience fatigue and will have to pace activities with rest periods. Platelet production will be decreased, and the client will be at risk for bleeding tendencies; oral hygiene will have to be provided by using a warm saline gargle instead of brushing the teeth and gums. The client will be at risk for infection owing to the decrease in WBC production and should report a temperature of 100° F (37.8° C) or higher.

 CN: Safety and infection control;  
CL: Evaluate

**83. 4.** The statement, "Your doctor stated your prognosis based on the differentiation of your cells" addresses the client's situation on an individual basis. The nurse is clarifying that clients have different prognoses—even though they may have the same type of leukemia—because of the cell differentiation. Stating that the client misunderstood is inappropriate for an advocate of the client and serves no useful purpose. The other statements are true but do not address this client's individual concern.

 CN: Psychosocial adaptation;  
CL: Synthesize


**84. 4.** Bleeding and infection are the major complications and causes of death for clients with AML. Bleeding is related to the degree of thrombocytopenia, and infection is related to the degree of neutropenia. Cardiac arrhythmias rarely occur as a result of AML. Liver or renal failure may occur, but neither is a major cause of death in AML.

 CN: Reduction of risk potential;  
CL: Synthesize


**85. 4.** Although the clinical manifestations of CML vary, clients usually have confusion and shortness of breath related to decreased capillary perfusion to the brain and lungs. Lymphadenopathy is rare in CML. Hyperplasia of the gum and bone pain are clinical manifestations of AML.

 CN: Reduction of risk potential;  
CL: Analyze


**86. 1.** The peak incidence of ALL is at 4 years of age. ALL is uncommon after 15 years of age. The median age at incidence of CML is 40 to 50 years. The peak incidence of AML occurs at 60 years of age. Two-thirds of cases of chronic lymphocytic leukemia occur in clients older than 60 years of age.

 CN: Physiological adaptation;  
CL: Analyze

**87. 1.** Clients with ALL are at risk for infection due to granulocytopenia. The nurse should place the client in a private room. Strict hand-washing procedures should be enforced and will be the most effective way to prevent infection. It is not necessary to have the client wear a mask. The client is not contagious and the staff does not need to wear gloves. The client can have visitors; however, they should be screened for infection and use hand-washing procedures.

 CN: Physiological adaptation;  
CL: Synthesize


**88. 4.** Clients with CLL develop unintentional weight loss; fever and drenching night sweats; enlarged, painful lymph nodes, spleen, and liver; decreased reaction to skin sensitivity tests (anergy); and susceptibility to viral infections. Enlarged, painless lymph nodes are a clinical manifestation of Hodgkin's lymphoma. A headache would not be one of the early signs and symptoms expected in CLL because CLL does not cross the blood-brain barrier and would not irritate the meninges. Hyperplasia of the gums is a clinical manifestation of AML.

 CN: Physiological adaptation;  
CL: Analyze


**89. 3.** Simple rinses with saline or baking soda solution are effective and moisten the oral mucosa. Commercial mouthwashes and lemon-glycerin swabs contain glycerin and alcohol, which are drying to the mucosa and should be avoided. Brushing after each meal is recommended, but every 4 hours may be too traumatic. During acute leukemia, the neutrophil and platelet counts are often low and a soft-bristle toothbrush, instead of the client's usual brush, should be used to prevent bleeding gums.

 CN: Reduction of risk potential;  
CL: Synthesize


**90. 3.** The client with acute leukemia experiences fatigue and deconditioning. Lying in bed and taking deep breaths will not help achieve the goals. The client must get out of bed to increase activity tolerance and improve tidal volume. Ambulating in the hall (using a HEPA filter mask if neutropenic) is a sensible activity and helps improve conditioning. Sitting up in a chair facilitates lung expansion. Using a stationary bicycle in the room allows the client to increase activity as tolerated.

 CN: Reduction of risk potential;  
CL: Synthesize

**91. 2.** Combination chemotherapy does not mean two groups of drugs, one to kill the cancer cells and one to treat the adverse effects of the chemotherapy. Combination chemotherapy means that multiple drugs are given to interrupt the cell growth cycle at different points, to decrease resistance to a chemotherapy agent, and to minimize the toxicity associated with use of a high dose of a single agent (i.e., by using multiple agents with different toxicities).

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**92. 1.** The biliary system is not especially prone to hemorrhage. Thrombocytopenia (a low platelet count) leaves the client at risk for a potentially life-threatening spontaneous hemorrhage in the gastrointestinal, respiratory, and intracranial cavities.


 CN: Physiological adaptation;  
CL: Analyze

**93. 1.** The primary purpose of reverse isolation is to reduce transmission of organisms to the client from sources outside the client's environment.

 CN: Safety and infection control;  
CL: Apply

## The Client with Lymphoma

**94. 2.** Painless and enlarged cervical lymph nodes, tachycardia, weight loss, weakness and fatigue, and night sweats are signs of Hodgkin's disease. Difficulty swallowing and breathing may occur, but only with mediastinal node involvement. Hepatomegaly is a late-stage manifestation.


 CN: Physiological adaptation;  
CL: Analyze

**95. 1.** The nurse must ensure that sterile technique is used when a biopsy is obtained. In most cases, a lymph node biopsy is sent immediately to the laboratory once it is placed in a specific solution in a closed container. It is not necessary to wear a gown and mask when obtaining the specimen. The nurse can assist with the procedure because the client may be at increased risk for infection.

 CN: Management of care; CL: Apply

**96. 3.** Assessing for an open airway is always first. The procedure involves the neck; the anesthesia may have affected the swallowing reflex, or the inflammation may have closed in on the airway, leading to ineffective air exchange. Once a patent airway is confirmed and an effective breathing pattern established, the circulation is checked. Vital signs and the incision are assessed


as soon as possible, but only after it is established that the airway is patent and the client is breathing normally. A neurologic assessment is completed as soon as possible after other important assessments.

 CN: Physiological adaptation;  
CL: Synthesize


**97. 3.** A definitive diagnosis of Hodgkin's disease is made if Reed-Sternberg cells are found in the histologic examination of the excisional lymph node biopsy. Tay-Sachs disease is an inherited disease carried by an autosomal recessive gene. Sarcoidosis is an inflammatory granulomatous disease. Duchenne's disease is a type of muscular disorder.

 CN: Physiological adaptation; CL: Apply

**98. 1.** Herpes zoster infections are common in clients with Hodgkin's disease. Discoloring of the teeth is not related to Hodgkin's disease but rather to the ingestion of iron supplements or some antibiotics such as tetracycline. Mild anemia is common in Hodgkin's disease, but the platelet count is not affected until the tumor has invaded the bone marrow. A cellular immunity defect occurs in Hodgkin's disease in which there is little or no reaction to skin sensitivity tests. This is called anergy.

 CN: Physiological adaptation;  
CL: Analyze

**99. 3.** A temperature higher than 100.4° F (38° C), profuse night sweats, and an unintentional weight loss of 10% of body weight represent the cluster of clinical manifestations known as the B symptoms. Forty percent of clients with Hodgkin's disease have B symptoms, and B symptoms are more common in advanced stages of the disease.

 CN: Physiological adaptation;  
CL: Analyze

**100. 1.** Analgesics are used as needed to relieve painful encroachment of enlarged lymph nodes. Perfumed shower gel will increase pruritus. Wearing a mask does not protect the client from infection if pathogens are not spread by airborne droplets. Antipyretics should be used to treat fever symptomatically after infection is ruled out.


 CN: Health promotion and maintenance;  
CL: Create

**101. 1.** In the staging process, the designations A and B signify, respectively, that symptoms were or were not present when Hodgkin's disease was found. The Roman numerals I through IV indicate the extent and location of involvement of the disease. Stage I indicates involvement of a single lymph node; stage II, two or more lymph nodes on the same side of the diaphragm; stage III, lymph


node regions on both sides of the diaphragm; and stage IV, diffuse disease of one or more extralymphatic organs.

 CN: Physiological adaptation; CL: Apply


**102. 3.** Encouraging the client to take slow, deep breaths during uncomfortable parts of procedures is the best method of decreasing the stress response of tightening and tensing the muscles. Slow, deep breathing affects the level of carbon dioxide in the brain to increase the client's sense of well-being. Allowing the client's family to stay with her may be appropriate if the family has a calming effect on the client. Silence can be therapeutic, but when the client is faced with a potentially life-threatening diagnosis and a new, invasive procedure, she really needs words in addition to touch unless another health care provider is talking to her. Expressing feelings is important, but the client will have to hold still for the procedure.

 CN: Psychosocial adaptation;  
CL: Synthesize

**103. 2.** A biopsy needle is inserted through a separate incision in the anesthetized area. The client will feel a pressure sensation when the biopsy is taken but should not feel actual pain. The client should be instructed to inform the physician if pain is felt so that more anesthetic agent can be administered to keep the client comfortable. The biopsy is performed after the aspiration and from a slightly different site so that the tissue is not disturbed by either test. The client will feel a suction-type pain for a moment when the aspiration is being performed, not the biopsy. A small incision is made for the biopsy to accommodate the larger-bore needle. This may require a stitch.

 CN: Psychosocial adaptation;  
CL: Synthesize


**104. 3.** Terminally ill clients most often describe feelings of isolation because they tend to be ignored; they are often left out of conversations (especially those dealing with the future); and they sense the attitudes of discomfort that many people feel in their presence. Helpful nursing measures include taking the time to be with the client; offering opportunities to talk about feelings; and answering questions honestly.

 CN: Psychosocial adaptation;  
CL: Synthesize

**105. 2.** It is incorrect that the survivor rate is directly proportional to the incidence of second malignancy. The survivor rate is indirectly proportional to the incidence of second malignancy, and regular screening is very important to detect a second malignancy, especially acute myeloid leukemia or myelodysplastic syndrome. Survivors should




know the stage of the disease and their current treatment plan so that they can remain active participants in their health care.


 CN: Physiological adaptation;  
CL: Evaluate

### The Client Who Is in Shock


**106. 3.** Nursing interventions and collaborative management are focused on correcting and maintaining adequate tissue perfusion. Inadequate tissue perfusion may be caused by hemorrhage, as in hypovolemic shock; by decreased cardiac output, as in cardiogenic shock; or by massive vasodilation of the vascular bed, as in neurogenic, anaphylactic, and septic shock. Fluid deficit, not fluid overload, occurs in shock.

 CN: Physiological adaptation;  
CL: Synthesize

**107. 4.** Typical signs and symptoms of hypovolemic shock include systolic blood pressure less than 90 mm Hg, narrowing pulse pressure, tachycardia, tachypnea, cool and clammy skin, decreased urine output, and mental status changes, such as irritability or anxiety. Unequal dilation of the pupils is related to central nervous system injury or possibly to a previous history of eye injury.

 CN: Physiological adaptation;  
CL: Analyze


**108. 1.** Urine output provides the most sensitive indication of the client's response to therapy for hypovolemic shock. Urine output should be consistently greater than 35 mL/hour. Blood pressure is a more accurate reflection of the adequacy of vasoconstriction than of tissue perfusion. Respiratory rate is not a sensitive indicator of fluid balance in the client recovering from hypovolemic shock.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**109. 1.** Causes of hypovolemic shock include external fluid loss, such as hemorrhage; internal fluid shifting, such as ascites and severe edema; and dehydration. Massive vasodilation is the initial phase of vasogenic or distributive shock, which can be further subdivided into three types of shock: septic, neurogenic, and anaphylactic. A severe antigen-antibody reaction occurs in anaphylactic shock. Gram-negative bacterial infection is the most common cause of septic shock. Loss of sympathetic tone (vasodilation) occurs in neurogenic shock.

 CN: Physiological adaptation;  
CL: Analyze


**110. 2.** The client who is receiving a blood product requires astute assessment for signs and symptoms of allergic reaction and anaphylaxis, including pruritus (itching), urticaria (hives), facial or glottal edema, and shortness of breath. If such a reaction occurs, the nurse should stop the transfusion immediately, but leave the I.V. line intact, and notify the physician. Usually, an antihistamine such as diphenhydramine hydrochloride (Benadryl) is administered. Epinephrine and corticosteroids may be administered in severe reactions. Fluid balance is not an immediate concern during the blood administration. The administration should not cause pain unless it is extravasating out of the vein, in which case the I.V. administration should be stopped. Administration of a unit of blood should not affect the level of consciousness.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**111. 2.** At medium doses (4 to 8  $\mu\text{g}/\text{kg}/\text{minute}$ ), dopamine hydrochloride slightly increases the heart rate and improves contractility to increase cardiac output and improve tissue perfusion. When given at low doses (0.5 to 3.0  $\mu\text{g}/\text{kg}/\text{minute}$ ), dopamine increases renal and mesenteric blood flow. At high doses (8 to 10  $\mu\text{g}/\text{kg}/\text{minute}$ ), dopamine produces vasoconstriction, which is an undesirable effect. Dopamine is not given to affect preload and afterload.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**112. 2.** The client who is receiving dopamine hydrochloride requires continuous blood pressure monitoring with an invasive or noninvasive device. The nurse may titrate the I.V. infusion to maintain a systolic blood pressure of 90 mm Hg. Administration of a pain medication concurrently with dopamine hydrochloride, which is a potent sympathomimetic with dose-related alpha-adrenergic agonist, beta 1-selective adrenergic agonist, and dopaminergic blocking effects, is not an essential nursing action for a client who is in shock with already low hemodynamic values. Arterial blood gas concentrations should be monitored according to the client's respiratory status and acid-base balance status and are not directly related to the dopamine hydrochloride dosage. Monitoring for signs of infection is not related to the nursing action for the client receiving dopamine hydrochloride.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**113. 1, 3, 4.** Analysis of the client's laboratory results would indicate that an INR of 8 is increased beyond therapeutic ranges. The client is also experiencing severe acute rectal bleeding and has a


hemoglobin level in the low range of normal and a hematocrit reflecting fluid volume loss. Getting the I.V. line started is crucial so that this client can receive FFP immediately. FFP contains concentrated clotting factors and provides an immediate reversal of the prolonged INR. Vitamin K 2.5 mg P.O. should be given next because it reverses the warfarin by returning the PT to normal values. However, the reversal process occurs over 1 to 2 hours. The other orders should be completed after these initial orders are in progress.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**114. 2.** Nursing interventions to provide warmth and rest and minimize anxiety decrease the body's need for oxygen and nutrients. This is important for a client who has lost 500 mL or a unit of blood in a short period from a gastric hemorrhage. If the client has been stabilized, the fluid and electrolyte balance has already been established for the present. The comfort of the client and family is always important and is actually accomplished while the client's oxygen consumption is being minimized, which is a priority and the primary rationale. These nursing interventions are not specific to the prevention of infection.

 CN: Physiological adaptation; CL: Apply


**115. 2.** Warm, flushed skin from a high cardiac output with vasodilation occurs in warm shock or the hyperdynamic phase (first phase) of septic shock. Other signs and symptoms of early septic shock include fever with restlessness and confusion; decreased blood pressure with tachypnea and tachycardia; increased or normal urine output; and nausea and vomiting or diarrhea. Cool, clammy skin occurs in the hypodynamic or cold phase (later phase). Hemorrhage is not a factor in septic shock.

 CN: Physiological adaptation; CL: Analyze


**116. 1.** The nurse monitors the blood levels of antibiotics, white blood cells, serum creatinine, and blood urea nitrogen because of the decreased perfusion to the kidneys, which are responsible for filtering out the Rocephin. It is possible that the clearance of the antibiotic has been decreased enough to cause toxicity. Increased levels of these laboratory values should be reported to the physician immediately. A spinal fluid analysis is done to examine cerebral spinal fluid, but there is no indication of central nervous system involvement in this case. Arterial blood gases are used to determine actual blood gas levels and assess acid-base balance. Serum osmolality is used to monitor fluid and electrolyte balance.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**117. 4.** Maintaining asepsis of indwelling urinary catheters is essential to prevent infection. Preventing septic shock is a major focus of nursing care because the mortality rate for septic shock is as high as 90% in some populations. Very young and elderly clients (those younger than age 2 or older than age 65) are at increased risk for septic shock. Administering I.V. fluid replacement therapy, obtaining vital signs every 4 hours on all clients, and monitoring red blood cell counts for elevation do not pertain to septic shock prevention.


 CN: Safety and infection control; CL: Synthesize

**118. 2.** ARDS is a complication associated with septic shock. ARDS causes respiratory failure and may lead to death, even after the client has recovered from shock. Anaphylaxis is a type of distributive or vasogenic shock. COPD is a functional category of pulmonary disease that consists of persistent obstruction of bronchial airflow and involves chronic bronchitis and chronic emphysema. Mitral valve prolapse is a condition in which the mitral valve is pushed back too far during ventricular contraction.

 CN: Physiological adaptation; CL: Analyze

### Managing Care Quality and Safety


**119. 3.** When two clients are to receive blood at the same time, the nurse should call and hang the clients' transfusions separately to avoid error. The nurse should call for and hang the first client's blood first because this client has experienced a change in blood pressure over a short period of time. The nurse should next call and hang the second client's blood transfusion as there is no indication that this client is unstable at this time. The nurse should not call for both units of transfusions at the same time due to the increased risk of misidentification. The nurse should not verify compatibility of both units at the same time due to the increased risk of misidentification. It is not necessary to involve two nurses because the second client can wait until the nurse has time to hang the blood.

 CN: Management of care; CL: Synthesize


**120. 1, 2, 3, 4.** If a blood transfusion is terminated, the nurse must send a freshly-collected blood sample to the blood bank and a urine sample to the laboratory; the nurse must send the blood component unit with the attached administration set and completed Transfusion Reaction Form to the blood bank. It is not necessary to inform Infection Control, but the Risk Management Department should be notified, since a transfusion reaction may be a significant liability issue.

 CN: Reduction of risk potential; CL: Synthesize

**121. 3.** The most current pharmacology information is found on electronic sources that are frequently updated and can be transmitted to a handheld digital assistant or by logging into the hospital's intranet, if available. The PDR and pharmacology textbooks are outdated once published and, therefore, may not have current information. The manufacturer's website has the potential for bias.

 CN: Safety and infection control;  
CL: Apply

**122. 1, 2, 3.** A National Patient Safety Goal of The Joint Commission is to improve the effectiveness of communication among caregivers. Abbreviations can be misinterpreted and all health care professionals should avoid the use of easily misunderstood abbreviations. The purpose of avoiding abbreviations is not to make it easier for clients to understand the medication orders or to make data entry easier.

 CN: Safety and infection control;  
CL: Synthesize

TEST  
4

## The Client with Respiratory Health Problems

- The Client with an Upper Respiratory Tract Infection
- The Client Undergoing Nasal Surgery
- The Client with Cancer of the Larynx
- The Client with Pneumonia
- The Client with Tuberculosis
- The Client with Chronic Obstructive Pulmonary Disease
- The Client with Asthma
- The Client with Lung Cancer
- The Client with Chest Trauma
- The Client with Acute Respiratory Distress Syndrome
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with an Upper Respiratory Tract Infection

1. A nurse is completing the health history for a client who has been taking echinacea for a head cold. The client asks, “Why isn’t this helping me feel better?” Which of the following responses by the nurse would be the **most** accurate?

- 1. “There is limited information as to the effectiveness of herbal products.”
- 2. “Antibiotics are the agents needed to treat a head cold.”
- 3. “The head cold should be gone within the month.”
- 4. “Combining herbal products with prescription antiviral medications is sure to help you.”

2. A nurse is teaching a client about taking antihistamines. Which of the following instructions should the nurse include in the teaching plan? Select all that apply.

- 1. Operating machinery and driving may be dangerous while taking antihistamines.
- 2. Continue taking antihistamines even if nasal infection develops.
- 3. The effect of antihistamines is not felt until a day later.
- 4. Do not use alcohol with antihistamines.
- 5. Increase fluid intake to 2,000 mL/day.

3. A client with allergic rhinitis is instructed on the correct technique for using an intranasal inhaler. Which of the following statements would demonstrate to the nurse that the client understands the instructions?

- 1. “I should limit the use of the inhaler to early morning and bedtime use.”
- 2. “It is important to not shake the canister because that can damage the spray device.”
- 3. “I should hold one nostril closed while I insert the spray into the other nostril.”
- 4. “The inhaler tip is inserted into the nostril and pointed toward the inside nostril wall.”

4. Which of the following would be an expected outcome for a client recovering from an upper respiratory tract infection? The client will:

- 1. Maintain a fluid intake of 800 mL every 24 hours.
- 2. Experience chills only once a day.
- 3. Cough productively without chest discomfort.
- 4. Experience less nasal obstruction and discharge.

5. The nurse teaches the client how to instill nose drops. Which of the following techniques is correct?

- 1. The client uses sterile technique when handling the dropper.
- 2. The client blows the nose gently before instilling drops.
- 3. The client uses a new dropper for each instillation.
- 4. The client sits in a semi-Fowler’s position with the head tilted forward after administration of the drops.

**6.** The nurse should include which of the following instructions in the teaching plan for a client with chronic sinusitis?

- 1. Avoid the use of caffeinated beverages.
- 2. Perform postural drainage every day.
- 3. Take hot showers twice daily.
- 4. Report a temperature of 102° F (38.9° C) or higher.

**7.** A client with allergic rhinitis asks the nurse what he should do to decrease his symptoms. Which of the following instructions would be appropriate for the nurse to give the client?

- 1. “Use your nasal decongestant spray regularly to help clear your nasal passages.”
- 2. “Ask the doctor for antibiotics. Antibiotics will help decrease the secretion.”
- 3. “It is important to increase your activity. A daily brisk walk will help promote drainage.”
- 4. “Keep a diary of when your symptoms occur. This can help you identify what precipitates your attacks.”

**8.** Guaifenesin (Robitussin) 300 mg four times a day has been ordered as an expectorant. The dosage strength of the liquid is 200 mg/5 mL. How many milliliters should the nurse administer for each dose?

\_\_\_\_\_ mL.

**9.** Pseudoephedrine (Sudafed) has been ordered as a nasal decongestant. Which of the following is a possible adverse effect of this drug?

- 1. Constipation.
- 2. Bradycardia.
- 3. Diplopia.
- 4. Restlessness.

### The Client Undergoing Nasal Surgery

**10.** A health care provider has just inserted nasal packing for a client with epistaxis. The client is taking ramipril (Altace) for hypertension. What should the nurse instruct the client to do?

- 1. Use 81 mg of aspirin daily for relief of discomfort.
- 2. Omit the next dose of ramipril (Altace).
- 3. Remove the packing if there is difficulty swallowing.
- 4. Avoid rigorous aerobic exercise.

**11.** A 27-year-old female has had elective nasal surgery for a deviated septum. Which of the following would indicate that bleeding was occurring even if the nasal drip pad remained dry and intact?

- 1. Nausea.
- 2. Repeated swallowing.
- 3. Increased respiratory rate.
- 4. Increased pain.

**12.** A client who has undergone outpatient nasal surgery is ready for discharge and has nasal packing in place. Which of the following discharge instructions would be appropriate for the client?

- 1. Avoid activities that elicit the Valsalva maneuver.
- 2. Take aspirin to control nasal discomfort.
- 3. Avoid brushing the teeth until the nasal packing is removed.
- 4. Apply heat to the nasal area to control swelling.

**13.** Which of the following statements should indicate to the nurse that a client has understood the discharge instructions provided after her nasal surgery?

- 1. “I should not shower until my packing is removed.”
- 2. “I will take stool softeners and modify my diet to prevent constipation.”
- 3. “Coughing every 2 hours is important to prevent respiratory complications.”
- 4. “It is important to blow my nose each day to remove the dried secretions.”

**14.** The nurse is planning to give preoperative instructions to a client who will be undergoing rhinoplasty. Which of the following instructions should be included?

- 1. After surgery, nasal packing will be in place for 7 to 10 days.
- 2. Normal saline nose drops will need to be administered preoperatively.
- 3. The results of the surgery will be immediately obvious postoperatively.
- 4. Aspirin-containing medications should not be taken for 2 weeks before surgery.

**15.** Which of the following assessments should be a **priority** immediately after nasal surgery?

- 1. Assessing the client’s pain.
- 2. Inspecting for periorbital ecchymosis.
- 3. Assessing respiratory status.
- 4. Measuring intake and output.

**16.** After nasal surgery, the client expresses concern about how to decrease facial pain and swelling while recovering at home. Which of the following discharge instructions would be **most** effective for decreasing pain and edema?

- 1. Take analgesics every 4 hours around the clock.
- 2. Use corticosteroid nasal spray as needed to control symptoms.
- 3. Use a bedside humidifier while sleeping.
- 4. Apply cold compresses to the area.

**17.** A client is being discharged with nasal packing in place. The nurse should instruct the client to:

- 1. Perform frequent mouth care.
- 2. Use normal saline nose drops daily.
- 3. Sneeze and cough with mouth closed.
- 4. Gargle every 4 hours with salt water.

**18.** Which of the following activities should the nurse teach the client to implement after the removal of nasal packing on the second postoperative day?

- 1. Avoid cleaning the nares until swelling has subsided.
- 2. Apply water-soluble jelly to lubricate the nares.
- 3. Keep a nasal drip pad in place to absorb secretions.
- 4. Use a bulb syringe to gently irrigate nares.

**19.** The nurse is teaching a client how to manage a nosebleed. Which of the following instructions would be appropriate to give the client?

- 1. "Tilt your head backward and pinch your nose."
- 2. "Lie down flat and place an ice compress over the bridge of the nose."
- 3. "Blow your nose gently with your neck flexed."
- 4. "Sit down, lean forward, and pinch the soft portion of your nose."

**20.** An elderly client had posterior packing inserted to control a severe nosebleed. After insertion of the packing, the client should be closely monitored for which of the following complications?

- 1. Vertigo.
- 2. Bell's palsy.
- 3. Hypoventilation.
- 4. Loss of gag reflex.

### The Client with Cancer of the Larynx

**21.** Postoperative nursing management of the client following a radical neck dissection for laryngeal cancer requires:

- 1. Complete bed rest minimizing head movement.
- 2. Vital signs once a shift.
- 3. Clear liquid diet started at 48 hours.
- 4. Frequent suctioning of the laryngectomy tube.

**22.** A client who has had a total laryngectomy appears withdrawn and depressed. He keeps the curtain drawn, refuses visitors, and indicates a desire to be left alone. Which nursing intervention would **most** likely be therapeutic for the client?

- 1. Discussing his behavior with his wife to determine the cause.
- 2. Exploring his future plans.
- 3. Respecting his need for privacy.
- 4. Encouraging him to express his feelings non-verbally and in writing.

**23.** The nurse is suctioning a client who had a laryngectomy. What is the **maximum** amount of time the nurse should suction the client?

- 1. 10 seconds.
- 2. 15 seconds.
- 3. 25 seconds.
- 4. 30 seconds.

**24.** When suctioning a tracheostomy or laryngectomy tube, the nurse should follow which of the following procedures?

- 1. Use a sterile catheter each time the client is suctioned.
- 2. Clean the catheter in sterile water after each use and reuse for no longer than 8 hours.
- 3. Protect the catheter in sterile packaging between suctioning episodes.
- 4. Use a clean catheter with each suctioning, and disinfect it in hydrogen peroxide between uses.

**25.** The client with a laryngectomy communicates to the nurse that he does not want his family to see him. He indicates that he thinks the opening in his throat is disgusting. Which of the following nursing diagnoses would be **most** appropriate?

- 1. *Deficient knowledge* about the care of a stoma.
- 2. *Disturbed personal identity* related to change in appearance.
- 3. *Disturbed body image* related to neck surgery.
- 4. *Hopelessness* related to irreversible changes in body functioning.

**26.** What areas of education should the nurse provide employees in a factory making products that cause respiratory irritation to reduce the risk of laryngeal cancer? Select all that apply.

- 1. Smoking cessation concurrent with counseling.
- 2. HEPA filter use in the home.
- 3. Limiting alcohol use.
- 4. Brushing teeth after every meal.
- 5. Raising the voice to be heard over the noise in the factory.

**27.** A client has had hoarseness for more than 2 weeks. The nurse should:

- 1. Refer to a health care provider for a prescription for an antibiotic.
- 2. Instruct the client to gargle with salt water at home.
- 3. Assess the client for dysphagia.
- 4. Instruct the client to take a throat analgesic.

**28.** A client has just returned from the postanesthesia care unit after undergoing a laryngectomy. Which of the following interventions should the nurse include in the plan of care?

- 1. Maintain the head of the bed at 30 to 40 degrees.
- 2. Teach the client how to use esophageal speech.
- 3. Initiate small feedings of soft foods.
- 4. Irrigate drainage tubes as needed.

**29.** Which of the following is an appropriate expected outcome for a client recovering from a total laryngectomy? The client will:

- 1. Regain the ability to taste and smell food.
- 2. Demonstrate appropriate care of the gastrostomy tube.
- 3. Communicate feelings about body image changes.
- 4. Demonstrate sterile suctioning technique for stoma care.

**30.** Which of the following home care instructions would be appropriate for a client with a laryngectomy?

- 1. Perform mouth care every morning and evening.
- 2. Provide adequate humidity in the home.
- 3. Maintain a soft, bland diet.
- 4. Limit physical activity to shoulder and neck exercises.

**31.** The nurse has reported to the hospital to work the evening shift on a respiratory unit. The nurse's assignment consists of four clients. Prioritize in order from **highest** to **lowest** priority how the nurse would assess the clients after receiving report.

1. An 85-year-old client with bacterial pneumonia, temperature of 102.2° F (42° C), and shortness of breath.

2. A 60-year-old client with chest tubes who is 2 days postoperative following a thoracotomy for lung cancer and is requesting something for pain.

3. A 35-year-old client with suspected tuberculosis who is complaining of a cough.

4. A 56-year-old client with emphysema who has a scheduled dose of a bronchodilator due to be administered, with no report of acute respiratory distress.





## The Client with Pneumonia

**32.** A nurse notes that a client has kyphosis and generalized muscle atrophy. Which of the following problems is a **priority** when the nurse develops a nursing plan of care?

- 1. Infection.
- 2. Confusion.
- 3. Ineffective coughing and deep breathing.
- 4. Difficulty chewing solid foods.

**33.** A client with deep vein thrombosis suddenly develops dyspnea, tachypnea, and chest discomfort. What should the nurse do **first**?

- 1. Elevate the head of the bed 30 to 45 degrees.
- 2. Encourage the client to cough and deep breathe.
- 3. Auscultate the lungs to detect abnormal breath sounds.
- 4. Contact the physician.

**34.** A 79-year-old female client is admitted to the hospital with a diagnosis of bacterial pneumonia. While obtaining the client's health history, the nurse learns that the client has osteoarthritis, follows a vegetarian diet, and is very concerned with cleanliness. Which of the following would **most** likely be a predisposing factor for the diagnosis of pneumonia?

- 1. Age.
- 2. Osteoarthritis.
- 3. Vegetarian diet.
- 4. Daily bathing.

**35.** Which of the following is significant data to gather from a client who has been diagnosed with pneumonia? Select all that apply.

- 1. Quality of breath sounds.
- 2. Presence of bowel sounds.
- 3. Occurrence of chest pain.
- 4. Amount of peripheral edema.
- 5. Color of nail beds.

**36.** A client with bacterial pneumonia is to be started on I.V. antibiotics. Which of the following diagnostic tests must be completed before antibiotic therapy begins?

- 1. Urinalysis.
- 2. Sputum culture.
- 3. Chest radiograph.
- 4. Red blood cell count.

**37.** When caring for the client who is receiving an aminoglycoside antibiotic, the nurse should monitor which of the following laboratory values?

- 1. Serum sodium.
- 2. Serum potassium.
- 3. Serum creatinine.
- 4. Serum calcium.

**38.** A client with pneumonia has a temperature of 102.6° F (39.2° C), is diaphoretic, and has a productive cough. The nurse should include which of the following measures in the plan of care?

- 1. Position changes every 4 hours.
- 2. Nasotracheal suctioning to clear secretions.
- 3. Frequent linen changes.
- 4. Frequent offering of a bedpan.

**39.** Bed rest is prescribed for a client with pneumonia during the acute phase of the illness. The nurse should determine the effectiveness of bed rest by assessing the client's:

- 1. Decreased cellular demand for oxygen.
- 2. Reduced episodes of coughing.
- 3. Diminished pain when breathing deeply.
- 4. Ability to expectorate secretions more easily.

**40.** The cyanosis that accompanies bacterial pneumonia is **primarily** caused by which of the following?

- 1. Decreased cardiac output.
- 2. Pleural effusion.
- 3. Inadequate peripheral circulation.
- 4. Decreased oxygenation of the blood.

**41.** A client with pneumonia is experiencing pleuritic chest pain. The nurse should assess the client for:

- 1. A mild but constant aching in the chest.
- 2. Severe midsternal pain.
- 3. Moderate pain that worsens on inspiration.
- 4. Muscle spasm pain that accompanies coughing.

**42.** Which of the following measures would **most** likely be successful in reducing pleuritic chest pain in a client with pneumonia?

- 1. Encourage the client to breathe shallowly.
- 2. Have the client practice abdominal breathing.
- 3. Offer the client incentive spirometry.
- 4. Teach the client to splint the rib cage when coughing.

**43.** The nurse administers two 325 mg aspirin every 4 hours to a client with pneumonia. The nurse should evaluate the outcome of administering the drug by assessing which of the following? Select all that apply.

- 1. Decreased pain when breathing.
- 2. Prolonged clotting time.
- 3. Decreased temperature.
- 4. Decreased respiratory rate.
- 5. Increased ability to expectorate secretions.

**44.** Which of the following mental status changes may occur when a client with pneumonia is first experiencing hypoxia?

- 1. Coma.
- 2. Apathy.
- 3. Irritability.
- 4. Depression.

**45.** The client with pneumonia develops mild constipation, and the nurse administers docusate sodium (Colace) as ordered. This drug works by:

- 1. Softening the stool.
- 2. Lubricating the stool.
- 3. Increasing stool bulk.
- 4. Stimulating peristalsis.

**46.** The unlicensed assistive personnel (UAP) reports to the registered nurse that a client admitted with pneumonia is very diaphoretic. The nurse reviews the following vital signs in the chart obtained by the UAP. The nurse should:

Vital Signs			
Time	8 AM	10 AM	12 PM
Temperature	38.3° C		38.8° C
Pulse	90	104	118
Respirations	16	18	24
Blood Pressure	112/74	110/68	116/78
Spo <sub>2</sub>	93%	92%	92%

- 1. Maintain complete bed rest.
- 2. Check the urine output.
- 3. Ask the UAP to change the linens.
- 4. Administer a beta blocker.

**47.** Which of the following is an expected outcome for an elderly client following treatment for bacterial pneumonia?

- 1. A respiratory rate of 25 to 30 breaths/minute.
- 2. The ability to perform activities of daily living without dyspnea.
- 3. A maximum loss of 5 to 10 lb of body weight.
- 4. Chest pain that is minimized by splinting the rib cage.

## The Client with Tuberculosis

**48.** Which of the following symptoms is common in clients with active tuberculosis?

- 1. Weight loss.
- 2. Increased appetite.
- 3. Dyspnea on exertion.
- 4. Mental status changes.

**49.** A client is receiving streptomycin in the treatment regimen of tuberculosis. The nurse should assess for:

- 1. Decreased serum creatinine.
- 2. Difficulty swallowing.
- 3. Hearing loss.
- 4. I.V. infiltration.



**50.** A client is receiving streptomycin for the treatment of tuberculosis. The nurse should assess the client for eighth cranial nerve damage by observing the client for:

- 1. Vertigo.
- 2. Facial paralysis.
- 3. Impaired vision.
- 4. Difficulty swallowing.

**51.** The nurse should teach clients that the most common route of transmitting tubercle bacilli from person to person is through contaminated:

- 1. Dust particles.
- 2. Droplet nuclei.
- 3. Water.
- 4. Eating utensils.

**52.** What is the rationale that supports multidrug treatment for clients with tuberculosis?

- 1. Multiple drugs potentiate the drugs' actions.
- 2. Multiple drugs reduce undesirable drug adverse effects.
- 3. Multiple drugs allow reduced drug dosages to be given.
- 4. Multiple drugs reduce development of resistant strains of the bacteria.

**53.** The client with tuberculosis is to be discharged home with community health nursing follow-up. Of the following nursing interventions, which should have the **highest** priority?

- 1. Offering the client emotional support.
- 2. Teaching the client about the disease and its treatment.
- 3. Coordinating various agency services.
- 4. Assessing the client's environment for sanitation.

**54.** The nurse is reading the results of a tuberculin skin test (see figure). The nurse should interpret the results as:

- 1. Negative.
- 2. Needing to be repeated.
- 3. Positive.
- 4. False.



**55.** Which of the following techniques for administering the Mantoux test is correct?

- 1. Hold the needle and syringe almost parallel to the client's skin.
- 2. Pinch the skin when inserting the needle.
- 3. Aspirate before injecting the medication.
- 4. Massage the site after injecting the medication.

**56.** Which of the following family members exposed to tuberculosis would be at **highest** risk for contracting the disease?

- 1. 45-year-old mother.
- 2. 17-year-old daughter.
- 3. 8-year-old son.
- 4. 76-year-old grandmother.

**57.** The nurse is teaching a client who has been diagnosed with tuberculosis how to avoid spreading the disease to family members. Which statement(s) by the client indicate(s) that he has understood the nurse's instructions? Select all that apply.

- 1. "I will need to dispose of my old clothing when I return home."
- 2. "I should always cover my mouth and nose when sneezing."
- 3. "It is important that I isolate myself from family when possible."
- 4. "I should use paper tissues to cough in and dispose of them promptly."
- 5. "I can use regular plates and utensils whenever I eat."

**58.** A client has a positive reaction to the Mantoux test. The nurse correctly interprets this reaction to mean that the client has:

- 1. Active tuberculosis.
- 2. Had contact with *Mycobacterium tuberculosis*.
- 3. Developed a resistance to tubercle bacilli.
- 4. Developed passive immunity to tuberculosis.

**59.** A client with tuberculosis is taking Isoniazid (INH). To help prevent development of peripheral neuropathies, the nurse should instruct the client to:

- 1. Adhere to a low-cholesterol diet.
- 2. Supplement the diet with pyridoxine (vitamin B<sub>6</sub>).
- 3. Get extra rest.
- 4. Avoid excessive sun exposure.

**60.** The nurse should caution sexually active female clients taking isoniazid (INH) that the drug has which of the following effects?

- 1. Increases the risk of vaginal infection.
- 2. Has mutagenic effects on ova.
- 3. Decreases the effectiveness of hormonal contraceptives.
- 4. Inhibits ovulation.

**61.** Clients who have had active tuberculosis are at risk for recurrence. Which of the following conditions increases that risk?

- 1. Cool and damp weather.
- 2. Active exercise and exertion.
- 3. Physical and emotional stress.
- 4. Rest and inactivity.

**62.** In which areas of the United States is the incidence of tuberculosis highest?

- 1. Rural farming areas.
- 2. Inner-city areas.
- 3. Areas where clean water standards are low.
- 4. Suburban areas with significant industrial pollution.

**63.** The nurse should include which of the following instructions when developing a teaching plan for a client who is receiving isoniazid and rifampin (Rifamate) for treatment of tuberculosis?

- 1. Take the medication with antacids.
- 2. Double the dosage if a drug dose is missed.
- 3. Increase intake of dairy products.
- 4. Limit alcohol intake.

**64.** A client who has been diagnosed with tuberculosis has been placed on drug therapy. The medication regimen includes rifampin (Rifadin). Which of the following instructions should the nurse include in the client's teaching plan related to the potential adverse effects of rifampin? Select all that apply.

- 1. Having eye examinations every 6 months.
- 2. Maintaining follow-up monitoring of liver enzymes.
- 3. Decreasing protein intake in the diet.
- 4. Avoiding alcohol intake.
- 5. The urine may have an orange color.

**65.** The nurse is providing follow-up care to a client with tuberculosis who does not regularly take his medication. Which nursing action would be **most** appropriate for this client?

- 1. Ask the client's spouse to supervise the daily administration of the medications.
- 2. Visit the client weekly to ask him whether he is taking his medications regularly.
- 3. Notify the physician of the client's noncompliance and request a different prescription.
- 4. Remind the client that tuberculosis can be fatal if it is not treated promptly.

## The Client with Chronic Obstructive Pulmonary Disease

**66.** The nurse is instructing a client with COPD how to do pursed-lip breathing. In which order should the nurse explain the steps to the client?

- 1. "Breathe in normally through your nose for 2 counts (while counting to yourself, one, two)."
- 2. "Relax your neck and shoulder muscles."
- 3. "Pucker your lips as if you were going to whistle."
- 4. "Breathe out slowly through pursed lips for 4 counts (while counting to yourself, one, two, three, four)."

**67.** The nurse reviews an arterial blood gas report for a client with chronic obstructive pulmonary disease (COPD).

pH 7.35; PCO<sub>2</sub> 62; PO<sub>2</sub> 70; HCO<sub>3</sub> 34

The nurse should:

- 1. Apply a 100% non-rebreather mask.
- 2. Assess the vital signs.
- 3. Reposition the client.
- 4. Prepare for intubation.

**68.** When developing a discharge plan to manage the care of a client with chronic obstructive pulmonary disease (COPD), the nurse should advise the client to expect to:

- 1. Develop respiratory infections easily.
- 2. Maintain current status.
- 3. Require less supplemental oxygen.
- 4. Show permanent improvement.

**69.** Which of the following indicates that the client with chronic obstructive pulmonary disease (COPD) who has been discharged to home understands his care plan?

- 1. The client promises to do pursed-lip breathing at home.
- 2. The client states actions to reduce pain.
- 3. The client says that he will use oxygen via a nasal cannula at 5 L/minute.
- 4. The client agrees to call the physician if dyspnea on exertion increases.

**70.** Which of the following physical assessment findings are normal for a client with advanced chronic obstructive pulmonary disease (COPD)?

- 1. Increased anteroposterior chest diameter.
- 2. Underdeveloped neck muscles.
- 3. Collapsed neck veins.
- 4. Increased chest excursions with respiration.

**71.** When instructing clients on how to decrease the risk of chronic obstructive pulmonary disease (COPD), the nurse should emphasize which of the following?

- 1. Participate regularly in aerobic exercises.
- 2. Maintain a high-protein diet.
- 3. Avoid exposure to people with known respiratory infections.
- 4. Abstain from cigarette smoking.

**72.** Which of the following is an expected outcome of pursed-lip breathing for clients with emphysema?

- 1. To promote oxygen intake.
- 2. To strengthen the diaphragm.
- 3. To strengthen the intercostal muscles.
- 4. To promote carbon dioxide elimination.

**73.** Which of the following is a priority goal for the client with chronic obstructive pulmonary disease (COPD)?

- 1. Maintaining functional ability.
- 2. Minimizing chest pain.
- 3. Increasing carbon dioxide levels in the blood.
- 4. Treating infectious agents.

**74.** A client's arterial blood gas values are as follows: pH, 7.31; PaO<sub>2</sub>, 80 mm Hg; PaCO<sub>2</sub>, 65 mm Hg; HCO<sub>3</sub><sup>-</sup>, 36 mEq/L. The nurse should assess the client for?

- 1. Cyanosis.
- 2. Flushed skin.
- 3. Irritability.
- 4. Anxiety.

**75.** When performing postural drainage, which of the following factors promotes the movement of secretions from the lower to the upper respiratory tract?

- 1. Friction between the cilia.
- 2. Force of gravity.
- 3. Sweeping motion of cilia.
- 4. Involuntary muscle contractions.

**76.** When teaching a client with chronic obstructive pulmonary disease to conserve energy, the nurse should teach the client to lift objects:

- 1. While inhaling through an open mouth.
- 2. While exhaling through pursed lips.
- 3. After exhaling but before inhaling.
- 4. While taking a deep breath and holding it.

**77.** The nurse teaches a client with chronic obstructive pulmonary disease (COPD) to assess for signs and symptoms of right-sided heart failure. Which of the following signs and symptoms should be included in the teaching plan?

- 1. Clubbing of nail beds.
- 2. Hypertension.
- 3. Peripheral edema.
- 4. Increased appetite.

**78.** The nurse assesses the respiratory status of a client who is experiencing an exacerbation of chronic obstructive pulmonary disease (COPD) secondary to an upper respiratory tract infection. Which of the following findings would be expected?

- 1. Normal breath sounds.
- 2. Prolonged inspiration.
- 3. Normal chest movement.
- 4. Coarse crackles and rhonchi.

**79.** A client with chronic obstructive pulmonary disease (COPD) is experiencing dyspnea and has a low PaO<sub>2</sub> level. The nurse plans to administer oxygen as ordered. Which of the following statements is true concerning oxygen administration to a client with COPD?

- 1. High oxygen concentrations will cause coughing and dyspnea.
- 2. High oxygen concentrations may inhibit the hypoxic stimulus to breathe.
- 3. Increased oxygen use will cause the client to become dependent on the oxygen.
- 4. Administration of oxygen is contraindicated in clients who are using bronchodilators.

**80.** Which of the following diets would be **most** appropriate for a client with chronic obstructive pulmonary disease (COPD)?

- 1. Low-fat, low-cholesterol diet.
- 2. Bland, soft diet.
- 3. Low-sodium diet.
- 4. High-calorie, high-protein diet.

**81.** The nurse administers theophylline (Theo-Dur) to a client. To evaluate the effectiveness of this medication, which of the following drug actions should the nurse anticipate?

- 1. Suppression of the client's respiratory infection.
- 2. Decrease in bronchial secretions.
- 3. Relaxation of bronchial smooth muscle.
- 4. Thinning of tenacious, purulent sputum.

**82.** The nurse is planning to teach a client with chronic obstructive pulmonary disease how to cough effectively. Which of the following instructions should be included?

- 1. Take a deep abdominal breath, bend forward, and cough three or four times on exhalation.
- 2. Lie flat on the back, splint the thorax, take two deep breaths, and cough.
- 3. Take several rapid, shallow breaths and then cough forcefully.
- 4. Assume a side-lying position, extend the arm over the head, and alternate deep breathing with coughing.

### The Client with Asthma

**83.** A client uses a metered-dose inhaler (MDI) to aid in management of his asthma. Which action by the client indicates to the nurse that he needs further instruction regarding its use? Select all that apply.

- 1. Activation of the MDI is not coordinated with inspiration.
- 2. The client inspires rapidly when using the MDI.
- 3. The client holds his breath for 3 seconds after inhaling with the MDI.
- 4. The client shakes the MDI after use.
- 5. The client performs puffs in rapid succession.

**84.** A 34-year-old female with a history of asthma is admitted to the emergency department. The nurse notes that the client is dyspneic, with a respiratory rate of 35 breaths/minute, nasal flaring, and use of accessory muscles. Auscultation of the lung fields reveals greatly diminished breath sounds. Based on these findings, which action should the nurse take to initiate care of the client?

- 1. Initiate oxygen therapy and reassess the client in 10 minutes.
- 2. Draw blood for an arterial blood gas analysis and send the client for a chest X-ray.
- 3. Encourage the client to relax and breathe slowly through the mouth.
- 4. Administer bronchodilators.

**85.** A client experiencing a severe asthma attack has the following arterial blood gas: pH 7.33;  $P_{CO_2}$  48;  $P_{O_2}$  58;  $HCO_3$  26. Which of the following orders should the nurse perform **first**?

- 1. Albuterol (Proventil) nebulizer.
- 2. Chest x-ray.
- 3. Ipratropium (Atrovent) inhaler.
- 4. Sputum culture.

**86.** A client with acute asthma is prescribed short-term corticosteroid therapy. Which is the expected outcome for the use of steroids in clients with asthma?

- 1. Promote bronchodilation.
- 2. Act as an expectorant.
- 3. Have an anti-inflammatory effect.
- 4. Prevent development of respiratory infections.

**87.** The nurse is teaching the client how to use a metered-dose inhaler (MDI) to administer a corticosteroid. Which of the following client actions indicates that he is using the MDI correctly? Select all that apply.

- 1. The inhaler is held upright.
- 2. The head is tilted down while inhaling the medicine.
- 3. The client waits 5 minutes between puffs.
- 4. The mouth is rinsed with water following administration.
- 5. The client lies supine for 15 minutes following administration.

**88.** A client is prescribed metaproterenol (Alupent) via a metered-dose inhaler, two puffs every 4 hours. The nurse instructs the client to report adverse effects. Which of the following are potential adverse effects of metaproterenol?

- 1. Irregular heartbeat.
- 2. Constipation.
- 3. Pedal edema.
- 4. Decreased pulse rate.

**89.** A client who has been taking flunisolide (Aerobid), two inhalations a day, for treatment of asthma, has painful, white patches in his mouth. Which response by the nurse would be **most** appropriate?

- 1. "This is an anticipated adverse effect of your medication. It should go away in a couple of weeks."
- 2. "You are using your inhaler too much and it has irritated your mouth."
- 3. "You have developed a fungal infection from your medication. It will need to be treated with an antifungal agent."
- 4. "Be sure to brush your teeth and floss daily. Good oral hygiene will treat this problem."

**90.** A nurse is teaching a client to use a metered-dose inhaler (MDI) to administer his bronchodilator medication. Indicate the correct order of the steps the client should take to use the MDI appropriately.

1. Shake the inhaler immediately before use.

2. Hold breath for 5 to 10 seconds and then exhale.

3. Activate the MDI on inhalation.

4. Breathe out through the mouth.

**91.** Which of the following is an appropriate expected outcome for an adult client with well-controlled asthma?

- 1. Chest X-ray demonstrates minimal hyperinflation.
- 2. Temperature remains lower than 100° F (37.8° C).
- 3. Arterial blood gas analysis demonstrates a decrease in  $PaO_2$ .
- 4. Breath sounds are clear.

**92.** Which of the following health promotion activities should the nurse include in the discharge teaching plan for a client with asthma?

- 1. Incorporate physical exercise as tolerated into the daily routine.
- 2. Monitor peak flow numbers after meals and at bedtime.
- 3. Eliminate stressors in the work and home environment.
- 4. Use sedatives to ensure uninterrupted sleep at night.

**93.** The nurse should teach the client with asthma that which of the following is one of the **most** common precipitating factors of an acute asthma attack?

- 1. Occupational exposure to toxins.
- 2. Viral respiratory infections.
- 3. Exposure to cigarette smoke.
- 4. Exercising in cold temperatures.

**94.** Which of the following findings would **most** likely indicate the presence of a respiratory infection in a client with asthma?

- 1. Cough productive of yellow sputum.
- 2. Bilateral expiratory wheezing.
- 3. Chest tightness.
- 4. Respiratory rate of 30 breaths/minute.

### The Client with Lung Cancer

**95.** The nurse has assisted the physician at the bedside with insertion of a left subclavian, triple lumen catheter in a client admitted with lung cancer. Suddenly, the client becomes restless and tachypneic. The nurse should:

- 1. Assess breath sounds.
- 2. Remove the catheter.
- 3. Insert a peripheral I.V.
- 4. Reposition the client.

**96.** A female client diagnosed with lung cancer is to have a left lower lobectomy. Which of the following **increase** the client's risk of developing postoperative pulmonary complications?

- 1. Height is 5 feet, 7 inches and weight is 110 lb.
- 2. The client tends to keep her real feelings to herself.
- 3. She ambulates and can climb one flight of stairs without dyspnea.
- 4. The client is 58 years of age.

**97.** The nurse in the perioperative area is preparing a client for surgery and notices that the client looks sad. The client says, "I'm scared of having cancer. It's so horrible and I brought it on myself. I should have quit smoking years ago." What would be the nurse's **best** response to the client?

- 1. "It's okay to be scared. What is it about cancer that you're afraid of?"
- 2. "It's normal to be scared. I would be, too. We'll help you through it."
- 3. "Don't be so hard on yourself. You don't know if your smoking caused the cancer."
- 4. "Do you feel guilty because you smoked?"

**98.** A client who underwent a left lower lobectomy has been out of surgery for 48 hours. She is receiving morphine sulfate via a patient-controlled analgesia (PCA) system. She tells the nurse that she has some pain in her left thorax that worsens when she coughs. The nurse should:

- 1. Let the client rest, so that she is not stimulated to cough.
- 2. Encourage the client to take deep breaths to help control the pain.
- 3. Check that the PCA device is functioning properly, and then reassure the client that the machine is working and will relieve her pain.
- 4. Obtain a more detailed assessment of the client's pain using a pain scale.

**99.** Which of the following areas is a priority to evaluate when completing discharge planning for a client who has had a lobectomy for treatment of lung cancer?

- 1. The support available to assist the client at home.
- 2. The distance the client lives from the hospital.
- 3. The client's ability to do home blood pressure monitoring.
- 4. The client's knowledge of the causes of lung cancer.

**100.** Which of the following would be a significant intervention to help prevent lung cancer?

- 1. Encourage cigarette smokers to have yearly chest radiographs.
- 2. Instruct people about techniques for smoking cessation.
- 3. Recommend that people have their houses and apartments checked for asbestos leakage.
- 4. Encourage people to install central air cleaners in their homes.

**101.** After a thoracotomy, the nurse instructs the client to perform deep-breathing exercises. Which of the following is an expected outcome of these exercises?

- 1. Deep breathing elevates the diaphragm, which enlarges the thorax and increases the lung surface available for gas exchange.
- 2. Deep breathing increases blood flow to the lungs to allow them to recover from the trauma of surgery.
- 3. Deep breathing controls the rate of air flow to the remaining lobe so that it will not become hyperinflated.
- 4. Deep breathing expands the alveoli and increases the lung surface available for ventilation.

**102.** Following a thoracotomy, the client has severe pain. Which of the following strategies for pain management will be **most** effective for this client?

- 1. Repositioning the client immediately after administering pain medication.
- 2. Reassessing the client 30 minutes after administering pain medication.
- 3. Verbally reassuring the client after administering pain medication.
- 4. Readjusting the pain medication dosage as needed according to the client's condition.

**103.** While assessing a thoracotomy incisional area from which a chest tube exits, the nurse feels a crackling sensation under the fingertips along the entire incision. Which of the following should be the nurse's **first** action?

- 1. Lower the head of the bed and call the physician.
- 2. Prepare an aspiration tray.
- 3. Mark the area with a skin pencil at the outer periphery of the crackling.
- 4. Turn off the suction of the chest drainage system.

**104.** When teaching a client to deep breathe effectively after a lobectomy, the nurse should instruct the client to do which of the following?

- 1. Contract the abdominal muscles, take a slow deep breath through the nose and hold it for 3 to 5 seconds, then exhale.
- 2. Contract the abdominal muscles, take a deep breath through the mouth, and exhale slowly as if trying to blow out a candle.
- 3. Relax the abdominal muscles, take a slow deep breath through the nose, and hold it for 3 to 5 seconds.
- 4. Relax the abdominal muscles, take a deep breath through the mouth, and exhale slowly over 10 seconds.

**105.** Which of the following rehabilitative measures should the nurse teach the client who has undergone chest surgery to prevent shoulder ankylosis?

- 1. Turn from side to side.
- 2. Raise and lower the head.
- 3. Raise the arm on the affected side over the head.
- 4. Flex and extend the elbow on the affected side.

**106.** When caring for a client with a chest tube and water-seal drainage system, the nurse should:

- 1. Verify that the air vent on the water-seal drainage system is capped when the suction is off.
- 2. Strip the chest drainage tubes at least every 4 hours if excessive bleeding occurs.
- 3. Ensure that the chest tube is clamped when moving the client out of the bed.
- 4. Make sure that the drainage apparatus is always below the client's chest level.

**107.** A client has a chest tube attached to a water-seal drainage system and the nurse notes that the fluid in the chest tube and in the water-seal column has stopped fluctuating. The nurse should determine that:

- 1. The lung has fully expanded.
- 2. The lung has collapsed.
- 3. The chest tube is in the pleural space.
- 4. The mediastinal space has decreased.

**108.** The nurse observes a constant gentle bubbling in the water-seal column of a water-seal chest drainage system. This observation should prompt the nurse to do which of the following?

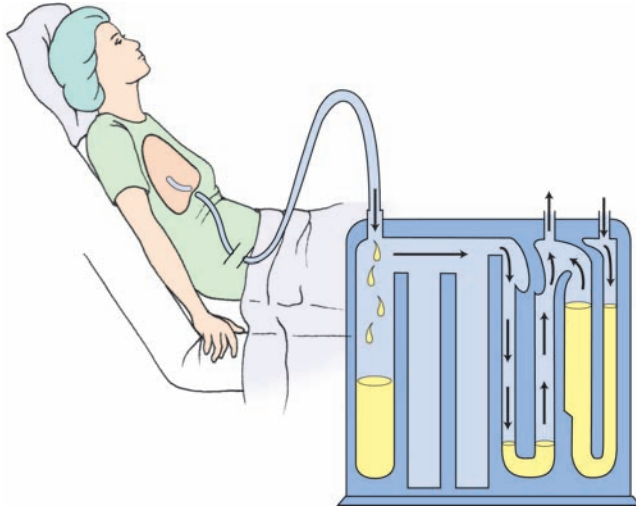
- 1. Continue monitoring as usual; this is expected.
- 2. Check the connectors between the chest and drainage tubes and where the drainage tube enters the collection bottle.
- 3. Decrease the suction to  $-15$  cm  $H_2O$  and continue observing the system for changes in bubbling during the next several hours.
- 4. Drain half of the water from the water-seal chamber.

**109.** A client who underwent a lobectomy and has a water-seal chest drainage system is breathing with a little more effort and at a faster rate than 1 hour ago. The client's pulse rate is also increased. The nurse should:

- 1. Check the tubing to ensure that the client is not lying on it or kinking it.
- 2. Increase the suction.
- 3. Lower the drainage bottles 2 to 3 feet below the level of the client's chest.
- 4. Ensure that the chest tube has two clamps on it to prevent air leaks.

**110.** The nurse is assessing a client who has a chest tube connected to a water-seal chest tube drainage system. According to the illustration shown, which should the nurse do?

- 1. Clamp the chest tube near the insertion site to prevent air from entering the pleural cavity.
- 2. Notify the physician of the amount of chest tube drainage.
- 3. Add water to maintain the water seal.
- 4. Lower the drainage system to maintain gravity flow.



**111.** Which of the following should be readily available at the bedside of a client with a chest tube in place?

- 1. A tracheostomy tray.
- 2. Another sterile chest tube.
- 3. A bottle of sterile water.
- 4. A spirometer.

### The Client with Chest Trauma

**112.** A nurse should interpret which of the following as an early sign of a tension pneumothorax in a client with chest trauma?

- 1. Diminished bilateral breath sounds.
- 2. Muffled heart sounds.
- 3. Respiratory distress.
- 4. Tracheal deviation.

**113.** A nurse is to administer 10 mg of morphine sulfate to a client with three fractured ribs. The available concentration for this drug is 15 mg/mL. How many milliliters should the nurse administer? Round to one decimal point.

\_\_\_\_\_ mL.

**114.** A 21-year-old male client is transported by ambulance to the emergency department after a serious automobile accident. He complains of severe pain in his right chest where he struck the steering wheel. Which is the **primary** client goal at this time?

- 1. Reduce the client's anxiety.
- 2. Maintain adequate oxygenation.
- 3. Decrease chest pain.
- 4. Maintain adequate circulating volume.

**115.** A client with rib fractures and a pneumothorax has a chest tube inserted that is connected to a water-seal chest tube drainage system. The nurse notes that the fluid in the water-seal column is fluctuating with each breath that the client takes. What is the significance of this fluctuation?

- 1. An obstruction is present in the chest tube.
- 2. The client is developing subcutaneous emphysema.
- 3. The chest tube system is functioning properly.
- 4. There is a leak in the chest tube system.

**116.** A client who is recovering from chest trauma is to be discharged home with a chest tube drainage system intact. The nurse should instruct the client to call the physician for which of the following?

- 1. Respiratory rate greater than 16 breaths/minute.
- 2. Continuous bubbling in the water-seal chamber.
- 3. Fluid in the chest tube.
- 4. Fluctuation of fluid in the water-seal chamber.

**117.** Which of the following findings would suggest pneumothorax in a trauma victim?

- 1. Pronounced crackles.
- 2. Inspiratory wheezing.
- 3. Dullness on percussion.
- 4. Absent breath sounds.

**118.** For a client with rib fractures and a pneumothorax, the physician prescribes morphine sulfate, 1 to 2 mg/hour, given I.V. as needed for pain. The nursing care goal is to provide adequate pain control so that the client can breathe effectively. Which of the following outcomes would indicate successful achievement of this goal?

- 1. Pain rating of 0 on a scale of 0 to 10 by the client.
- 2. Decreased client anxiety.
- 3. Respiratory rate of 26 breaths/minute.
- 4. PaO<sub>2</sub> of 70 mm Hg.

**119.** A client undergoes surgery to repair lung injuries. Postoperative orders include the transfusion of one unit of packed red blood cells at a rate of 60 mL/hour. How long would this transfusion take to infuse?

- 1. 2 hours.
- 2. 4 hours.
- 3. 6 hours.
- 4. 8 hours.

**120.** The primary reason for infusing blood at a rate of 60 mL/hour is to help prevent which of the following complications?

- 1. Emboli formation.
- 2. Fluid volume overload.
- 3. Red blood cell hemolysis.
- 4. Allergic reaction.

**121.** A client's chest tube is to be removed by the physician. Which of the following items should the nurse have ready to be placed directly over the wound when the chest tube is removed?

- 1. Butterfly dressing.
- 2. Montgomery strap.
- 3. Fine-mesh gauze dressing.
- 4. Petroleum gauze dressing.

**122.** A client has been in an automobile accident and the nurse is assessing the client for possible pneumothorax. The nurse should assess the client for:

- 1. Sudden, sharp chest pain.
- 2. Wheezing breath sounds over affected side.
- 3. Hemoptysis.
- 4. Cyanosis.

**123.** The physician has inserted a chest tube in a client with a pneumothorax. The nurse should evaluate the effectiveness of the chest tube:

- 1. For administration of oxygen.
- 2. To promote formation of lung scar tissue.
- 3. To insert antibiotics into the pleural space.
- 4. To remove air and fluid.

### The Client with Acute Respiratory Distress Syndrome

**124.** The nurse has placed the intubated client with acute respiratory distress syndrome (ARDS) in prone position for 30 minutes. Which of the following would require the nurse to discontinue prone positioning and return the client to the supine position? Select all that apply.

- 1. The family is coming in to visit.
- 2. The client has increased secretions requiring frequent suctioning.
- 3. The SpO<sub>2</sub> and PO<sub>2</sub> have decreased.
- 4. The client is tachycardic with drop in blood pressure.
- 5. The face has increased skin breakdown and edema.

**125.** The nurse has calculated a low PaO<sub>2</sub>/FIO<sub>2</sub> (P/F) ratio < 150 for a client with acute respiratory distress syndrome (ARDS). The nurse should place the client in which position to improve oxygenation, ventilation distribution, and drainage of secretions?

- 1. Supine.
- 2. Semi-fowlers.
- 3. Lateral side.
- 4. Prone.

**126.** A client with acute respiratory distress syndrome (ARDS) has fine crackles at lung bases and the respirations are shallow at a rate of 28 breaths/minute. The client is restless and anxious. In addition to monitoring the arterial blood gas results, the nurse should do which of the following? Select all that apply.

- 1. Monitor serum creatinine and blood urea nitrogen levels.
- 2. Administer a sedative.
- 3. Keep the head of the bed flat.
- 4. Administer humidified oxygen.
- 5. Auscultate the lungs.

**127.** Which of the following interventions would be **most** likely to prevent the development of acute respiratory distress syndrome (ARDS)?

- 1. Teaching cigarette smoking cessation.
- 2. Maintaining adequate serum potassium levels.
- 3. Monitoring clients for signs of hypercapnia.
- 4. Replacing fluids adequately during hypovolemic states.

**128.** The nurse interprets which of the following as an early sign of acute respiratory distress syndrome (ARDS) in a client at risk?

- 1. Elevated carbon dioxide level.
- 2. Hypoxia not responsive to oxygen therapy.
- 3. Metabolic acidosis.
- 4. Severe, unexplained electrolyte imbalance.

**129.** A client with acute respiratory distress syndrome (ARDS) is showing signs of increased dyspnea. The nurse reviews a report of blood gas values that recently arrived, shown below.

Laboratory Results	
Blood chemistry	Result
pH	7.35
PaCO <sub>2</sub>	25 mm Hg
Hco <sub>3</sub> <sup>-</sup>	22 mEq/L
PaO <sub>2</sub>	95 mm Hg

Which finding should the nurse report to the physician?

- 1. pH.
- 2. PaCO<sub>2</sub>.
- 3. HCO<sub>3</sub><sup>-</sup>.
- 4. PaO<sub>2</sub>.



**130.** A client with acute respiratory distress syndrome (ARDS) is on a ventilator. The client's peak inspiratory pressures and spontaneous respiratory rate are increasing, and the  $PO_2$  is not improving. Using the SBAR (Situation-Background-Assessment-Recommendation) technique for communication, the nurse calls the physician with the recommendation for:

- 1. Initiating I.V. sedation.
- 2. Starting a high-protein diet.
- 3. Providing pain medication.
- 4. Increasing the ventilator rate.

**131.** A client has the following arterial blood gas values: pH, 7.52;  $PaO_2$ , 50 mm Hg;  $PaCO_2$ , 28 mm Hg;  $HCO_3^-$ , 24 mEq/L. Based upon the client's  $PaO_2$ , which of the following conclusions would be accurate?

- 1. The client is severely hypoxic.
- 2. The oxygen level is low but poses no risk for the client.
- 3. The client's  $PaO_2$  level is within normal range.
- 4. The client requires oxygen therapy with very low oxygen concentrations.

**132.** A client has the following arterial blood gas values: pH, 7.52;  $PaO_2$ , 50 mm Hg;  $PaCO_2$ , 28 mm Hg;  $HCO_3^-$ , 24 mEq/L. The nurse determines that which of the following is a possible cause for these findings?

- 1. Chronic obstructive pulmonary disease (COPD).
- 2. Diabetic ketoacidosis with Kussmaul's respirations.
- 3. Myocardial infarction.
- 4. Pulmonary embolus.

**133.** Which of the following interventions should the nurse anticipate in a client who has been diagnosed with acute respiratory distress syndrome (ARDS)?

- 1. Tracheostomy.
- 2. Use of a nasal cannula.
- 3. Mechanical ventilation.
- 4. Insertion of a chest tube.

**134.** Which of the following conditions can place a client at risk for acute respiratory distress syndrome (ARDS)?

- 1. Septic shock.
- 2. Chronic obstructive pulmonary disease.
- 3. Asthma.
- 4. Heart failure.

**135.** Which one of the following assessments is most appropriate for determining the correct placement of an endotracheal tube in a mechanically ventilated client?

- 1. Assessing the client's skin color.
- 2. Monitoring the respiratory rate.
- 3. Verifying the amount of cuff inflation.
- 4. Auscultating breath sounds bilaterally.

**136.** Which of the following nursing interventions would promote effective airway clearance in a client with acute respiratory distress?

- 1. Administering oxygen every 2 hours.
- 2. Turning the client every 4 hours.
- 3. Administering sedatives to promote rest.
- 4. Suctioning if cough is ineffective.

**137.** Which of the following complications is associated with mechanical ventilation?

- 1. Gastrointestinal hemorrhage.
- 2. Immunosuppression.
- 3. Increased cardiac output.
- 4. Pulmonary emboli.

**138.** A client is admitted to the emergency department with a headache, weakness, and slight confusion. The physician diagnoses carbon monoxide poisoning. What should the nurse do first?

- 1. Initiate gastric lavage.
- 2. Maintain body temperature.
- 3. Administer 100% oxygen by mask.
- 4. Obtain a psychiatric referral.

**139.** A confused client with carbon monoxide poisoning experiences dizziness when ambulating to the bathroom. The nurse should:

- 1. Put all four side rails up on the bed.
- 2. Ask the unlicensed personnel to place restraints on the client's upper extremities.
- 3. Request that the client's roommate put the call light on when the client is attempting to get out of bed.
- 4. Check on the client at regular intervals to ascertain the need to use the bathroom.

**140.** Which of the following are expected outcomes for a client with pulmonary disease?

- 1. A relatively matched ventilation-to-perfusion ratio.
- 2. A low ventilation-to-perfusion ratio.
- 3. A high ventilation-to-perfusion ratio.
- 4. An equal  $PaO_2$  and  $PaCO_2$  ratio.

## Managing Care Quality and Safety

**141.** The nurse should place a client being admitted to the hospital with suspected tuberculosis on what type of isolation?

- 1. Standard precautions.
- 2. Contact precautions.
- 3. Droplet precautions.
- 4. Airborne precautions.

**142.** A client has developed a hospital-acquired pneumonia. When preparing to administer cephalexin (Keflex) 500 mg, the nurse notices that the pharmacy sent cefazolin (Kefzol). What should the nurse do? Select all that apply.

- 1. Administer the cefazolin (Kefzol).
- 2. Verify the medication order as written by the physician.
- 3. Contact the pharmacy and speak to a pharmacist.
- 4. Request that cephalexin (Keflex) be sent promptly.
- 5. Return the cefazolin (Kefzol) to the pharmacy.

**143.** A nurse receives the taped change-of-shift report for assigned clients and prioritizes client rounds. In what order should the nurse assess these clients?

1. A client with an endotracheal tube transferred out of the intensive care unit that day.

2. A client with type 2 diabetes who had a cerebrovascular accident 4 days ago.

3. A client with cellulitis of the left lower extremity with a fever of 100.8°F (38.2°C).

4. A client receiving D5W I.V. at 125 mL/hour with 75 mL remaining.

**144.** Which of the following individuals should the nurse consider to have the **highest** priority for receiving seasonal influenza vaccination?

- 1. A 60-year-old man with a hiatal hernia.
- 2. A 36-year-old woman with three children.
- 3. A 50-year-old woman caring for a spouse with cancer.
- 4. A 60-year-old woman with osteoarthritis.

**145.** The nurse is a member of a team that is planning a client-centered approach to care of clients with chronic obstructive pulmonary disease (COPD) using the Chronic Care Model (CCM). The team should focus on improving quality of care and delivery in which of the following areas? Select all that apply.

- 1. The community.
- 2. Clinical information systems.
- 3. Delivery system design.
- 4. Administrative leadership.
- 5. Emphasis on the acute care setting.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question.

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

### The Client with an Upper Respiratory Tract Infection

**1. 1.** At this time, there is no strong research evidence to warrant recommendations of herbal products for management of colds; further study is needed to show evidence of therapeutic effects and indications. Antibiotics are effective against bacteria; the head cold may have a viral cause. An uncomplicated upper respiratory tract infection subsides within 2 to 3 weeks. There may be a drug-drug interaction with herbal products and prescriptions.


🔑 CN: Basic care and comfort;  
CL: Synthesize

**2. 1, 4, 5.** Antihistamines have an anticholinergic action and a drying effect and reduce nasal, salivary, and lacrimal gland hypersecretion (runny nose, tearing, and itching eyes). An adverse effect is drowsiness, so operating machinery and driving are not recommended. There is also an additive depressant effect when alcohol is combined with antihistamines, so alcohol should be avoided during antihistamine use. The client should ensure adequate fluid intake of at least 8 glasses per day due to the drying effect of the drug. Antihistamines have


no antibacterial action. The effect of antihistamines is prompt, not delayed.

 CN: Pharmacological and parenteral therapies; CL: Create


**3. 3.** When using an intranasal inhaler, it is important to close off one nostril while inhaling the spray into the other nostril to ensure the best inhalation of the spray. Use of the inhaler is not limited to mornings and bedtime. The canister should be shaken immediately before use. The inhaler tip should be inserted into the nostril and pointed toward the outside nostril wall to maximize inhalation of the medication.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**4. 4.** A client recovering from an upper respiratory tract infection should report decreasing or no nasal discharge and obstruction. Daily fluid intake should be increased to more than 1 L every 24 hours to liquefy secretions. The temperature should be below 100° F (37.8° C) with no chills or diaphoresis. A productive cough with chest pain indicates a pulmonary infection, not an upper respiratory tract infection.

 CN: Physiological adaptation; CL: Evaluate

**5. 2.** The client should blow the nose before instilling nose drops. Instilling nose drops is a clean technique. The dropper should be cleaned after each administration, but it does not need to be changed. The client should assume a position that will allow the medication to reach the desired area; this is usually a supine position.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**6. 3.** The client with chronic sinusitis should be instructed to take hot showers in the morning and evening to promote drainage of secretions. There is no need to limit caffeine intake. Performing postural drainage will inhibit removal of secretions, not promote it. Clients should elevate the head of the bed to promote drainage. Clients should report all temperatures higher than 100.4° F (38° C), because a temperature that high can indicate infection.

 CN: Reduction of risk potential; CL: Synthesize

**7. 4.** It is important for clients with allergic rhinitis to determine the precipitating factors so that they can be avoided. Keeping a diary can help identify these triggers. Nasal decongestant sprays should not be used regularly because they can cause a rebound effect. Antibiotics are not appropriate for allergic rhinitis because an infection is not present.

Increasing activity will not control the client's symptoms; in fact, walking outdoors may increase them if the client is allergic to pollen.

 CN: Health promotion and maintenance; CL: Synthesize


**8. 7.5 mL**

$$300 \text{ mg}/X = 200 \text{ mg}/5 \text{ mL}$$

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

 CN: Pharmacological and parenteral therapies; CL: Apply

**9. 4.** Adverse effects of pseudoephedrine (Sudafed) are experienced primarily in the cardiovascular system and through sympathetic effects on the central nervous system (CNS). The most common CNS adverse effects include restlessness, dizziness, tension, anxiety, insomnia, and weakness. Common cardiovascular adverse effects include tachycardia, hypertension, palpitations, and arrhythmias. Constipation and diplopia are not adverse effects of pseudoephedrine. Tachycardia, not bradycardia, is an adverse effect of pseudoephedrine.

 CN: Pharmacological and parenteral therapies; CL: Analyze

## The Client Undergoing Nasal Surgery

**10. 4.** Epistaxis, or *nosebleed*, is a common, sudden emergency. Commonly, no apparent explanation for the bleeding is known. With significant blood loss, systemic symptoms, such as vertigo, increased pulse, shortness of breath, decreased blood pressure, and pallor, will occur. Because aerobic exercise may increase blood pressure and increased blood pressure can cause epistaxis, the client with hypertension should avoid it. Aspirin inhibits platelet aggregation, reducing the ability of the blood to clot. The client should continue to take his antihypertension medication, ramipril (Altace). Posterior nasal packing should be left in place for 1 to 3 days.

 CN: Health promotion and maintenance; CL: Synthesize

**11. 2.** Because of the dense nasal packing, bleeding may not be apparent through the nasal drip pad. Instead, the blood may run down the throat, causing the client to swallow frequently. The back of the throat, where the blood will be apparent, can be assessed with a flashlight. An accumulation of blood in the stomach can cause nausea and vomiting, but nausea would not be the initial indicator of bleeding. An increased respiratory rate occurs in shock but is not an early sign of bleeding in a client who has undergone nasal surgery. Increased pain

warrants further assessment but is not an indicator of bleeding.

 CN: Reduction of risk potential;  
CL: Analyze

**12. 1.** The client should be instructed to avoid any activities that cause Valsalva's maneuver (e.g., constipation, vigorous coughing, exercise) in order to reduce bleeding and stress on suture lines. The client should not take aspirin because of its antiplatelet properties, which may cause bleeding. Oral hygiene is important to rid the mouth of old dried blood and to enhance the client's appetite. Cool compresses, not heat, should be applied to decrease swelling and control discoloration of the area.

 CN: Physiological adaptation; CL: Create


**13. 2.** Constipation can cause straining during defecation, which can induce bleeding. Showering is not contraindicated. The client should take measures to prevent coughing, which can cause bleeding. The client should avoid blowing her nose for 48 hours after the packing is removed. Thereafter, she should blow her nose gently, using the open-mouth technique to minimize bleeding in the surgical area.

 CN: Physiological adaptation;  
CL: Evaluate

**14. 4.** Aspirin-containing medications should be discontinued for 2 weeks before surgery to decrease the risk of bleeding. Nasal packing is usually removed the day after surgery. Normal saline nose drops are not routinely administered preoperatively. The results of the surgery will not be obvious immediately after surgery because of edema and ecchymosis.


 CN: Reduction of risk potential;  
CL: Create

**15. 3.** Immediately after nasal surgery, ineffective breathing patterns may develop as a result of the nasal packing and nasal edema. Nasal packing may dislodge, leading to obstruction. Assessing for airway obstruction is a priority. Assessing for pain is important, but it is not as high a priority as assessment of the airways. It is too early to detect ecchymosis. Measuring intake and output is not typically a priority nursing assessment after nasal surgery.

 CN: Physiological adaptation;  
CL: Analyze

**16. 4.** Applying cold compresses helps to decrease facial swelling and pain from edema. Analgesics may decrease pain, but they do not decrease edema. A corticosteroid nasal spray would not be administered postoperatively because it can impair healing. Use of a bedside humidifier promotes


comfort by providing moisture for nasal mucosa, but it does not decrease edema.

 CN: Basic care and comfort;  
CL: Synthesize

**17. 1.** Frequent mouth care is important to provide comfort and encourage eating. Mouth care promotes moist mucous membranes. Nose drops cannot be used with nasal packing in place. When sneezing and coughing, the client should do so with the mouth open to decrease the chance of dislodging the packing. Gargling should not be attempted with packing in place.

 CN: Basic care and comfort; CL: Create

**18. 2.** After removal of nasal packing, the client should be instructed to apply water-soluble jelly to the nares to lubricate the nares and promote comfort. Swelling gradually subsides over several weeks; the client can gently clean the nares as soon as packing is removed. A nasal drip pad is not needed after removal of packing. Irrigation with a bulb syringe may interfere with healing and introduce infection.

 CN: Basic care and comfort;  
CL: Synthesize

**19. 4.** The client should assume a sitting position and lean forward. Firm pressure should be applied to the soft portion of the nose for approximately 10 minutes. Tilting the head backward can cause the client to swallow blood, which can obscure the amount of bleeding and also can lead to nausea. Ice compresses may be applied, but the client should not lie flat. Blowing the nose is to be avoided because it can increase bleeding.

 CN: Reduction of risk potential;  
CL: Synthesize


**20. 3.** Posterior packing may alter the respiratory status of the client, especially in elderly clients, causing hypoventilation. Clients should be observed carefully for changes in level of consciousness, respiratory rate, and heart rate and rhythm after the insertion of the packing. Vertigo does not occur as a result of the insertion of posterior packing. Bell's palsy, a disorder of the seventh cranial nerve, is not associated with epistaxis or nasal packing. Loss of gag reflex does not occur as a result of the insertion of posterior packing.

 CN: Reduction of risk potential;  
CL: Analyze

## The Client with Cancer of the Larynx

**21. 4.** The nurse must maintain patency of the airway with frequent suctioning of the laryngectomy tube that can become occluded from secretions,


blood, and mucus plugs. Once the client is hemodynamically stable, getting out of bed should be encouraged to prevent postoperative complications. Vital signs should be monitored more frequently in a postoperative client. A swallow study is done at approximately 5 to 7 days after surgery, prior to starting oral intake.

 CN: Physiological adaptation;  
CL: Synthesize

**22. 4.** The client has undergone body changes and permanent loss of verbal communication. He may feel isolated and insecure. The nurse can encourage him to express his feelings and use this information to develop an appropriate plan of care. Discussing the client's behavior with his wife may not reveal his feelings. Exploring future plans is not appropriate at this time because more information about the client's behavior is needed before proceeding to this level. The nurse can respect the client's need for privacy while also encouraging him to express his feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**23. 1.** A client should be suctioned for no longer than 10 seconds at a time. Suctioning for longer than 10 seconds may reduce the client's oxygen level so much that he becomes hypoxic.


 CN: Reduction of risk potential;  
CL: Apply

**24. 1.** The recommended technique is to use a sterile catheter each time the client is suctioned. There is a danger of introducing organisms into the respiratory tract when strict aseptic technique is not used. Reusing a suction catheter is not consistent with aseptic technique. The nurse does not use a clean catheter when suctioning a tracheostomy or a laryngectomy; it is a sterile procedure.

 CN: Reduction of risk potential;  
CL: Apply

**25. 3.** *Disturbed body image* is the most appropriate nursing diagnosis based on the client's statements at this time. Most clients are concerned about how their family members will respond to the physical changes that have occurred as a result of radical neck surgery. The nurse should allow the client to communicate any negative feelings or concerns that exist because of the surgery. Referral to a support group for laryngectomy clients may be helpful to the client and family members in coping with the changes in their lives. The client's feelings are not related to a knowledge deficit, but rather to a permanent change in physical appearance and functioning. The diagnosis of *Disturbed personal identity* refers to a client's inability to distinguish self from nonself. *Hopelessness* may be an issue for


the client experiencing a body image disturbance; however, there are no data to support this diagnosis at this time.

 CN: Psychosocial adaptation;  
CL: Analyze


**26. 1, 3.** The primary risk factors for laryngeal cancer are smoking and alcohol abuse. Smoking cessation is most successful with a support group or counseling. Heavy drinking should be avoided since the risk increases with amount of alcohol consumption. HEPA filters help trap small particles and allergens to reduce allergy symptoms and asthma. Poor oral hygiene is not a risk factor, nor is over-using the voice.

 CN: Health promotion and maintenance;  
CL: Create

**27. 3.** Hoarseness occurring longer than 2 weeks is a warning sign of laryngeal cancer. The nurse should first assess other signs, such as a lump in the neck or throat, persistent sore throat or cough, earache, pain, and difficulty swallowing (dysphagia). Gargling with salt water may lead to increased irritation. There is no indication of infection warranting an antibiotic. An oral analgesic would provide only temporary relief of discomfort if hoarseness is accompanied by a sore throat.


 CN: Physiological adaptation;  
CL: Synthesize

**28. 1.** Immediately after surgery, the client should be maintained in a position with the head of the bed elevated 30 to 40 degrees (semi-Fowler's position) to decrease tissue edema, facilitate breathing, and decrease pain related to edema formation. Immediately postoperatively, the client should be provided alternative means of communicating, such as a communication board. As healing progresses and edema subsides, a speech therapist should work with the client to explore various voice restoration options, such as the use of a voice prosthesis, electrolarynx, artificial larynx, or esophageal speech. Food is not initiated in the immediate postoperative phase; enteral feedings are usually used to meet nutritional needs until edema subsides. Irrigation of the drainage tubes is an inappropriate action.

 CN: Basic care and comfort;  
CL: Synthesize

**29. 3.** It is important that the client be able to communicate his or her feelings about the body image changes that have occurred as a result of surgery. Open communication helps promote adjustment. The client may not regain the ability to taste and smell food because of no longer breathing through the nose or because of radiation therapy treatments, or both. A gastrostomy tube would not typically be placed after a total laryngectomy, nor

would it be necessary for the client to demonstrate sterile suctioning technique for stoma care. The client would use clean technique.

 CN: Physiological adaptation;  
CL: Evaluate

**30. 2.** Adequate humidity should be provided in the home to help keep secretions moist. A bedside humidifier is recommended. A high fluid intake is also important to liquefy secretions. Mouth care is important to prevent drying of mucous membranes and should be performed frequently throughout the day, especially before and after meals, to help stimulate appetite. The client may eat any food that can be chewed and swallowed comfortably. The client may resume physical activity as tolerated.

 CN: Reduction of risk potential;  
CL: Synthesize

### 31.

1. An 85-year-old client with bacterial pneumonia, temperature of 102.2° F (42° C), and shortness of breath.

2. A 60-year-old client with chest tubes who is 2 days postoperative following a thoracotomy for lung cancer and is requesting something for pain.

4. A 56-year-old client with emphysema who has a scheduled dose of a bronchodilator due to be administered, with no report of acute respiratory distress.


3. A 35-year-old client with suspected tuberculosis who is complaining of a cough.

The elderly client with pneumonia, an elevated temperature, and shortness of breath is the most acutely ill client described and should be the client with the highest priority. The elevated temperature and shortness of breath can lead to a decrease in the client's oxygen levels, and can predispose the client to dehydration and confusion. Then the nurse should assess the client with the thoracotomy who is requesting pain medication and administer any needed medication. The client with emphysema should be the next priority so that the bronchodilator can be administered on schedule as close as possible. The nurse would then assess the client with suspected tuberculosis and a cough.

 CN: Management of care;  
CL: Synthesize

## The Client with Pneumonia


**32. 3.** In kyphosis, the thoracic spine bends forward with convexity of the curve in a posterior direction, making effective coughing and deep breathing difficult. Although the client may develop other problems because respiratory status deteriorates when pulmonary secretions are not adequately cleared from airways, ineffective coughing and deep breathing should receive priority attention.

 CN: Physiological adaptation;  
CL: Synthesize


**33. 1.** Elevating the head of the bed facilitates breathing because the lungs are able to expand as the diaphragm descends. Coughing and deep breathing do not alleviate the symptoms of a pulmonary embolus, nor does lung auscultation. The physician must be kept informed of changes in a client's status, but the priority in this case is alleviating the symptoms.

 CN: Reduction of risk potential;  
CL: Synthesize

**34. 1.** The client's age is a predisposing factor for pneumonia; pneumonia is more common in elderly or debilitated clients. Other predisposing factors include smoking, upper respiratory tract infections, malnutrition, immunosuppression, and the presence of a chronic illness. Osteoarthritis, a nutritionally sound vegetarian diet, and frequent bathing are not predisposing factors for pneumonia.

 CN: Reduction of risk potential;  
CL: Analyze


**35. 1, 3, 5.** A respiratory assessment, which includes auscultating breath sounds and assessing the color of the nail beds, is a priority for clients with pneumonia. Assessing for the presence of chest pain is also an important respiratory assessment as chest pain can interfere with the client's ability to breathe deeply. Auscultating bowel sounds and assessing for peripheral edema may be appropriate assessments, but these are not priority assessments for the client with pneumonia.

 CN: Physiological adaptation;  
CL: Analyze


**36. 2.** A sputum specimen is obtained for culture to determine the causative organism. After the organism is identified, an appropriate antibiotic can be prescribed. Beginning antibiotic therapy before obtaining the sputum specimen may alter the results of the test. Neither a urinalysis, a chest radiograph, nor a red blood cell count needs to be obtained before initiation of antibiotic therapy for pneumonia.

 CN: Reduction of risk potential;  
CL: Apply


**37. 3.** It is essential to monitor serum creatinine in the client receiving an aminoglycoside antibiotic because of the potential of this type of drug to cause acute tubular necrosis. Aminoglycoside antibiotics do not affect serum sodium, potassium, or calcium levels.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**38. 3.** Frequent linen changes are appropriate for this client because of the diaphoresis. Diaphoresis produces general discomfort. The client should be kept dry to promote comfort. Position changes need to be done every 2 hours. Nasotracheal suctioning is not indicated with the client's productive cough. Frequent offering of a bedpan is not indicated by the data provided in this scenario.

 CN: Basic care and comfort; CL: Synthesize


**39. 1.** Exudate in the alveoli interferes with ventilation and the diffusion of gases in clients with pneumonia. During the acute phase of the illness, it is essential to reduce the body's need for oxygen at the cellular level; bed rest is the most effective method for doing so. Bed rest does not decrease coughing or promote clearance of secretions, and it does not reduce pain when taking deep breaths.

 CN: Physiological adaptation; CL: Evaluate


**40. 4.** A client with pneumonia has less lung surface available for the diffusion of gases because of the inflammatory pulmonary response that creates lung exudate and results in reduced oxygenation of the blood. The client becomes cyanotic because blood is not adequately oxygenated in the lungs before it enters the peripheral circulation. Decreased cardiac output may be a comorbid condition in some clients with pneumonia; however, it is not the cause of cyanosis. Pleural effusions are a potential complication of pneumonia but are not the primary cause of decreased oxygenation. Inadequate peripheral circulation is also not the cause of the cyanosis that develops with bacterial pneumonia.

 CN: Physiological adaptation; CL: Analyze


**41. 3.** Chest pain in pneumonia is generally caused by friction between the pleural layers. It is more severe on inspiration than on expiration, secondary to chest wall movement. Pleuritic chest pain is usually described as sharp, not mild or aching. Pleuritic chest pain is not localized to the sternum, and it is not the result of a muscle spasm.

 CN: Physiological adaptation; CL: Analyze


**42. 4.** The pleuritic pain is triggered by chest movement and is particularly severe during coughing. Splinting the chest wall will help reduce the discomfort of coughing. Deep breathing is essential to prevent further atelectasis. Abdominal breathing is not as effective in decreasing pleuritic chest pain as is splinting of the rib cage. Incentive spirometry facilitates effective deep breathing but does not decrease pleuritic chest pain.

 CN: Physiological adaptation; CL: Synthesize


**43. 1, 3.** Aspirin is administered to clients with pneumonia because it is an analgesic that helps control chest discomfort and an antipyretic that helps reduce fever. Aspirin has an anticoagulant effect, but that is not the reason for prescribing it for a client with pneumonia, and the use of the drug will be short term. Aspirin does not affect the respiratory rate, and does not facilitate expectoration of secretions.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**44. 3.** Clients who are experiencing hypoxia characteristically exhibit irritability, restlessness, or anxiety as initial mental status changes. As the hypoxia becomes more pronounced, the client may become confused and combative. Coma is a late clinical manifestation of hypoxia. Apathy and depression are not symptoms of hypoxia.

 CN: Physiological adaptation; CL: Analyze

**45. 1.** Docusate sodium (Colace) is a stool softener that allows fluid and fatty substances to enter the stool and soften it. Docusate sodium does not lubricate the stool, increase stool bulk, or stimulate peristalsis.

 CN: Pharmacological and parenteral therapies; CL: Apply

**46. 2.** A client with pneumonia experiencing diaphoresis is at risk for dehydration. The fluid status, intake, and output should be monitored closely. The client is febrile, causing an increase in heart rate. Fluid volume deficit may also increase the heart rate. A beta blocker is not indicated since the underlying cause of the tachycardia can be treated with acetaminophen (Tylenol) and fluid volume. Bed rest limits lung expansion and sitting up and deep breathing should be encouraged in a client with pneumonia. The blood pressure is stable enough to allow the client to get out of bed to the chair, with assistance to ensure safety.


 CN: Physiological adaptation; CL: Synthesize

**47. 2.** An expected outcome for a client recovering from pneumonia would be the ability to perform activities of daily living without experiencing dyspnea. A respiratory rate of 25 to 30 breaths/minute indicates the client is experiencing tachypnea, which would not be expected on recovery. A weight loss of 5 to 10 lb is undesirable; the expected outcome would be to maintain normal weight. A client who is recovering from pneumonia should experience decreased or no chest pain.


 CN: Management of care; CL: Evaluate

### The Client with Tuberculosis


**48. 1.** Tuberculosis typically produces anorexia and weight loss. Other signs and symptoms may include fatigue, low-grade fever, and night sweats. Increased appetite is not a symptom of tuberculosis; dyspnea on exertion and change in mental status are not common symptoms of tuberculosis.

 CN: Physiological adaptation;  
CL: Analyze

**49. 3.** Streptomycin can cause toxicity to the eighth cranial nerve, which is responsible for hearing, balance, and body position sense. Nephrotoxicity is a side effect that would be indicated with an increase in creatinine. Streptomycin is given via intramuscular injection.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**50. 1.** The eighth cranial nerve is the vestibulo-ocochlear nerve, which is responsible for hearing and equilibrium. Streptomycin can damage this nerve (ototoxicity). Symptoms of ototoxicity include vertigo, tinnitus, hearing loss, and ataxia. Facial paralysis would result from damage to the facial nerve (VII). Impaired vision would result from damage to the optic (II), oculomotor (III), or the trochlear (IV) nerves. Difficulty swallowing would result from damage to the glossopharyngeal (IX) or the vagus (X) nerve.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**51. 2.** Tubercle bacilli are spread by airborne droplet nuclei. Droplet nuclei are the residue of evaporated droplets containing the bacilli, which remain suspended and are circulated in the air. Dust particles and water do not spread tubercle bacilli. Tuberculosis is not spread by eating utensils, dishes, or other fomites.

 CN: Safety and infection control;  
CL: Apply

**52. 4.** Use of a combination of antituberculosis drugs slows the rate at which organisms develop drug resistance. Combination therapy also appears to be more effective than single-drug therapy. Many drugs potentiate (or inhibit) the actions of other drugs; however, this is not the rationale for using multiple drugs to treat tuberculosis. Treatment with multiple drugs does not reduce adverse effects and may expose the client to more adverse effects. Combination therapy may allow some medications (e.g., antihypertensives) to be given in reduced dosages; however, reduced dosages are not prescribed for antibiotics and antituberculosis drugs.

 CN: Pharmacological and parenteral therapies; CL: Apply


**53. 2.** Ensuring that the client is well educated about tuberculosis is the highest priority. Education of the client and family is essential to help the client understand the need for completing the prescribed drug therapy to cure the disease. Offering the client emotional support, coordinating various agency services, and assessing the environment may be part of the care for the client with tuberculosis; however, these interventions are of less importance than education about the disease process and its treatment.

 CN: Basic care and comfort;  
CL: Synthesize

**54. 3.** The tuberculin test is positive. The test should be interpreted 2 to 3 days after administering the purified protein derivative (PPD) by measuring the size of the firm, raised area (induration). Positive responses indicate that the client may have been exposed to the tuberculosis bacteria. A negative response is indicated by the absence of a firm, raised area, or an area that is less than 5 mm in diameter. Since the test is positive, it is not necessary to redo the test. The test is positive, not false.

 CN: Physiological adaptation;  
CL: Analyze


**55. 1.** The Mantoux test is administered via intradermal injection. The appropriate technique for an intradermal injection includes holding the needle and syringe almost parallel to the client's skin, keeping the skin slightly taut when the needle is inserted, and inserting the needle with the bevel side up. There is no need to aspirate, a technique that assesses for incorrect placement in a blood vessel, when giving an intradermal injection. The injection site is not massaged.

 CN: Pharmacological and parenteral therapies; CL: Apply

**56. 4.** Elderly persons are believed to be at higher risk for contracting tuberculosis because of decreased immunocompetence. Other high-risk



populations in the United States include the urban poor, clients with acquired immunodeficiency syndrome, and minority groups.

 CN: Safety and infection control;  
CL: Analyze


**57. 2, 4, 5.** When teaching the client how to avoid the transmission of tubercle bacilli, it is important for the client to understand that the organism is transmitted by droplet infection. Therefore, covering the mouth and nose when sneezing, using paper tissues to cough in with prompt disposal, and using regular plates and utensils indicate that the client has understood the nurse's instructions about preventing the spread of airborne droplets. It is not essential to discard clothing, nor does the client need to isolate himself from family members.

 CN: Health promotion and maintenance;  
CL: Evaluate


**58. 2.** A positive Mantoux skin test indicates that the client has been exposed to tubercle bacilli. Exposure does not necessarily mean that active disease exists. A positive Mantoux test does not mean that the client has developed resistance. Unless involved in treatment, the client may still develop active disease at any time. Immunity to tuberculosis is not possible.

 CN: Reduction of risk potential;  
CL: Analyze

**59. 2.** INH competes for the available vitamin B<sub>6</sub> in the body and leaves the client at risk for development of neuropathies related to vitamin deficiency. Supplemental vitamin B<sub>6</sub> is routinely prescribed. Following a low-cholesterol diet, getting extra rest, and avoiding excessive sun exposure will not prevent the development of peripheral neuropathies.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**60. 3.** INH interferes with the effectiveness of hormonal contraceptives, and female clients of childbearing age should be counseled to use an alternative form of birth control while taking the drug. INH does not increase the risk of vaginal infection, nor does it affect the ova or ovulation.


 CN: Pharmacological and parenteral therapies; CL: Apply

**61. 3.** Tuberculosis can be controlled but never completely eradicated from the body. Periods of intense physical or emotional stress increase the likelihood of recurrence. Clients should be taught to recognize the signs and symptoms of a potential


recurrence. Weather and activity levels are not related to recurrences of tuberculosis.

 CN: Physiological adaptation;  
CL: Analyze

**62. 2.** Statistics show that of the four geographic areas described, most cases of tuberculosis are found in inner-core residential areas of large cities, where health and sanitation standards tend to be low. Substandard housing, poverty, and crowded living conditions also generally characterize these city areas and contribute to the spread of the disease. Farming areas have a low incidence of tuberculosis. Variations in water standards and industrial pollution are not correlated to tuberculosis incidence.

 CN: Safety and infection control;  
CL: Analyze

**63. 4.** Isoniazid and rifampin (Rifamate) is a hepatotoxic drug. The client should be warned to limit intake of alcohol during drug therapy. The drug should be taken on an empty stomach. If antacids are needed for gastrointestinal distress, they should be taken 1 hour before or 2 hours after the drug is administered. The client should not double the dose of the drug because of potential toxicity. The client taking the drug should avoid foods that are rich in tyramine, such as cheese and dairy products, or he may develop hypertension.

 CN: Pharmacological and parenteral therapies; CL: Create

**64. 2, 4, 5.** A potential adverse effect of rifampin (Rifadin) is hepatotoxicity. Clients should be instructed to avoid alcohol intake while taking rifampin and keep follow-up appointments for periodic monitoring of liver enzyme levels to detect liver toxicity. Rifampin causes the urine to turn an orange color and the client should understand that this is normal. It is not necessary to restrict protein intake in the diet or have the eyes examined due to rifampin therapy.

 CN: Pharmacological and parenteral therapies; CL: Create

**65. 1.** Directly observed therapy (DOT) can be implemented with clients who are not compliant with drug therapy. In DOT, a responsible person, who may be a family member or a health care provider, observes the client taking the medication. Visiting the client, changing the prescription, or threatening the client will not ensure compliance if the client will not or cannot follow the prescribed treatment.


 CN: Safety and infection control;  
CL: Synthesize

## The Client with Chronic Obstructive Pulmonary Disease

**66. 2, 1, 3, 4.** The nurse should instruct the client to first relax the neck and shoulders and then take several normal breaths. After taking a breath in, the client should pucker the lips, and finally breathe out through pursed lips.

 CN: Health promotion and maintenance;  
CL: Apply


**67. 2.** Clients with chronic COPD have CO<sub>2</sub> retention and the respiratory drive is stimulated when the PO<sub>2</sub> decreases. The heart rate, respiratory rate, and blood pressure should be evaluated to determine if the client is hemodynamically stable. Symptoms, such as dyspnea, should also be assessed. Oxygen supplementation, if indicated, should be titrated upward in small increments. There is no indication that the client is experiencing respiratory distress requiring intubation.

 CN: Physiological adaptation;  
CL: Synthesize

**68. 1.** A client with COPD is at high risk for development of respiratory infections. COPD is slowly progressive; therefore, maintaining current status and establishing a goal that the client will require less supplemental oxygen are unrealistic expectations. Treatment may slow progression of the disease, but permanent improvement is highly unlikely.


 CN: Management of care;  
CL: Synthesize

**69. 4.** Increasing dyspnea on exertion indicates that the client may be experiencing complications of COPD. Therefore, the nurse should notify the physician. Extracting promises from clients is not an outcome criterion. Pain is not a common symptom of COPD. Clients with COPD use low-flow oxygen supplementation (1 to 2 L/minute) to avoid suppressing the respiratory drive, which, for these clients, is stimulated by hypoxia.

 CN: Basic care and comfort;  
CL: Evaluate

**70. 1.** Increased anteroposterior chest diameter is characteristic of advanced COPD. Air is trapped in the overextended alveoli, and the ribs are fixed in an inspiratory position. The result is the typical barrel-chested appearance. Overly developed, not underdeveloped, neck muscles are associated with COPD because of their increased use in the work of breathing. Distended, not collapsed, neck veins are associated with COPD as a symptom of the heart failure that the client may experience secondary to the increased workload on the heart to pump blood


into the pulmonary vasculature. Diminished, not increased, chest excursion is associated with COPD.

 CN: Physiological adaptation;  
CL: Analyze


**71. 4.** Cigarette smoking is the primary cause of COPD. Other risk factors include exposure to environmental pollutants and chronic asthma. Participating in an aerobic exercise program, although beneficial, will not decrease the risk of COPD. Insufficient protein intake and exposure to people with respiratory infections do not increase the risk of COPD.

 CN: Health promotion and maintenance;  
CL: Synthesize

**72. 4.** Pursed-lip breathing prolongs exhalation and prevents air trapping in the alveoli, thereby promoting carbon dioxide elimination. By prolonging exhalation and helping the client relax, pursed-lip breathing helps the client learn to control the rate and depth of respiration. Pursed-lip breathing does not promote the intake of oxygen, strengthen the diaphragm, or strengthen intercostal muscles.

 CN: Physiological adaptation;  
CL: Evaluate

**73. 1.** A priority goal for the client with COPD is to manage the signs and symptoms of the disease process so as to maintain the client's functional ability. Chest pain is not a typical symptom of COPD. The carbon dioxide concentration in the blood is increased to an abnormal level in clients with COPD; it would not be a goal to increase the level further. Preventing infection would be a goal of care for the client with COPD.

 CN: Basic care and comfort;  
CL: Synthesize


**74. 2.** The high PaCO<sub>2</sub> level causes flushing due to vasodilation. The client also becomes drowsy and lethargic because carbon dioxide has a depressant effect on the central nervous system. Cyanosis is a sign of hypoxia. Irritability and anxiety are not common with a PaCO<sub>2</sub> level of 65 mm Hg but are associated with hypoxia.

 CN: Reduction of risk potential;  
CL: Analyze


**75. 2.** The principle behind using postural drainage is that gravity will help move secretions from smaller to larger airways. Postural drainage is best used after percussion has loosened secretions. Coughing or suctioning is then used to remove secretions. Movement of cilia is not sufficient to move secretions. Muscle contractions do not move secretions within the lungs.

 CN: Physiological adaptation; CL: Apply


**76. 2.** Exhaling requires less energy than inhaling. Therefore, lifting while exhaling saves energy and reduces perceived dyspnea. Pursing the lips prolongs exhalation and provides the client with more control over breathing. Lifting after exhaling but before inhaling is similar to lifting with the breath held. This should not be recommended because it is similar to the Valsalva maneuver, which can stimulate cardiac arrhythmias.

 CN: Basic care and comfort;  
CL: Synthesize

**77. 3.** Right-sided heart failure is a complication of COPD that occurs because of pulmonary hypertension. Signs and symptoms of right-sided heart failure include peripheral edema, jugular venous distention, hepatomegaly, and weight gain due to increased fluid volume. Clubbing of nail beds is associated with conditions of chronic hypoxemia. Hypertension is associated with left-sided heart failure. Clients with heart failure have decreased appetites.

 CN: Physiological adaptation;  
CL: Synthesize

**78. 4.** Exacerbations of COPD are commonly caused by respiratory infections. Coarse crackles and rhonchi would be auscultated as air moves through airways obstructed with secretions. In COPD, breath sounds are diminished because of an enlarged anteroposterior diameter of the chest. Expiration, not inspiration, becomes prolonged. Chest movement is decreased as lungs become overdistended.


 CN: Physiological adaptation;  
CL: Analyze

**79. 2.** Clients who have a long history of COPD may retain carbon dioxide (CO<sub>2</sub>). Gradually the body adjusts to the higher CO<sub>2</sub> concentration, and the high levels of CO<sub>2</sub> no longer stimulate the respiratory center. The major respiratory stimulant then becomes hypoxemia. Administration of high concentrations of oxygen eliminates this respiratory stimulus and leads to hypoventilation. Oxygen can be drying if it is not humidified, but it does not cause coughing and dyspnea. Increased oxygen use will not create an oxygen dependency; clients should receive oxygen as needed. Oxygen is not contraindicated with the use of bronchodilators.


 CN: Physiological adaptation; CL: Apply

**80. 4.** The client should eat high-calorie, high-protein meals to maintain nutritional status and prevent weight loss that results from the increased work of breathing. The client should be encouraged to eat small, frequent meals. A low-fat, low-cholesterol diet is indicated for clients with


coronary artery disease. The client with COPD does not necessarily need to follow a sodium-restricted diet, unless otherwise medically indicated. There is no need for the client to eat bland, soft foods.

 CN: Basic care and comfort;  
CL: Synthesize

**81. 3.** Theophylline (Theo-Dur) is a bronchodilator that is administered to relax airways and decrease dyspnea. Theophylline is not used to treat infections and does not decrease or thin secretions.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**82. 1.** The goal of effective coughing is to conserve energy, facilitate removal of secretions, and minimize airway collapse. The client should assume a sitting position with feet on the floor if possible. The client should bend forward slightly and, using pursed-lip breathing, exhale. After resuming an upright position, the client should use abdominal breathing to slowly and deeply inhale. After repeating this process three or four times, the client should take a deep abdominal breath, bend forward, and cough three or four times upon exhalation (“huff” cough). Lying flat does not enhance lung expansion; sitting upright promotes full expansion of the thorax. Shallow breathing does not facilitate removal of secretions, and forceful coughing promotes collapse of airways. A side-lying position does not allow for adequate chest expansion to promote deep breathing.

 CN: Basic care and comfort; CL: Create

## The Client with Asthma

**83. 1, 2, 3, 4, 5.** Utilization of an MDI requires coordination between activation and inspiration; deep breaths to ensure that medication is distributed into the lungs, holding the breath for 10 seconds or as long as possible to disperse the medication into the lungs, shaking up the medication in the MDI before use, and a sufficient amount of time between puffs to provide an adequate amount of inhalation medication.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**84. 4.** In an acute asthma attack, diminished or absent breath sounds can be an ominous sign indicating lack of air movement in the lungs and impending respiratory failure. The client requires immediate intervention with inhaled bronchodilators, I.V. corticosteroids and, possibly, I.V. theophylline (Theo-Dur). Administering oxygen and reassessing the client 10 minutes later would delay needed medical intervention, as would drawing blood for


an arterial blood gas analysis and obtaining a chest X-ray. It would be futile to encourage the client to relax and breathe slowly without providing the necessary pharmacologic intervention.

 CN: Management of care; CL: Synthesize


**85. 1.** The arterial blood gas reveals a respiratory acidosis with hypoxia. A quick-acting bronchodilator, albuterol, should be administered via nebulizer to improve gas exchange. Ipratropium is a maintenance treatment for bronchospasm that can be used with albuterol. A chest x-ray and sputum sample can be obtained once the client is stable.

 CN: Physiological adaptation;  
CL: Synthesize


**86. 3.** Corticosteroids have an anti-inflammatory effect and act to decrease edema in the bronchial airways and decrease mucus secretion. Corticosteroids do not have a bronchodilator effect, act as expectorants, or prevent respiratory infections.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**87. 1, 4.** The client should shake the inhaler and hold it upright when administering the drug. The head should be tilted back slightly. The client should wait about 1 to 2 minutes between puffs. The mouth should be rinsed following the use of a corticosteroid MDI to decrease the likelihood of developing an oral infection. The client does not need to lie supine; instead, the client will likely be able to breathe more freely if sitting upright.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**88. 1.** Irregular heartbeats should be reported promptly to the care provider. Metaproterenol (Alupent) may cause irregular heartbeat, tachycardia, or anginal pain because of its adrenergic effect on beta-adrenergic receptors in the heart. It is not recommended for use in clients with known cardiac disorders. Metaproterenol does not cause constipation, pedal edema, or bradycardia.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**89. 3.** Use of oral inhalant corticosteroids such as flunisolide (AeroBid) can lead to the development of oral thrush, a fungal infection. Once developed, thrush must be treated by antifungal therapy; it will not resolve on its own. Fungal infections can develop even without overuse of the corticosteroid inhaler. Although good oral hygiene can help prevent development of a fungal infection, it cannot be used alone to treat the problem.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**90.**


1. Shake the inhaler immediately before use.

4. Breathe out through the mouth.


3. Activate the MDI on inhalation.

2. Hold breath for 5 to 10 seconds and then exhale.

When using inhalers, clients should first shake the inhaler to activate the MDI, and then breathe out through the mouth. Next, the client should activate the MDI while inhaling, hold the breath for 5 to 10 seconds, and then exhale normally.

 CN: Pharmacological and parenteral therapies; CL: Apply


**91. 4.** Between attacks, breath sounds should be clear on auscultation with good air flow present throughout lung fields. Chest X-rays should be normal. The client should remain afebrile. Arterial blood gases should be normal.

 CN: Physiological adaptation;  
CL: Evaluate

**92. 1.** Physical exercise is beneficial and should be incorporated as tolerated into the client's schedule. Peak flow numbers should be monitored daily, usually in the morning (before taking medication). Peak flow does not need to be monitored after each meal. Stressors in the client's life should be modified but cannot be totally eliminated. Although adequate sleep is important, it is not recommended that sedatives be routinely taken to induce sleep.


 CN: Reduction of risk potential;  
CL: Create

**93. 2.** The most common precipitator of asthma attacks is viral respiratory infection. Clients with asthma should avoid people who have the flu or a cold and should get yearly flu vaccinations. Environmental exposure to toxins or heavy particulate matter can trigger asthma attacks; however, far fewer asthmatics are exposed to such toxins than are exposed to viruses. Cigarette smoke can also trigger asthma attacks, but to a lesser extent than viral respiratory infections. Some asthmatic attacks are triggered by exercising in cold weather.

 CN: Reduction of risk potential;  
CL: Synthesize


**94. 1.** A cough productive of yellow sputum is the most likely indicator of a respiratory infection. The other signs and symptoms—wheezing, chest tightness, and increased respiratory rate—are all

findings associated with an asthma attack and do not necessarily mean an infection is present.


 CN: Physiological adaptation;  
CL: Analyze

## The Client with Lung Cancer


**95. 1.** The nurse should first assess for bilateral breath sounds since a complication of central line insertion is a pneumothorax which would cause an increase in respiratory rate and drop in oxygen, causing irritability. The nurse should also assess blood pressure and heart rate for the complication of bleeding. A chest x-ray will be performed to determine correct placement and complications. A central line was most likely placed because peripheral I.V. access was not available or adequate for the client. Repositioning may be considered after assessments are done.

 CN: Physiological adaptation;  
CL: Synthesize

**96. 1.** Risk factors for postoperative pulmonary complications include malnourishment, which is indicated by this client's height and weight. It is thought that emotional responses can affect overall health; however, not verbalizing one's feelings is not a contributing factor in postoperative pulmonary complications. The client's current activity level and age do not place her at increased risk for complications.


 CN: Physiological adaptation;  
CL: Analyze

**97. 1.** Acknowledging the basic feeling the client expresses—fear—and asking an open-ended question allows the client to explain any fears. The other options dismiss the client's feelings and may give false reassurance or label the client's feelings. The client should be encouraged to explore feelings about a cancer diagnosis.


 CN: Psychosocial adaptation;  
CL: Synthesize

**98. 4.** Systematic pain assessment is necessary for adequate pain management in the postoperative client. Guidelines from a variety of health care agencies and nursing groups recommend that institutions adopt a pain assessment scale to assist in facilitating pain management. Even though the client is receiving morphine sulfate by PCA, assessment is needed if she is experiencing pain. The concern is not to eliminate coughing but to control pain adequately. Coughing is necessary to prevent postoperative atelectasis and pneumonia. Breathing exercises may help control pain in some circumstances; however, most clients with thoracic surgery

require parenteral opioid analgesics in the early postoperative period. Although it is necessary that the PCA device be checked periodically to ensure that it is functioning properly, if the machine is functional and the client's pain is not relieved, further intervention, beginning with a pain assessment, is indicated.

 CN: Basic care and comfort;  
CL: Synthesize


**99. 1.** Because clients are discharged as soon as possible from the hospital, it is essential to evaluate the support they have to assist them with self-care at home. The distance the client lives from the hospital is not a critical factor in discharge planning. There are no data indicating that home blood pressure monitoring is needed. Knowledge of the causes of lung cancer, although important, is not the most essential area to evaluate given the client's postoperative status.

 CN: Psychosocial adaptation;  
CL: Synthesize

**100. 2.** Epidermoid cancer involving the larger bronchi is almost entirely associated with heavy cigarette smoking. The American Cancer Society reports that smoking is responsible for more than 80% of lung cancers in men and women. The prevalence of lung cancer is related to the duration and intensity of the smoking, so nurses can best prevent lung cancer by persuading clients to stop smoking. Chest radiographs aid in detection of lung cancer; they do not prevent it. Exposure to asbestos has been implicated as a risk factor for lung cancer, but cigarette smoking is the major risk factor. There are no data to support the use of home air cleaners in the prevention of lung cancer.


 CN: Health promotion and maintenance;  
CL: Synthesize

**101. 4.** Deep breathing helps prevent microatelectasis and pneumonitis and also helps force air and fluid out of the pleural space into the chest tubes. More than half of the ventilatory process is accomplished by the rise and fall of the diaphragm. The diaphragm is the major muscle of respiration; deep breathing causes it to descend, not elevate, thereby increasing the ventilating surface. Deep breathing increases blood flow to the lungs; however, the primary reason for deep breathing is to expand alveoli and prevent atelectasis. The remaining lobe naturally hyperinflates to fill the space created by the resected lobe. This is an expected phenomenon.


 CN: Physiological adaptation;  
CL: Evaluate

**102. 2.** It is essential that the nurse evaluate the effects of pain medication after the medication has


had time to act; reassessment is necessary to determine the effectiveness of the pain management plan. Although it is prudent to check for discomfort related to positioning when assessing the client's pain, repositioning the client immediately after administering pain medication is not necessary. Verbally reassuring the client after administering pain medication may be useful to help instill confidence in the treatment plan; however, it is not as important as evaluating the effectiveness of the medication. Readjusting the pain medication dosage as needed according to the client's condition is essential, but the effectiveness of the medication must be evaluated first.

 CN: Physiological adaptation;  
CL: Synthesize


**103. 3.** This crackling sensation is subcutaneous emphysema. Subcutaneous emphysema is not an unusual finding, and it is not dangerous if confined. But progression can be serious, especially if the neck is involved; a tracheotomy may be needed. If emphysema progresses noticeably in 1 hour, the physician should be notified. Lowering the head of the bed will not arrest the progress or provide any further information. A tracheotomy tray would be useful if subcutaneous emphysema progresses to the neck. Subcutaneous emphysema may progress if the chest drainage system does not adequately remove air and fluid; therefore, the system should not be turned off.

 CN: Physiological adaptation;  
CL: Synthesize


**104. 1.** The recommended procedure for teaching clients postoperatively to deep breathe includes contracting (pulling in) the abdominal muscles and taking a slow, deep breath through the nose. This breath is held 3 to 5 seconds, which facilitates alveolar ventilation by improving the inspiratory phase of ventilation. Exhaling slowly as if trying to blow out a candle is a technique used in pursed-lip breathing to facilitate exhalation in clients with chronic obstructive pulmonary disease. It is recommended that the abdominal muscles be contracted, not relaxed, to promote deep breathing. The client should breathe through the nose.

 CN: Physiological adaptation;  
CL: Synthesize


**105. 3.** A client who has undergone chest surgery should be taught to raise the arm on the affected side over the head to help prevent shoulder ankylosis. This exercise helps restore normal shoulder movement, prevents stiffening of the shoulder joint, and improves muscle tone and power. Turning from side to side, raising and lowering the head, and flexing and extending the elbow on the affected side do not exercise the shoulder joint.

 CN: Basic care and comfort;  
CL: Synthesize


**106. 4.** The drainage apparatus is always kept *below* the client's chest level to prevent back flow of fluid into the pleural space. The air vent must always be open in the closed chest drainage system to allow air from the client to escape. Stripping a chest tube causes excessive negative intrapleural pressure and is not recommended. Clamping a chest tube when moving a client is not recommended.

 CN: Physiological adaptation;  
CL: Synthesize

**107. 1.** Cessation of fluid fluctuation in the tubing can mean one of several things: the lung has fully expanded and negative intrapleural pressure has been re-established; the chest tube is occluded; or the chest tube is not in the pleural space. Fluid fluctuation occurs because, during inspiration, intrapleural pressure exceeds the negative pressure generated in the water-seal system. Therefore, drainage moves toward the client. During expiration, the pleural pressure exceeds that generated in the water-seal system, and fluid moves away from the client. When the lung is collapsed or the chest tube is in the pleural space, fluid fluctuation is likely to be noted. The chest tube is not inserted in the mediastinal space.

 CN: Physiological adaptation;  
CL: Analyze

**108. 2.** There should never be constant bubbling in the water-seal bottle; normally the bubbling is intermittent. Constant bubbling in the water-seal bottle indicates an air leak, which means that less negative pressure is being exerted on the pleural space. Decreasing the suction or draining part of the water in the water-seal chamber will not reduce the leak.

 CN: Physiological adaptation;  
CL: Synthesize

**109. 1.** In this case, there may be some obstruction to the flow of air and fluid out of the pleural space, causing air and fluid to collect and build up pressure. This prevents the remaining lung from re-expanding and can cause a mediastinal shift to the opposite side. The nurse's first response is to assess the tubing for kinks or obstruction. Increasing the suction is not done without a physician's order. The normal position of the drainage bottles is 2 to 3 feet below chest level. Clamping the tubes obstructs the flow of air and fluid out of the pleural space and should not be done.

 CN: Physiological adaptation;  
CL: Synthesize

**110. 4.** To promote chest tube drainage the drainage system must be lower than the client's lungs. The amount of drainage is not abnormal; it is not necessary to notify the physician. The nurse should chart the amount and color of drainage every 4 to 8 hours. The chest tube does not need to be clamped;

the tubing connection is intact. There is sufficient water to maintain a water seal.


 CN: Physiological adaptation;  
CL: Synthesize

**111. 3.** A bottle of sterile water should be readily available and in view when a client has a chest tube so that the tube can be immediately submerged in the water if the chest tube system becomes disconnected. The chest tube should be reconnected to the water-seal system as soon as a sterile functioning system can be re-established. There is no need for a tracheostomy tray, another chest tube, or a spirometer to be placed at the bedside for emergency use.

 CN: Physiological adaptation; CL: Apply

### The Client with Chest Trauma

**112. 3.** Respiratory distress or arrest is a universal finding of a tension pneumothorax. Unilateral, diminished, or absent breath sounds is a common finding. Tracheal deviation is an inconsistent and late finding. Muffled heart sounds are suggestive of pericardial tamponade.

 CN: Physiological adaptation;  
CL: Analyze

**113. 0.7 mL**

$$\begin{aligned} 10 \text{ mg} : X \text{ mL} &= 15 \text{ mg} : 1 \text{ mL} \\ 15 \text{ mg} \times X \text{ mL} &= 10 \text{ mg} \times 1 \text{ mL} \\ 15X &= 10 \\ X &= 0.6667 \\ X &= 0.67 \text{ mL.} \end{aligned}$$


 CN: Pharmacological and parenteral therapies; CL: Apply

**114. 2.** Blunt chest trauma may lead to respiratory failure, and maintenance of adequate oxygenation is the priority for the client. Decreasing the client's anxiety is related to maintaining effective respirations and oxygenation. Although pain is distressing to the client and can increase anxiety and decrease respiratory effectiveness, pain control is secondary to maintaining oxygenation. Maintaining adequate circulatory volume is also secondary to maintaining adequate oxygenation.


 CN: Physiological adaptation;  
CL: Synthesize

**115. 3.** Fluctuation of fluid in the water-seal column with respirations indicates that the system is functioning properly. If an obstruction were present in the chest tube, fluid fluctuation would be absent. Subcutaneous emphysema occurs when air pockets can be palpated beneath the client's skin around

the chest tube insertion site. A leak in the system is indicated when continuous bubbling occurs in the water-seal column.

 CN: Physiological adaptation;  
CL: Analyze


**116. 2.** Continuous bubbling in the water-seal chamber indicates a leak in the system, and the client needs to be instructed to notify the physician if continuous bubbling occurs. A respiratory rate of more than 16 breaths/minute may not be unusual and does not necessarily mean that the client should notify the physician. Fluid in the chest tube is expected, as is fluctuation of the fluid in the water-seal chamber.

 CN: Physiological adaptation;  
CL: Synthesize


**117. 4.** Pneumothorax means that the lung has collapsed and is not functioning. The nurse will hear no sounds of air movement on auscultation. Movement of air through mucus produces crackles. Wheezing occurs when airways become obstructed. Dullness on percussion indicates increased density of lung tissue, usually caused by accumulation of fluid.

 CN: Physiological adaptation; CL: Evaluate


**118. 1.** If the client reports no pain, then the objective of adequate pain relief has been met. Decreased anxiety is not related only to pain control; it could also be related to other factors. A respiratory rate of 26 breaths/minute is not within normal limits. A PaO<sub>2</sub> of 70 mm Hg is not within normal limits.

 CN: Physiological adaptation;  
CL: Evaluate

**119. 2.** One unit of packed red blood cells is about 250 mL. If the blood is delivered at a rate of 60 mL/hour, it will take about 4 hours to infuse the entire unit. The transfusion of a single unit of packed red blood cells should not exceed 4 hours to prevent the growth of bacteria and minimize the risk of septicemia.


 CN: Pharmacological and parenteral therapies; CL: Apply

**120. 2.** Too-rapid infusion of blood, or any intravenous fluid, can cause fluid volume overload and related problems such as pulmonary edema. Emboli formation, red blood cell hemolysis, and allergic reaction are not related to rapid infusion.


 CN: Pharmacological and parenteral therapies; CL: Apply

**121. 4.** Immediately after chest tube removal, a petroleum gauze is placed over the wound and covered with a dry sterile dressing. This serves as an airtight seal to prevent air leakage or air movement


in either direction. Bandages are not applied directly over wounds. Montgomery straps are used in place of adhesive tape when a dressing requires very frequent changes and the constant removal of adhesive tape would damage the skin. Montgomery straps are not placed over open wounds. Mesh gauze would allow air movement.

 CN: Physiological adaptation;  
CL: Apply

**122.** 1. Pneumothorax signs and symptoms include sudden, sharp chest pain; tachypnea; and tachycardia. Other signs and symptoms include diminished or absent breath sounds over the affected lung, anxiety, and restlessness. Breath sounds are diminished or absent over the affected side. Hemoptysis and cyanosis are not typically present with a moderate pneumothorax.

 CN: Physiological adaptation;  
CL: Analyze

**123.** 4. A chest tube is inserted to re-expand the lung and remove air and fluid. Oxygen is not administered through a chest tube. Chest tubes are not inserted to promote scar tissue formation. Antibiotics are not used to treat a pneumothorax.

 CN: Basic care and comfort;  
CL: Evaluate


### The Client with Acute Respiratory Distress Syndrome

**124.** 3, 4, 5. The prone position is used to improve oxygenation, ventilation, and perfusion. The importance of placing clients with ARDS in prone positioning should be explained to the family. The positioning allows for mobilization of secretions and the nurse can provide suctioning. Clinical judgment must be used to determine the length of time in the prone position. If the client's hemodynamic status, oxygenation, or skin is compromised, the client should be returned to the supine position for evaluation. Facial edema is expected with the prone position, but the skin breakdown is of concern.

 CN: Physiological adaptation;  
CL: Synthesize

**125.** 4. Prone positioning is used to improve oxygenation in clients with acute respiratory distress syndrome (ARDS) who are receiving mechanical ventilation. The positioning allows for recruitment of collapsed alveolar units, improvement in ventilation, reduction in shunting, mobilization of secretions, and improvement in functional reserve capacity (FRC). When the client is supine, side-to-side repositioning should be done every


2 hours with the head of the bed elevated at least 30 degrees.

 CN: Physiological adaptation;  
CL: Synthesize


**126.** 1, 4, 5. Acute respiratory distress syndrome (ARDS) may cause renal failure and superinfection, so the nurse should monitor urine output and urine chemistries. Treatment of hypoxemia can be complicated because changes in lung tissue leave less pulmonary tissue available for gas exchange, thereby causing inadequate perfusion. Humidified oxygen may be one means of promoting oxygenation. The client has crackles in the lung bases, so the nurse should continue to assess breath sounds. Sedatives should be used with caution in clients with ARDS. The nurse should try other measures to relieve the client's restlessness and anxiety. The head of the bed should be elevated to 30 degrees to promote chest expansion and prevent atelectasis.

 CN: Management of care; CL: Create

**127.** 4. One of the major risk factors for development of ARDS is hypovolemic shock. Adequate fluid replacement is essential to minimize the risk of ARDS in these clients. Teaching smoking cessation does not prevent ARDS. An abnormal serum potassium level and hypercapnia are not risk factors for ARDS.

 CN: Physiological adaptation;  
CL: Synthesize

**128.** 2. A hallmark of early ARDS is refractory hypoxemia. The client's PaO<sub>2</sub> level continues to fall, despite higher concentrations of administered oxygen. Elevated carbon dioxide and metabolic acidosis occur late in the disorder. Severe electrolyte imbalances are not indicators of ARDS.

 CN: Physiological adaptation;  
CL: Analyze


**129.** 2. The normal range for partial pressure of arterial carbon dioxide (PaCO<sub>2</sub>) is 35 to 45 mm Hg. Thus, this client's PaCO<sub>2</sub> level is low. The client is experiencing respiratory alkalosis (carbonic acid deficit) due to hyperventilation. The nurse should report this finding to the physician because it requires intervention. The increase in ventilation decreases the PaCO<sub>2</sub> level, which leads to decreased carbonic acid and alkalosis. The bicarbonate level is normal in uncompensated respiratory alkalosis along with the normal PaO<sub>2</sub> level. Normal serum pH is 7.35 to 7.45; in uncompensated respiratory alkalosis, the serum pH is greater than 7.45.

 CN: Reduction of risk potential;  
CL: Analyze


**130.** 1. The client may be fighting the ventilator breaths. Sedation is indicated to improve




compliance with the ventilator in an attempt to lower peak inspiratory pressures. The workload of breathing does indicate the need for increased protein calories; however, this will not correct the respiratory problems with high pressures and respiratory rate. There is no indication that the client is experiencing pain. Increasing the rate on the ventilator is not indicated with the client's increased spontaneous rate.

 CN: Physiological adaptation;  
CL: Synthesize

**131. 1.** Normal PaO<sub>2</sub> level ranges from 80 to 100 mm Hg. When the PaO<sub>2</sub> value falls to 50 mm Hg, the nurse should be alert for signs of hypoxia and impending respiratory failure. An oxygen level this low poses a severe risk for respiratory failure. The PaO<sub>2</sub> is not within normal range. The client will require oxygenation at a concentration that maintains the PaO<sub>2</sub> at 55 to 60 mm Hg or more.

 CN: Physiological adaptation;  
CL: Analyze

**132. 4.** A PaCO<sub>2</sub> of 28 mm Hg and PaO<sub>2</sub> of 50 mm Hg are both abnormal; the PaO<sub>2</sub> of 50 mm Hg signifies acute respiratory failure. In evaluating possible causes for this disorder, the nurse should consider conditions that lead to hypoxia and hyperventilation, such as pulmonary embolus. COPD is typically associated with respiratory acidosis and elevated PaCO<sub>2</sub>. The client with diabetic ketoacidosis most often has metabolic acidosis. A myocardial infarction does not often cause an acid-base imbalance because the primary problem is cardiac in origin.

 CN: Physiological adaptation;  
CL: Analyze


**133. 3.** Endotracheal intubation and mechanical ventilation are required in ARDS to maintain adequate respiratory support. Endotracheal intubation, not a tracheostomy, is usually the initial method of maintaining an airway. The client requires mechanical ventilation; nasal oxygen will not provide adequate oxygenation. Chest tubes are used to remove air or fluid from intrapleural spaces.

 CN: Physiological adaptation; CL: Apply


**134. 1.** The two risk factors most commonly associated with the development of ARDS are gram-negative septic shock and gastric content aspiration. Nurses should be particularly vigilant in assessing a client for onset of ARDS if the client has experienced direct lung trauma or a systemic inflammatory response syndrome (which can be caused by any physiologic insult that leads to widespread inflammation). Chronic obstructive pulmonary disease, asthma, and heart failure are not direct causes of ARDS.

 CN: Reduction of risk potential;  
CL: Apply


**135. 4.** Auscultation for bilateral breath sounds is the most appropriate method for determining cuff placement. The nurse should also look for the symmetrical rise and fall of the chest and should note the location of the exit mark on the tube. Assessments of skin color, respiratory rate, and the amount of cuff inflation cannot validate the placement of the endotracheal tube.

 CN: Basic care and comfort;  
CL: Evaluate


**136. 4.** The nurse should suction the client if the client is not able to cough up secretions and clear the airway. Administering oxygen will not promote airway clearance. The client should be turned every 2 hours to help move secretions; every 4 hours is not often enough. Administering sedatives is contraindicated in acute respiratory distress because sedatives can depress respirations.

 CN: Physiological adaptation;  
CL: Synthesize

**137. 1.** Gastrointestinal hemorrhage occurs in about 25% of clients receiving prolonged mechanical ventilation because of the development of stress ulcers. Clients who are receiving steroid therapy and those with a previous history of ulcers are most likely to be at risk. Other possible complications include incorrect ventilation, oxygen toxicity, fluid imbalance, decreased cardiac output, pneumothorax, infection, and atelectasis.


 CN: Physiological adaptation;  
CL: Analyze

**138. 3.** Carbon monoxide poisoning develops when carbon monoxide combines with hemoglobin. Because carbon monoxide combines more readily with hemoglobin than oxygen does, tissue anoxia results. The nurse should administer 100% oxygen by mask to reduce the half-life of carboxyhemoglobin. Gastric lavage is used for ingested poisons. With tissue anoxia, metabolism is diminished, with a subsequent lowering of the body's temperature, thus steps to increase body temperature would be required. Unless the carbon monoxide poisoning is intentional, a psychiatric referral would be inappropriate.


 CN: Physiological adaptation;  
CL: Synthesize

**139. 4.** Confusion and vertigo are risk factors for falls. Measures must be taken to minimize the risk of injury. The nurse or unlicensed personnel should check on the client regularly to determine needs regarding elimination. Restraints, including bed rails and extremity restraints, should be used only to ensure the person's safety or the safety of others, and there must be a written order from a physician

before using them. The nurse should never ask the roommate of a client to be responsible for the client's safety.


 CN: Safety and infection control;  
CL: Synthesize

**140. 1.** In the normal lung, the volume of blood perfusing the lungs each minute is approximately equal to the amount of fresh gas that reaches the alveoli each minute. Blood gas analysis evaluates respiratory function; the level of dissolved oxygen (PaO<sub>2</sub>) should be greater than the level of dissolved carbon dioxide (PaCO<sub>2</sub>).

 CN: Physiological adaptation;  
CL: Evaluate

### Managing Care Quality and Safety

**141. 4.** Airborne precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g. mycobacterium tuberculosis, measles, varicella virus [chickenpox], and possibly SARS-CoV). The preferred placement is in an isolation single-client room that is equipped with special air handling and ventilation. A negative pressure room, or an area that exhausts room air directly outside or through HEPA filters, should be used if recirculation is unavoidable. Standard precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that the blood, body fluids, secretions, and excretions of all clients may contain transmissible infectious agents. Standard precautions include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Contact precautions are for clients with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission. Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a health care facility, special air handling and ventilation are not required to prevent droplet transmission.

 CN: Safety and infection control;  
CL: Synthesize

**142. 2, 3, 4, 5.** One of the “five rights” of drug administration is “right medication.” Kefzol was not the medication ordered. The pharmacist is the professional resource and serves as a check to ensure that clients receive the right medication. Return-

ing unwanted medications to the pharmacy will decrease the opportunity for a medication error by the nurse who follows the current nurse.

 CN: Safety and infection control;  
CL: Synthesize

**143.**

1. A client with an endotracheal tube transferred out of the intensive care unit that day.

3. A client with cellulitis of the left lower extremity with a fever of 100.8°F (38.2°C).

4. A client receiving D5W I.V. at 125 mL/hour with 75 mL remaining.

2. A client with type 2 diabetes who had a cerebrovascular accident 4 days ago.

Because two major complications of endotracheal tube intubation, inadvertent extubation and aspiration, can be catastrophic events, assessment of this client is the first priority. Cellulitis is a serious infection as there is inflammation of subcutaneous tissues; third spacing of fluid may promote the formation of a fluid volume deficit, which can be exacerbated by the fever due to insensible fluid loss. The nurse should assess this client next to determine current vital signs and fluid status. The nurse should assess the client with the I.V. fluids next because the new bag of fluids will need to be hung in 30 to 40 minutes. I.V. therapy necessitates that the client be assessed for signs and symptoms of adequate hydration (moist mucous membranes, elastic skin turgor, vital signs within normal limits, adequate urine output, and level of consciousness within normal limits), and the I.V. access site needs to be assessed. From the information provided, there is no indication that the client who had the cerebrovascular accident is unstable. Thus, this client is the last priority for assessment.

 CN: Management of care;  
CL: Synthesize

**144. 3.** Individuals who are household members or home care providers for high-risk individuals are high-priority targeted groups for immunization against influenza to prevent transmission to those who have a decreased capacity to deal with the disease. The wife who is caring for a husband with cancer has the highest priority of the clients described because her husband is likely to be immunocompromised and particularly susceptible to the flu. A healthy 60-year-old man or a healthy 36-year-old woman is not in a high-priority category

for influenza vaccination. A 60-year-old woman with osteoarthritis does not have a higher priority for influenza vaccination than a home care provider.

 CN: Reduction of risk potential;  
CL: Analyze

**145. 1, 2, 3.** The process of changing a health care system from an acute care model to a Chronic Care Model (CCM) uses continuous quality improvement (CQI) methods. The goal of the CCM is to improve the health of chronically ill clients. The CCM

identifies six basic areas upon which health care organizations need to focus to improve quality of care and delivery: health systems, delivery system design, decision support, clinical information systems, self-management support, and the community. This system requires health care services that are client-centered and coordinated among members of the health care staff and the client and family. CCM does not focus on the administrative leadership or the care in the acute care setting alone.

 CN: Management of care; CL: Synthesize

**TEST**  
**5**

# The Client with Upper Gastrointestinal Tract Health Problems

- The Client with Disorders of the Oral Cavity
- The Client with Peptic Ulcer Disease
- The Client with Cancer of the Stomach
- The Client with Gastroesophageal Reflux Disease
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Disorders of the Oral Cavity

1. The nurse is teaching a group of teenage boys who are on a baseball team about the risks of chewing tobacco. Which of the following should the nurse instruct the teenagers to report to their parents and physicians? Select all that apply.

- 1. Dysphagia.
- 2. Sensitive teeth.
- 3. Unexplained mouth pain.
- 4. Lump in the neck.
- 5. Decreased saliva.
- 6. White patch on the mucosa.

2. A nurse is caring for a client who has just returned from surgery to treat a fractured mandible. Which of the following items should always be available at this client's bedside? Select all that apply.

- 1. Nasogastric tube.
- 2. Wire cutters.
- 3. Oxygen cannula.
- 4. Suction equipment.
- 5. Code cart.

3. Which of the following interventions is **most** appropriate for a client who has stomatitis?

- 1. Drinking hot tea at frequent intervals.
- 2. Gargling with antiseptic mouthwash.
- 3. Using an electric toothbrush.
- 4. Eating a soft, bland diet.

4. A client who has a history of a mitral valve prolapse tells the nurse that she is scheduled to get her teeth cleaned. Which of the following replies by the nurse is **most** appropriate?

- 1. "The physician will need to reevaluate the status of your heart condition before your dental appointment."
- 2. "Be sure to remind your dentist that you have a heart condition."
- 3. "It is important for you to care for your teeth because your heart condition makes you more susceptible to developing oral infections."
- 4. "We will prescribe a prophylactic antibiotic for you to take before getting your teeth cleaned."

5. Amoxicillin trihydrate (Amoxil) 300 mg P.O. has been prescribed for a client with an oral infection. The medication is available in a liquid suspension that is available as 250 mg/5 mL. How many milliliters would the nurse administer?

\_\_\_\_\_ mL.

6. During the assessment of a client's mouth, the nurse notes the absence of saliva. The client has pain in the area of the ear. The client has been nothing-by-mouth (NPO) for several days because of the insertion of a nasogastric tube. Based on these findings, the nurse suspects that the client may be developing which of the following mouth conditions?

- 1. Stomatitis.
- 2. Oral candidiasis.
- 3. Parotitis.
- 4. Gingivitis.

7. The nurse is preparing a community presentation on oral cancer. Which of the following is a **primary** risk factor for oral cancer that the nurse should include in the presentation?

- 1. Use of alcohol.
- 2. Frequent use of mouthwash.
- 3. Lack of vitamin B<sub>12</sub>.
- 4. Lack of regular teeth cleaning by a dentist.

8. A client has entered a smoking cessation program to quit a two-pack-a-day cigarette habit. He tells the nurse that he has not smoked a cigarette for 3 weeks, but is afraid he is going to “slip up” and smoke because of current job pressures. What would be the **most** appropriate reply for the nurse to make in response to the client’s comments?

- 1. “Don’t worry about it. Everybody has difficulty quitting smoking, and you should expect to as well.”
- 2. “If you increase your self-control, I am sure you will be able to avoid smoking.”
- 3. “Try taking a couple of days of vacation to relieve the stress of your job.”
- 4. “It is good that you can talk about your concerns. Try calling a friend when you want to smoke.”

9. A client who was in a motor vehicle accident has a fractured mandible. Surgery has been performed to immobilize the injury by wiring the jaw. In the immediate postoperative phase, the nurse should:

- 1. Prevent nausea and vomiting.
- 2. Maintain a patent airway.
- 3. Provide frequent oral hygiene.
- 4. Establish a way for the client to communicate.

10. A client has returned from surgery during which her jaws were wired as treatment for a fractured mandible. The client is in stable condition. The nurse is instructing the unlicensed nursing personnel (UAP) on how to properly position the client. Which instructions about positioning would be appropriate for the nurse to give the UAP?

- 1. Keep the client in a side-lying position with the head slightly elevated.
- 2. Do not reposition the client without the assistance of a registered nurse.
- 3. The client can assume any position that is comfortable.
- 4. Keep the client’s head elevated on two pillows at all times.

11. A client who has had her jaws wired begins to vomit. What should be the nurse’s **first** action?

- 1. Insert a nasogastric (NG) tube and connect it to suction.
- 2. Use wire cutters to cut the wire.
- 3. Suction the client’s airway as needed.
- 4. Administer an antiemetic intravenously.

## The Client with Peptic Ulcer Disease

12. A nurse teaches a client experiencing heartburn to take 1½ oz of Maalox when symptoms appear. How many milliliters should the client take?

\_\_\_\_\_ mL.

13. The nurse has been assigned to provide care for four clients at the beginning of the day shift. In what order should the nurse assess these clients?

1. A client awaiting surgery for a hiatal hernia repair at 11 a.m.

2. A client with suspected gastric cancer who is on nothing-by-mouth (NPO) status for tests.

3. A client with peptic ulcer disease experiencing a sudden onset of acute stomach pain.

4. A client who is requesting pain medication 2 days after surgery to repair a fractured jaw.

14. The nurse is caring for a client who has just had an upper GI endoscopy. The client’s vital signs must be taken every 30 minutes for 2 hours after the procedure. The nurse assigns an unlicensed nursing personnel (UAP) to take the vital signs. One hour later, the UAP reports the client, who was previously afebrile, has developed a temperature of 101.8° F (38.8° C). What should the nurse do in response to this reported assessment data?

- 1. Promptly assess the client for potential perforation.
- 2. Tell the assistant to change thermometers and retake the temperature.
- 3. Plan to give the client acetaminophen (Tylenol) to lower the temperature.
- 4. Ask the assistant to bathe the client with tepid water.

**15.** A client is admitted to the hospital after vomiting bright red blood and is diagnosed with a bleeding duodenal ulcer. The client develops a sudden, sharp pain in the midepigastic region along with a rigid, boardlike abdomen. These clinical manifestations most likely indicate which of the following?

- 1. An intestinal obstruction has developed.
- 2. Additional ulcers have developed.
- 3. The esophagus has become inflamed.
- 4. The ulcer has perforated.

**16.** When obtaining a nursing history on a client with a suspected gastric ulcer, which signs and symptoms should the nurse expect to assess? Select all that apply.

- 1. Epigastric pain at night.
- 2. Relief of epigastric pain after eating.
- 3. Vomiting.
- 4. Weight loss.
- 5. Melena.

**17.** The nurse is caring for a client who has had a gastroscopy. Which of the following signs and symptoms may indicate that the client is developing a complication related to the procedure? Select all that apply.

- 1. The client has a sore throat.
- 2. The client has a temperature of 100° F (37.8° C).
- 3. The client appears drowsy following the procedure.
- 4. The client has epigastric pain.
- 5. The client experiences hematemesis.

**18.** A client with peptic ulcer disease tells the nurse that he has black stools, which he has not reported to his physician. Based on this information, which nursing diagnosis would be appropriate for this client?

- 1. *Ineffective coping* related to fear of diagnosis of chronic illness.
- 2. *Deficient knowledge* related to unfamiliarity with significant signs and symptoms.
- 3. *Constipation* related to decreased gastric motility.
- 4. *Imbalanced nutrition: Less than body requirements* related to gastric bleeding.

**19.** A client with peptic ulcer disease is taking ranitidine (Zantac). What is the expected outcome of this drug?

- 1. Heal the ulcer.
- 2. Protect the ulcer surface from acids.
- 3. Reduce acid concentration.
- 4. Limit gastric acid secretion.

**20.** A client with a peptic ulcer reports epigastric pain that frequently awakens her during the night. The nurse should instruct the client to do which activities? Select all that apply.

- 1. Obtain adequate rest to reduce stimulation.
- 2. Eat small, frequent meals throughout the day.
- 3. Take all medications on time as ordered.
- 4. Sit up for one hour when awakened at night.
- 5. Stay away from crowded areas.

**21.** A client with peptic ulcer disease reports that he has been nauseated most of the day and is now feeling light-headed and dizzy. Based upon these findings, which nursing actions would be most appropriate for the nurse to take? Select all that apply.

- 1. Administering an antacid hourly until nausea subsides.
- 2. Monitoring the client's vital signs.
- 3. Notifying the physician of the client's symptoms.
- 4. Initiating oxygen therapy.
- 5. Reassessing the client in an hour.

**22.** The nurse is preparing to teach a client with a peptic ulcer about the diet that should be followed after discharge. The nurse should explain that the diet will most likely consist of which of the following?

- 1. Bland foods.
- 2. High-protein foods.
- 3. Any foods that are tolerated.
- 4. Large amounts of milk.

**23.** The nurse finds a client who has been diagnosed with a peptic ulcer surrounded by papers from his briefcase and arguing on the telephone with a coworker. The nurse's response to observing these actions should be based on knowledge that:

- 1. Involvement with his job will keep the client from becoming bored.
- 2. A relaxed environment will promote ulcer healing.
- 3. Not keeping up with his job will increase the client's stress level.
- 4. Setting limits on the client's behavior is an important nursing responsibility.

**24.** A client with a peptic ulcer has been instructed to avoid intense physical activity and stress. Which strategy should the client incorporate into the home care plan?

- 1. Conduct physical activity in the morning so that he can rest in the afternoon.
- 2. Have the family agree to perform the necessary yard work at home.
- 3. Give up jogging and substitute a less demanding hobby.
- 4. Incorporate periods of physical and mental rest in his daily schedule.

**25.** A client is to take one daily dose of ranitidine (Zantac) at home to treat her peptic ulcer. The client understands proper drug administration of ranitidine when she says that she will take the drug at which of the following times?

- 1. Before meals.
- 2. With meals.
- 3. At bedtime.
- 4. When pain occurs.

**26.** A client has been taking aluminum hydroxide (Amphojel) 30 mL six times per day at home to treat his peptic ulcer. He tells the nurse that he has been unable to have a bowel movement for 3 days. Based on this information, the nurse would determine that which of the following is the **most** likely cause of the client's constipation?

- 1. The client has not been including enough fiber in his diet.
- 2. The client needs to increase his daily exercise.
- 3. The client is experiencing an adverse effect of the aluminum hydroxide.
- 4. The client has developed a gastrointestinal obstruction.

**27.** A client is taking an antacid for treatment of a peptic ulcer. Which of the following statements best indicates that the client understands how to correctly take the antacid?

- 1. "I should take my antacid before I take my other medications."
- 2. "I need to decrease my intake of fluids so that I don't dilute the effects of my antacid."
- 3. "My antacid will be most effective if I take it whenever I experience stomach pains."
- 4. "It is best for me to take my antacid 1 to 3 hours after meals."

**28.** Which of the following would be an expected outcome for a client with peptic ulcer disease? The client will:

- 1. Demonstrate appropriate use of analgesics to control pain.
- 2. Explain the rationale for eliminating alcohol from the diet.
- 3. Verbalize the importance of monitoring hemoglobin and hematocrit every 3 months.
- 4. Eliminate contact sports from his or her lifestyle.

### The Client with Cancer of the Stomach

**29.** A nurse is admitting a client who has been admitted with a diagnosis of upper GI bleeding to the hospital. The nurse should assess the client for which of the following? Select all that apply.

- 1. Dry, flushed skin.
- 2. Decreased urine output.
- 3. Tachycardia.
- 4. Widening pulse pressure.
- 5. Rapid respirations.
- 6. Thirst.

**30.** A client with suspected gastric cancer undergoes an endoscopy of the stomach. Which of the following assessments made after the procedure would indicate the development of a potential complication?

- 1. The client complains of a sore throat.
- 2. The client displays signs of sedation.
- 3. The client experiences a sudden increase in temperature.
- 4. The client demonstrates a lack of appetite.

**31.** A client has been diagnosed with adenocarcinoma of the stomach and is scheduled to undergo a subtotal gastrectomy (Billroth II procedure). During preoperative teaching, the nurse is reinforcing information about the surgical procedure. Which of the following explanations is **most** accurate?

- 1. The procedure will result in enlargement of the pyloric sphincter.
- 2. The procedure will result in anastomosis of the gastric stump to the jejunum.
- 3. The procedure will result in removal of the duodenum.
- 4. The procedure will result in repositioning of the vagus nerve.

**32.** The client tells the nurse that since his diagnosis of stomach cancer, he has been having trouble sleeping and is frequently preoccupied with thoughts about how his life will change. He says, "I wish my life could stay the same." Based on this information, which one of the following nursing diagnoses would be appropriate at this time?

- 1. *Ineffective coping* related to the diagnosis of cancer.
- 2. *Insomnia* related to fear of the unknown.
- 3. *Grieving* related to the diagnosis of cancer.
- 4. *Anxiety* related to the need for gastric surgery.

**33.** After a subtotal gastrectomy, the nasogastric tube drainage will be what color for about 12 to 24 hours after surgery?

- 1. Dark brown.
- 2. Bile green.
- 3. Bright red.
- 4. Cloudy white.

**34.** After a subtotal gastrectomy, care of the client's nasogastric (NG) tube and drainage system should include which of the following nursing interventions?

- 1. Irrigate the tube with 30 mL of sterile water every hour, if needed.
- 2. Reposition the tube if it is not draining well.
- 3. Monitor the client for nausea, vomiting, and abdominal distention.
- 4. Turn the machine to high suction if the drainage is sluggish on low suction.

**35.** A client who is recovering from gastric surgery is receiving I.V. fluids to be infused at 100 mL/hour. The I.V. tubing delivers 15 gtt/mL. The nurse should infuse the solution at a flow rate of how many drops per minute to ensure that the client receives 100 mL/hour?

\_\_\_\_\_ gtt/minute.

**36.** Following a gastrectomy, the nurse should position the client in which of the following positions?

- 1. Prone.
- 2. Supine.
- 3. Low Fowler's.
- 4. Right or left Sims.

**37.** As part of the client's discharge planning after a subtotal gastrectomy, the nurse has identified *Imbalanced nutrition: Less than body requirements* as a major nursing diagnosis. To help the client meet nutritional goals at home, the nurse should develop a plan of care that includes which of the following interventions?

- 1. Instruct the client to increase the amount eaten at each meal.
- 2. Encourage the client to eat smaller amounts more frequently.
- 3. Explain that if vomiting occurs after a meal, nothing more should be eaten that day.
- 4. Inform the client that bland foods are typically less nutritional and should be used minimally.

**38.** As a result of a gastric resection, the client is at risk for development of dumping syndrome. The nurse should prepare a plan of care for this client based on knowledge that this problem stems **primarily** from which of the following gastrointestinal changes?

- 1. Excess secretion of digestive enzymes in the intestines.
- 2. Rapid emptying of stomach contents into the small intestine.
- 3. Excess glycogen production by the liver.
- 4. Loss of gastric enzymes.

**39.** To reduce the risk of dumping syndrome, the nurse should teach the client to do which of the following?

- 1. Sit upright for 30 minutes after meals.
- 2. Drink liquids with meals, avoiding caffeine.
- 3. Avoid milk and other dairy products.
- 4. Decrease the carbohydrate content of meals.

**40.** A client who is recovering from a subtotal gastrectomy experiences dumping syndrome. The client asks the nurse, "When will I be able to eat three meals a day again like I used to?" Which of the following responses by the nurse is **most** appropriate?

- 1. "Eating six meals a day is time-consuming, isn't it?"
- 2. "You will have to eat six small meals a day for the rest of your life."
- 3. "You will be able to tolerate three meals a day before you are discharged."
- 4. "Most clients can resume their normal meal patterns in about 6 to 12 months."

**41.** What should the nurse teach a client about how to avoid the dumping syndrome? Select all that apply.

- 1. Consume three regularly-spaced meals per day.
- 2. Eat a diet with high carbohydrate foods with each meal.
- 3. Reduce fluids with meals, but take them between meals.
- 4. Obtain adequate amounts of protein and fat in each meal.
- 5. Eat in a relaxing environment.

**42.** After surgery for gastric cancer, a client is scheduled to undergo radiation therapy. It will be **most** important for the nurse to include information about which of the following in the client's teaching plan?

- 1. Nutritional intake.
- 2. Management of alopecia.
- 3. Exercise and activity levels.
- 4. Access to community resources.

**43.** One month following a subtotal gastrectomy for cancer, the nurse is evaluating the nursing care goal related to nutrition. Which of the following indicates that the client has attained the goal? The client has:

- 1. Regained weight loss.
- 2. Resumed normal dietary intake of three meals a day.
- 3. Controlled nausea and vomiting through regular use of antiemetics.
- 4. Achieved optimal nutritional status through oral or parenteral feedings.



## The Client with Gastroesophageal Reflux Disease

**44.** Which of the following instructions should the nurse include in the teaching plan for a client who is experiencing gastroesophageal reflux disease (GERD)?

- 1. Limit caffeine intake to two cups of coffee per day.
- 2. Do not lie down for 2 hours after eating.
- 3. Follow a low-protein diet.
- 4. Take medications with milk to decrease irritation.

**45.** The client is scheduled to have an upper gastrointestinal tract series of x-rays. Following the x-rays, the nurse should instruct the client to:

- 1. Take a laxative.
- 2. Follow a clear liquid diet.
- 3. Administer an enema.
- 4. Take an antiemetic.

**46.** A client who has been diagnosed with gastroesophageal reflux disease (GERD) complains of heartburn. To decrease the heartburn, the nurse should instruct the client to eliminate which of the following items from the diet?

- 1. Lean beef.
- 2. Air-popped popcorn.
- 3. Hot chocolate.
- 4. Raw vegetables.

**47.** The client with gastroesophageal reflux disease (GERD) complains of a chronic cough. The nurse understands that in a client with GERD this symptom may be indicative of which of the following conditions?

- 1. Development of laryngeal cancer.
- 2. Irritation of the esophagus.
- 3. Esophageal scar tissue formation.
- 4. Aspiration of gastric contents.

**48.** Bethanechol (Urecholine) has been ordered for a client with gastroesophageal reflux disease (GERD). The nurse should assess the client for which of the following adverse effects?

- 1. Constipation.
- 2. Urinary urgency.
- 3. Hypertension.
- 4. Dry oral mucosa.

**49.** The client attends two sessions with the dietitian to learn about diet modifications to minimize gastroesophageal reflux. The teaching would be considered successful if the client says that she will decrease her intake of which of the following foods?

- 1. Fats.
- 2. High-sodium foods.
- 3. Carbohydrates.
- 4. High-calcium foods.

**50.** Which of the following dietary measures would be useful in preventing esophageal reflux?

- 1. Eating small, frequent meals.
- 2. Increasing fluid intake.
- 3. Avoiding air swallowing with meals.
- 4. Adding a bedtime snack to the dietary plan.

**51.** The nurse is obtaining a health history from a client who has a sliding hiatal hernia associated with reflux. The nurse should ask the client about the presence of which of the following symptoms?

- 1. Heartburn.
- 2. Jaundice.
- 3. Anorexia.
- 4. Stomatitis.

**52.** Which of the following factors would **most** likely contribute to the development of a client's hiatal hernia?

- 1. Having a sedentary desk job.
- 2. Being 5 feet, 3 inches tall and weighing 190 lb.
- 3. Using laxatives frequently.
- 4. Being 40 years old.

**53.** Which of the following nursing interventions would **most** likely promote self-care behaviors in the client with a hiatal hernia?

- 1. Introduce the client to other people who are successfully managing their care.
- 2. Include the client's daughter in the teaching so that she can help implement the plan.
- 3. Ask the client to identify other situations in which he demonstrated responsibility for himself.
- 4. Reassure the client that he will be able to implement all aspects of the plan successfully.

**54.** The client has been taking magnesium hydroxide (milk of magnesia) at home in an attempt to control hiatal hernia symptoms. The nurse should assess the client for which of the following conditions most commonly associated with the ongoing use of magnesium-based antacids?

- 1. Anorexia.
- 2. Weight gain.
- 3. Diarrhea.
- 4. Constipation.

**55.** Which of the following lifestyle modifications should the nurse encourage the client with a hiatal hernia to include in activities of daily living?

- 1. Daily aerobic exercise.
- 2. Eliminating smoking and alcohol use.
- 3. Balancing activity and rest.
- 4. Avoiding high-stress situations.

**56.** In developing a teaching plan for the client with a hiatal hernia, the nurse's assessment of which work-related factors would be **most** useful?

- 1. Number and length of breaks.
- 2. Body mechanics used in lifting.
- 3. Temperature in the work area.
- 4. Cleaning solvents used.

**57.** The nurse instructs the client on health maintenance activities to help control symptoms from her hiatal hernia. Which of the following statements would indicate that the client has understood the instructions?

- 1. "I'll avoid lying down after a meal."
- 2. "I can still enjoy my potato chips and cola at bedtime."
- 3. "I wish I didn't have to give up swimming."
- 4. "If I wear a girdle, I'll have more support for my stomach."

**58.** The physician prescribes metoclopramide hydrochloride (Reglan) for the client with hiatal hernia. The nurse plans to instruct the client that this drug is used in hiatal hernia therapy to accomplish which of the following objectives?

- 1. Increase tone of the esophageal sphincter.
- 2. Neutralize gastric secretions.
- 3. Delay gastric emptying.
- 4. Reduce secretion of digestive juices.

**59.** The nurse should instruct the client to avoid which of the following drugs while taking metoclopramide hydrochloride (Reglan)?

- 1. Antacids.
- 2. Antihypertensives.
- 3. Anticoagulants.
- 4. Alcohol.

**60.** Cimetidine (Tagamet) may also be used to treat hiatal hernia. The nurse should understand that this drug is used to prevent which of the following?

- 1. Esophageal reflux.
- 2. Dysphagia.
- 3. Esophagitis.
- 4. Ulcer formation.

**61.** The client asks the nurse whether he will need surgery to correct his hiatal hernia. Which reply by the nurse would be **most** accurate?

- 1. "Surgery is usually required, although medical treatment is attempted first."
- 2. "Hiatal hernia symptoms can usually be successfully managed with diet modifications, medications, and lifestyle changes."
- 3. "Surgery is not performed for this type of hernia."
- 4. "A minor surgical procedure to reduce the size of the diaphragmatic opening will probably be planned."

## Managing Care Quality and Safety

**62.** Which of the following hospitalized clients is at risk to develop parotitis?

- 1. A 50-year-old client with nausea and vomiting who is on nothing-by-mouth status.
- 2. A 75-year-old client with diabetes who has ill-fitting dentures.
- 3. An 80-year-old client who has poor oral hygiene and is dehydrated.
- 4. A 65-year-old client with lung cancer who has a feeding tube in place.

**63.** The nurse instructs the unlicensed nursing personnel (UAP) on how to provide oral hygiene for a client who cannot perform this task for himself. Which of the following techniques should the nurse tell the UAP to incorporate into the client's daily care?

- 1. Assess the oral cavity each time mouth care is given and record observations.
- 2. Use a soft toothbrush to brush the client's teeth after each meal.
- 3. Swab the client's tongue, gums, and lips with a soft foam applicator every 2 hours.
- 4. Rinse the client's mouth with mouthwash several times a day.

**64.** The nurse is developing standards of care for a client with gastroesophageal reflux disease and wants to review current evidence for practice. Which one of the following resources will provide the **most** helpful information?

- 1. A review in the Cochrane Library.
- 2. A literature search in a database, such as the Cumulative Index to Nursing and Allied Health Literature (CINHAL).
- 3. An online nursing textbook.
- 4. The online policy and procedure manual at the health care agency.

**65.** The nurse in the intensive care unit is giving a report to the nurse in the post surgical unit about a client who had a gastrectomy. The most effective way to assure essential information about the client is reported is to?

- 1. Give the report face-to face with both nurses in a quiet room.
- 2. Audiotape the report for future reference and documentation.
- 3. Use a printed checklist with information individualized for the client.
- 4. Document essential transfer information in the client's electronic health record.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Disorders of the Oral Cavity

**1. 1, 3, 4, 6.** Chewing tobacco has become a more common practice among teenagers. It is important that they understand that this increases their risk for oral cancer. They should be instructed to inspect their mouth frequently and report any observed lesions or other changes in the oral mucosa. Signs and symptoms that are potential indicators of oral cancer are dysphagia, unexplained mouth pain, a lump in the neck, and white patches on the mucosa (leukoplakia). Other indications may be a painless mouth ulcer, a reddened patch (erythroplasia), and rough patches on the mucosa. Sensitive teeth and decreased saliva are not associated with oral cancer.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**2. 2, 4.** Following surgery for a fractured mandible, the client's jaws will be wired. The nurse should be prepared to intervene quickly in case the client develops respiratory distress or begins to choke or vomit. Wire cutters or scissors should always be available in case the wires need to be cut in a medical emergency. Suction equipment should be available to help clear the client's airway if necessary. It is not necessary to keep a nasogastric tube or oxygen cannula at the client's bedside. Cardio-pulmonary arrest is unlikely, so a code cart is not needed at the bedside.

🔑 CN: Safety and infection control;  
CL: Apply

**3. 4.** Clients with stomatitis (inflammation of the mouth) have significant discomfort, which impacts their ability to eat and drink. They will be most comfortable eating soft, bland foods, and avoiding temperature extremes in their food and liquids. Gargling with an antiseptic mouthwash will be irritating to the mucosa. Mouth care should include gentle brushing with a soft toothbrush and flossing.

🔑 CN: Basic care and comfort;  
CL: Synthesize

**4. 4.** Clients who are at risk for developing infective endocarditis due to cardiac conditions such as mitral valve prolapse must take prophylactic antibiotics before any dental procedure that may cause bleeding. The client is not more susceptible to developing oral infections. Rather, the client is more susceptible to developing endocarditis that results from oral bacteria that enter the circulation during the dental procedure. The physician does not necessarily need to re-evaluate the heart condition of a client who is stable, but antibiotics must be prescribed. It is not enough to simply remind the dentist about the heart condition.

🔑 CN: Reduction of risk potential;  
CL: Synthesize

**5. 6 mL.** To administer 300 mg P.O., the nurse will need to administer 6 mL. The following formula is used to calculate the correct dosage:

$$300 \text{ mg}/X \text{ mL} = 250 \text{ mg}/5 \text{ mL}$$

🔑 CN: Pharmacological and parenteral therapies; CL: Apply

**6. 3.** The lack of saliva, pain near the area of the ear, and the prolonged NPO status of the client should lead the nurse to suspect the development of parotitis, or inflammation of the parotid gland. Parotitis usually develops in cases of dehydration combined with poor oral hygiene or when clients have been NPO for an extended period. Preventive measures include the use of sugarless hard candy or gum to stimulate saliva production, adequate hydration, and frequent mouth care. Stomatitis (inflammation of the mouth) produces excessive salivation and a sore mouth. Oral candidiasis (thrush) causes bluish white mouth lesions. Gingivitis can be recognized by the inflamed gingiva and bleeding that occur during toothbrushing.


🔑 CN: Basic care and comfort; CL: Analyze

**7. 1.** Chronic and excessive use of alcohol can lead to oral cancer. Smoking and use of smokeless tobacco are other significant risk factors. Additional risk factors include chronic irritation such as a broken tooth or ill-fitting dentures, poor dental hygiene, overexposure to sun (lip cancer), and syphilis. Use of mouthwash, lack of vitamin B<sub>12</sub>, and lack of regular teeth cleaning appointments have not been implicated as primary risk factors for oral cancer.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**8. 4.** It is important for individuals who are engaged in smoking cessation efforts to feel comfortable with sharing their fears of failure with others and seeking support. Although fewer than 5% of smokers successfully quit on their first attempt, it is not helpful to tell a client that he should anticipate

failure. Telling the client to exercise more self-control does not provide him with support. Taking a vacation to avoid job pressures does not address the issue of fearing he will smoke a cigarette when in a stressful situation.

 CN: Psychosocial adaptation;  
CL: Synthesize


**9. 2.** The priority of care in the immediate post-operative phase is to maintain a patent airway. The nurse should observe the client carefully for signs of respiratory distress. If the client becomes nauseated, antiemetics should be administered to decrease the chance of vomiting with obstruction of the airway and aspiration of vomitus. Providing frequent oral hygiene and an alternative means of communication are important aspects of nursing care, but maintaining a patent airway is most important.

 CN: Physiological adaptation;  
CL: Synthesize

**10. 1.** Immediately after surgery the client should be placed on the side with the head slightly elevated. This position helps facilitate removal of secretions and decreases the likelihood of aspiration should vomiting occur. A registered nurse does not need to be present to reposition the client, unless the client's condition warrants the presence of the nurse. Although it is important to elevate the head, there is no need to keep the client's head elevated on two pillows unless that position is comfortable for the client.

 CN: Reduction of risk potential;  
CL: Synthesize

**11. 3.** The nurse's first action is to clear the client's airway as necessary. Inserting an NG tube or administering an antiemetic may prevent future vomiting episodes, but these procedures are not helpful when the client is actually vomiting. Cutting the wires is done only as a last resort or in case of respiratory or cardiac arrest.

 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Peptic Ulcer Disease

#### 12. 45 mL

$$1 \text{ oz} = 30 \text{ mL}$$

$$\frac{1 \text{ oz}}{1.5 \text{ oz}} = \frac{30 \text{ mL}}{X \text{ mL}}$$

$$1X = 1.5 \times 30$$

$$X = 45 \text{ mL.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

#### 13.

3. A client with peptic ulcer disease experiencing a sudden onset of acute stomach pain.

4. A client who is requesting pain medication 2 days after surgery to repair a fractured jaw.

2. A client with suspected gastric cancer who is on nothing-by-mouth (NPO) status for tests.

1. A client awaiting surgery for a hiatal hernia repair at 11 a.m.

The client with peptic ulcer disease who is experiencing a sudden onset of acute stomach pain should be assessed first by the nurse. The sudden onset of stomach pain could be indicative of a perforated ulcer, which would require immediate medical attention. It is also important for the nurse to thoroughly assess the nature of the client's pain. The client with the fractured jaw is experiencing pain and should be assessed next. The nurse should then assess the client who is NPO for tests to ensure NPO status and comfort. Last, the nurse can assess the client before surgery.

 CN: Management of care; CL: Synthesize

**14. 1.** A sudden spike in temperature following an endoscopic procedure may indicate perforation of the GI tract. The nurse should promptly conduct a further assessment of the client, looking for further indicators of perforation, such as a sudden onset of acute upper abdominal pain; a rigid, boardlike abdomen; and developing signs of shock. Telling the assistant to change thermometers is not an appropriate action and only further delays the appropriate action of assessing the client. The nurse would not administer acetaminophen without further assessment of the client or without a physician's order; a suspected perforation would require that the client be placed on nothing-by-mouth status. Asking the assistant to bathe the client before any assessment by the nurse is inappropriate.

 CN: Management of care; CL: Synthesize

**15. 4.** The body reacts to perforation of an ulcer by immobilizing the area as much as possible. This results in boardlike abdominal rigidity, usually with extreme pain. Perforation is a medical emergency requiring immediate surgical intervention because peritonitis develops quickly after perforation. An intestinal obstruction would not cause midepigastic pain. The development of additional ulcers or esophageal inflammation would not cause a rigid, boardlike abdomen.

 CN: Physiological adaptation;  
CL: Analyze

**16. 3, 4, 5.** Vomiting and weight loss are common with gastric ulcers. The client may also have blood in the stools (melena) from gastric bleeding. Clients with a gastric ulcer are most likely to complain of a burning epigastric pain that occurs about 1 hour after eating. Eating frequently aggravates the pain. Clients with duodenal ulcers are more likely to complain about pain that occurs during the night and is frequently relieved by eating.

 CN: Physiological adaptation;  
CL: Analyze


**17. 2, 4, 5.** Following a gastroscopy, the nurse should monitor the client for complications, which include perforation and the potential for aspiration. An elevated temperature, complaints of epigastric pain, or the vomiting of blood (hematemesis) are all indications of a possible perforation and should be reported promptly. A sore throat is a common occurrence following a gastroscopy. Clients are usually sedated to decrease anxiety and the nurse would anticipate that the client will be drowsy following the procedure.

 CN: Reduction of risk potential;  
CL: Analyze

**18. 2.** Black, tarry stools are an important warning sign of bleeding in peptic ulcer disease. Digested blood in the stool causes it to be black. The odor of the stool is very offensive. Clients with peptic ulcer disease should be instructed to report the incidence of black stools promptly to their primary health care provider. The data do not support the other diagnoses.

 CN: Reduction of risk potential;  
CL: Analyze

**19. 4.** Histamine-2 (H<sub>2</sub>) receptor antagonists, such as ranitidine, reduce gastric acid secretion. Antisecretory, or proton-pump inhibitors, such as omeprazole (Prilosec), help ulcers heal quickly in 4 to 8 weeks. Cytoprotective drugs, such as sucralfate (Carafate), protect the ulcer surface against acid, bile, and pepsin. Antacids reduce acid concentration and help reduce symptoms.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**20. 1, 2, 3, 4.** The nurse should encourage the client to reduce stimulation that may enhance gastric secretion. The nurse can also advise the client to utilize health practices that will prevent recurrences of ulcer pain, such as avoiding fatigue and elimination of smoking. Eating small, frequent meals helps to prevent gastric distention if not actively bleeding and decreases distension and release of gastrin. Medications should be administered promptly to maintain optimum levels. After awakening during the night, the client should eat a small snack and

return to bed, keeping the head of the bed elevated for an hour after eating. It is not necessary to stay away from crowded areas.

 CN: Physiological adaptation;  
CL: Synthesize

**21. 2, 3.** The symptoms of nausea and dizziness in a client with peptic ulcer disease may be indicative of hemorrhage and should not be ignored. The appropriate nursing actions at this time are for the nurse to monitor the client's vital signs and notify the physician of the client's symptoms. To administer an antacid hourly or to wait 1 hour to reassess the client would be inappropriate; prompt intervention is essential in a client who is potentially experiencing a gastrointestinal hemorrhage. The nurse would notify the physician of assessment findings and then initiate oxygen therapy if ordered by the physician.

 CN: Physiological adaptation;  
CL: Synthesize


**22. 3.** Diet therapy for ulcer disease is a controversial issue. There is no scientific evidence that diet therapy promotes healing. Most clients are instructed to follow a diet that they can tolerate. There is no need for the client to ingest only a bland or high-protein diet. Milk may be included in the diet, but it is not recommended in excessive amounts.

 CN: Basic care and comfort; CL: Apply


**23. 2.** A relaxed environment is an essential component of ulcer healing. Nurses can help clients understand the importance of relaxation and explore with them ways to balance work and family demands to promote healing. Being involved with his work may prevent boredom; however, this client is upset and argumentative. Not keeping up with his job will probably increase the client's stress level, but the nurse's response is best if it is based on the fact that a relaxed environment is an essential component of ulcer healing. Nurses cannot set limits on a client's behavior; clients must make the decision to make lifestyle changes.

 CN: Basic care and comfort; CL: Apply


**24. 4.** It would be most effective for the client to develop a health maintenance plan that incorporates regular periods of physical and mental rest in the daily schedule. Strategies should be identified to deal with the types of physical and mental stressors that the client needs to cope with in the home and work environments. Scheduling physical activity to occur only in the morning would not be restful or practical. There is no need for the client to avoid yard work or jogging if these activities are not stressful.

 CN: Psychosocial adaptation;  
CL: Synthesize


**25. 3.** Ranitidine blocks secretion of hydrochloric acid. Clients who take only one daily dose of ranitidine are usually advised to take it at bedtime to inhibit nocturnal secretion of acid. Clients who take the drug twice a day are advised to take it in the morning and at bedtime. It is not necessary to take the drug before meals. The client should take the drug regularly, not just when pain occurs.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**26. 3.** It is most likely that the client is experiencing an adverse effect of the antacid. Antacids with aluminum salt products, such as aluminum hydroxide, form insoluble salts in the body. These precipitate and accumulate in the intestines, causing constipation. Increasing dietary fiber intake or daily exercise may be a beneficial lifestyle change for the client but is not likely to relieve the constipation caused by the aluminum hydroxide. Constipation, in isolation from other symptoms, is not a sign of a bowel obstruction.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**27. 4.** Antacids are most effective if taken 1 to 3 hours after meals and at bedtime. When an antacid is taken on an empty stomach, the duration of the drug's action is greatly decreased. Taking antacids 1 to 3 hours after a meal lengthens the duration of action, thus increasing the therapeutic action of the drug. Antacids should be administered about 2 hours after other medications to decrease the chance of drug interactions. It is not necessary to decrease fluid intake when taking antacids. If antacids are taken more frequently than recommended, the likelihood of developing adverse effects increases. Therefore, the client should not take antacids as often as desired to control pain.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**28. 2.** Alcohol is a gastric irritant that should be eliminated from the intake of the client with peptic ulcer disease. Analgesics are not used to control ulcer pain; many analgesics are gastric irritants. The client's hemoglobin and hematocrit typically do not need to be monitored every 3 months, unless gastrointestinal bleeding is suspected. The client can maintain an active lifestyle and does not need to eliminate contact sports as long as they are not stress-inducing.

 CN: Reduction of risk potential; CL: Evaluate

## The Client with Cancer of the Stomach

**29. 2, 3, 5, 6.** The client who is experiencing upper GI bleeding is at risk for developing hypovolemic shock from blood loss. Therefore, the signs and symptoms the nurse should expect to find are those related to hypovolemia, including decreased urine output, tachycardia, rapid respirations, and thirst. The client's skin would be cool and clammy, not dry and flushed. The client would also be likely to develop hypotension, which would lead to a narrowing pulse pressure, not a widening pulse pressure.

 CN: Physiological adaptation; CL: Analyze


**30. 3.** The most likely complication of an endoscopic procedure is perforation. A sudden temperature spike within 1 to 2 hours after the procedure is indicative of a perforation and should be reported immediately to the physician. A sore throat is to be anticipated after an endoscopy. Clients are given sedatives during the procedure, so it is expected that they will display signs of sedation after the procedure is completed. A lack of appetite could be the result of many factors, including the disease process.

 CN: Reduction of risk potential; CL: Analyze

**31. 2.** A Billroth II procedure bypasses the duodenum and connects the gastric stump directly to the jejunum. The pyloric sphincter is removed, along with some of the stomach fundus.

 CN: Physiological adaptation; CL: Apply

**32. 3.** The information presented most clearly supports a nursing diagnosis of *Grieving*. The feelings expressed in this situation are more related to grieving about the changes that will occur in the client's life as a result of the diagnosis of gastric cancer than to fear of the unknown or anxiety about the surgery. There is no evidence of ineffective coping at this time.

 CN: Psychosocial adaptation; CL: Analyze

**33. 1.** About 12 to 24 hours after a subtotal gastrectomy, gastric drainage is normally brown, which indicates digested blood. Bile green or cloudy white drainage is not expected during the first 12 to 24 hours after a subtotal gastrectomy. Drainage during the first 6 to 12 hours contains some bright red blood, but large amounts of blood or excessive bloody drainage should be reported to the physician promptly.


 CN: Reduction of risk potential; CL: Apply

**34. 3.** Nausea, vomiting, or abdominal distention indicates that gas and secretions are accumulating within the gastric pouch due to impaired peristalsis or edema at the operative site and may indicate that the drainage system is not working properly. Saline solution is used to irrigate NG tubes. Hypotonic solutions such as water increase electrolyte loss. In addition, a physician's order is needed to irrigate the NG tube because this procedure could disrupt the suture line. After gastric surgery, only the surgeon repositions the NG tube because of the danger of rupturing or dislodging the suture line. The amount of suction varies with the type of tube used and is ordered by the physician. High suction may create too much tension on the gastric suture line.


 CN: Reduction of risk potential;  
CL: Synthesize

**35. 25 gtt/minute.** To administer I.V. fluids at 100 mL/hour using tubing that has a drip factor of 15 gtt/mL, the nurse should use the following formula:

$$100 \text{ mL}/60 \text{ minutes} \times 15 \text{ gtt}/1 \text{ mL} = 25 \text{ gtt}/\text{minute}.$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**36. 3.** A client who has had abdominal surgery is best placed in a low Fowler's position postoperatively. This positioning relaxes abdominal muscles and provides for maximum respiratory and cardiovascular function. The prone, supine, or Sims position would not be tolerated by a client who has had abdominal surgery, nor do those positions support respiratory or cardiovascular functioning.

 CN: Physiological adaptation;  
CL: Synthesize

**37. 2.** Because of the client's reduced stomach capacity, frequent small feedings are recommended. Early satiety can result, and large quantities of food are not well tolerated. Each client should progress at his or her own pace, gradually increasing the amount of food eaten. The goal is three meals daily if possible, but this can take 6 months or longer to achieve. Nausea can be episodic and can result from eating too fast or eating too much at one time. Eating less and eating more slowly, rather than not eating at all, can be a solution. Bland foods are recommended as starting foods because they are easily digested and are less irritating to the healing mucosa. Bland foods are not less nutritional.


 CN: Basic care and comfort; CL: Create

**38. 2.** After a gastric resection, ingested food moves rapidly from the remaining stomach into the duodenum or jejunum. The food has not undergone adequate preliminary digestion in the stomach. It is concentrated (hypertonic), distends the intestine,


and stimulates significant secretion of insulin by the pancreas, as well as a shift of fluid into the bowel. The dumping syndrome results from these factors, which are initiated by the rapid movement of food out of the stomach. After gastric resection, excess digestive enzymes are not secreted and the liver does not produce glycogen. Dumping syndrome is not caused by loss of gastric secretions.

 CN: Reduction of risk potential;  
CL: Apply

**39. 4.** Carbohydrates are restricted, but protein, including meat and dairy products, is recommended because it is digested more slowly. Lying down for 30 minutes after a meal is encouraged to slow movement of the food bolus. Fluids are restricted to reduce the bulk of food. There is no need to avoid caffeine.

 CN: Basic care and comfort;  
CL: Synthesize

**40. 4.** The symptoms related to dumping syndrome that occur after a gastrectomy usually disappear by 6 to 12 months after surgery. Most clients can begin to resume normal meal patterns after signs of the dumping syndrome have stopped. Acknowledging that eating six meals a day is time-consuming does not address the client's question and makes an assumption about the client's concerns. It is not necessarily true that a six-meal-a-day dietary pattern will be required for the rest of the client's life. Clients will not be able to eat three meals a day before hospital discharge.

 CN: Physiological adaptation;  
CL: Synthesize

**41. 3, 4, 5.** Dumping syndrome results in excessive, rapid emptying of gastric contents. The nurse should instruct the client to avoid dumping syndrome by eating small, frequent meals rather than three large meals, having a diet high in protein and fat and low in carbohydrates, reducing fluids with meals but taking them between meals, and relaxing when eating. The client should eat slowly and regularly and rest after meals.


 CN: Health promotion and maintenance;  
CL: Create

**42. 1.** Clients who have had gastric surgery are prone to postoperative complications, such as dumping syndrome and postprandial hypoglycemia, that can affect nutritional intake. Vitamin absorption can also be an issue, depending on the extent of the gastric surgery. Radiation therapy to the upper gastrointestinal area also can affect nutritional intake by causing anorexia, nausea, and esophagitis. The client would not be expected to develop alopecia. Exercise and activity levels as well as access to

community resources are important teaching areas, but nutritional intake is a priority need.

 CN: Reduction of risk potential;  
CL: Synthesize

**43. 4.** An appropriate expected outcome is for the client to achieve optimal nutritional status through the use of oral feedings or total parenteral nutrition (TPN). TPN may be used to supplement oral intake, or it may be used alone if the client cannot tolerate oral feedings. The client would not be expected to regain lost weight within 1 month after surgery or to tolerate a normal dietary intake of three meals a day. Nausea and vomiting would not be considered an expected outcome of gastric surgery, and regular use of antiemetics would not be anticipated.

 CN: Physiological adaptation;  
CL: Evaluate

### The Client with Gastroesophageal Reflux Disease

**44. 2.** The nurse should instruct the client to not lie down for about 2 hours after eating to prevent reflux. Caffeinated beverages decrease pressure in the lower esophageal sphincter and milk increases gastric acid secretion, so these beverages should be avoided. The client is encouraged to follow a high-protein, low-fat diet, and avoid foods that are irritating.

 CN: Reduction of risk potential;  
CL: Synthesize

**45. 1.** The client should take a laxative after an upper gastrointestinal series to stimulate a bowel movement. This examination involves the administration of barium, which must be promptly eliminated from the body because it may harden and cause an obstruction. A clear liquid diet would have no effect on stimulating removal of the barium. The client should not have nausea and an antiemetic would not be necessary; additionally, the antiemetic will decrease peristalsis and increase the likelihood of eliminating the barium. An enema would be ineffective because the barium is too high in the gastrointestinal tract.


 CN: Reduction of risk potential;  
CL: Synthesize

**46. 3.** With GERD, eating substances that decrease lower esophageal sphincter pressure causes heartburn. A decrease in the lower esophageal sphincter pressure allows gastric contents to reflux into the lower end of the esophagus. Foods that can cause a decrease in esophageal sphincter pressure include fatty foods, chocolate, caffeinated beverages, peppermint, and alcohol. A diet high in protein and


low in fat is recommended for clients with GERD. Lean beef, popcorn, and raw vegetables would be acceptable.

 CN: Physiological adaptation;  
CL: Synthesize

**47. 4.** Clients with GERD can develop pulmonary symptoms, such as coughing, wheezing, and dyspnea, that are caused by the aspiration of gastric contents. GERD does not predispose the client to the development of laryngeal cancer. Irritation of the esophagus and esophageal scar tissue formation can develop as a result of GERD. However, GERD is more likely to cause painful and difficult swallowing.

 CN: Physiological adaptation;  
CL: Analyze


**48. 2.** Bethanechol (Urecholine), a cholinergic drug, may be used in GERD to increase lower esophageal sphincter pressure and facilitate gastric emptying. Cholinergic adverse effects may include urinary urgency, diarrhea, abdominal cramping, hypotension, and increased salivation. To avoid these adverse effects, the client should be closely monitored to establish the minimum effective dose.

 CN: Pharmacological and parenteral therapies;  
CL: Analyze

**49. 1.** Fats are associated with decreased esophageal sphincter tone, which increases reflux. Obesity contributes to the development of hiatal hernia, and a low-fat diet might also aid in weight loss. Carbohydrates and foods high in sodium or calcium do not affect gastroesophageal reflux.

 CN: Basic care and comfort;  
CL: Evaluate

**50. 1.** Esophageal reflux worsens when the stomach is overdistended with food. Therefore, an important measure is to eat small, frequent meals. Fluid intake should be decreased during meals to reduce abdominal distention. Avoiding air swallowing does not prevent esophageal reflux. Food intake in the evening should be strictly limited to reduce the incidence of nighttime reflux, so bedtime snacks are not recommended.

 CN: Basic care and comfort;  
CL: Synthesize

**51. 1.** Heartburn, the most common symptom of a sliding hiatal hernia, results from reflux of gastric secretions into the esophagus. Regurgitation of gastric contents and dysphagia are other common symptoms. Jaundice, which results from a high concentration of bilirubin in the blood, is not associated with hiatal hernia. Anorexia is not a typical symptom of hiatal hernia. Stomatitis is inflammation of the mouth.


 CN: Physiological adaptation;  
CL: Analyze




**52. 2.** Any factor that increases intra-abdominal pressure, such as obesity, can contribute to the development of hiatal hernia. Other factors include abdominal straining, frequent heavy lifting, and pregnancy. Hiatal hernia is also associated with older age and occurs in women more frequently than in men. Having a sedentary desk job, using laxatives frequently, or being 40 years old is not likely to be a contributing factor in development of a hiatal hernia.

 CN: Reduction of risk potential;  
CL: Analyze

**53. 3.** Self-responsibility is the key to individual health maintenance. Using examples of situations in which the client has demonstrated self-responsibility can be reinforcing and supporting. The client has ultimate responsibility for his personal health habits. Meeting other people who are managing their care and involving family members can be helpful, but individual motivation is more important. Reassurance can be helpful but is less important than individualization of care.

 CN: Basic care and comfort;  
CL: Synthesize

**54. 3.** The magnesium salts in magnesium hydroxide are related to those found in laxatives and may cause diarrhea. Aluminum salt products can cause constipation. Many clients find that a combination product is required to maintain normal bowel elimination. The use of magnesium hydroxide does not cause anorexia or weight gain.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**55. 2.** Smoking and alcohol use both reduce esophageal sphincter tone and can result in reflux. They therefore should be avoided by clients with hiatal hernia. Daily aerobic exercise, balancing activity and rest, and avoiding high-stress situations may increase the client's general health and well-being, but they are not directly associated with hiatal hernia.

 CN: Health promotion and maintenance;  
CL: Synthesize


**56. 2.** Bending, especially after eating, can cause gastroesophageal reflux. Lifting heavy objects increases intra-abdominal pressure. Assessing the client's lifting techniques enables the nurse to evaluate the client's knowledge of factors contributing to hiatal hernia and how to prevent complications. Number and length of breaks, temperature in the work area, and cleaning solvents used are not directly related to treatment of hiatal hernia.

 CN: Basic care and comfort; CL: Create


**57. 1.** A client with a hiatal hernia should avoid the recumbent position immediately after meals to minimize gastric reflux. Bedtime snacks, as well as high-fat foods and carbonated beverages, should be avoided. Excessive vigorous exercise also should be avoided, especially after meals, but there is no reason why the client must give up swimming. Wearing tight, constrictive clothing such as a girdle can increase intra-abdominal pressure and thus lead to reflux of gastric juices.

 CN: Basic care and comfort;  
CL: Evaluate


**58. 1.** Metoclopramide hydrochloride (Reglan) increases esophageal sphincter tone and facilitates gastric emptying; both actions reduce the incidence of reflux. Other drugs, such as antacids or histamine receptor antagonists, may also be prescribed to help control reflux and esophagitis and to decrease or neutralize gastric secretions. Reglan is not effective in decreasing or neutralizing gastric secretions.

 CN: Pharmacological and parenteral therapies; CL: Apply

**59. 4.** Metoclopramide hydrochloride (Reglan) can cause sedation. Alcohol and other central nervous system depressants add to this sedation. A client who is taking this drug should be cautioned to avoid driving or performing other hazardous activities for a few hours after taking the drug. Clients may take antacids, antihypertensives, and anticoagulants while on metoclopramide.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**60. 3.** Cimetidine (Tagamet) is a histamine receptor antagonist that decreases the quantity of gastric secretions. It may be used in hiatal hernia therapy to prevent or treat the esophagitis and heartburn associated with reflux. Cimetidine is not used to prevent reflux, dysphagia, or ulcer development.

 CN: Pharmacological and parenteral therapies; CL: Apply

**61. 2.** Most clients can be treated successfully with a combination of diet restrictions, medications, weight control, and lifestyle modifications. Surgery to correct a hiatal hernia, which commonly produces complications, is performed only when medical therapy fails to control the symptoms.


 CN: Reduction of risk potential;  
CL: Synthesize

### Managing Care Quality and Safety

**62. 3.** Parotitis is inflammation of the parotid gland. Although any of the clients listed could develop parotitis, given the data provided, the one most likely to develop parotitis is the elderly client who is dehydrated with poor oral hygiene. Any client who experiences poor oral hygiene is at risk for developing parotitis. To help prevent parotitis, it is essential for the nurse to ensure the client receives oral hygiene at regular intervals and has an adequate fluid intake.

 CN: Reduction of risk potential;  
CL: Analyze


**63. 2.** A soft toothbrush should be used to brush the client's teeth after every meal and more often as needed. Mechanical cleaning is necessary to maintain oral health, stimulate gingiva, and remove plaque. Assessing the oral cavity and recording observations is the responsibility of the nurse, not the nursing assistant. Swabbing with a safe foam applicator does not provide enough friction to clean the mouth. Mouthwash can be a drying irritant and is not recommended for frequent use.

 CN: Basic care and comfort;  
CL: Synthesize

**64. 1.** The Cochrane Library provides systematic reviews of health care interventions and will provide the best resource for evidence for nursing care. CINAHL offers key word searches to published articles in nursing and allied health literature, but not reviews. A nursing textbook has information about nursing care which may include evidence-based practices, but textbooks may not have the most up-to-date information. While the policy and procedure manual may be based on evidence-based practices, the most current practices will be found in evidence-based reviews of literature.

 CN: Management of care; CL: Apply

**65. 3.** Using an individualized printed checklist assures that all key information is reported; the checklist can then serve as a record to which nurses can refer later. Giving a verbal report leaves room for error in memory; using an audiotape or an electronic health record requires nurses to spend unnecessary time retrieving information.

 CN: Safety and infection control;  
CL: Apply

**TEST**  
**6**

# The Client with Lower Gastrointestinal Tract Health Problems

- The Client with Cancer of the Colon
- The Client with Hemorrhoids
- The Client with Inflammatory Bowel Disease
- The Client with an Intestinal Obstruction
- The Client with an Ileostomy
- The Client Receiving Total Parenteral Nutrition
- The Client with Diverticular Disease
- The Client with Appendicitis
- The Client with an Inguinal Hernia
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Cancer of the Colon

**1.** Which of the following guidelines reflects the current American Cancer Society recommendations for screening for colon cancer in individuals who are **not** at high risk?

- 1. Annual digital rectal examination should begin at age 40.
- 2. Annual fecal testing for occult blood should begin at age 50.
- 3. Individuals should obtain a baseline barium enema at age 40.
- 4. Individuals should obtain a baseline colonoscopy at age 45.

**2.** A client refuses to look at or care for her colostomy. Which of the following statements by the nurse would be **most** appropriate?

- 1. "It has been 4 days since your surgery and you will soon be discharged. You have to learn to care for your colostomy before you leave the hospital."
- 2. "I think we will need to teach your husband to care for your colostomy if you are not going to be able to do it."
- 3. "I understand how you are feeling. It is important for you to feel attractive and you think having a colostomy changes your attractiveness."
- 4. "I can see that you are upset. Would you like to share your concerns with me?"

**3.** Which of the following has been identified as a potential risk factor for the development of colon cancer?

- 1. Chronic constipation.
- 2. Long-term use of laxatives.
- 3. History of smoking.
- 4. History of inflammatory bowel disease.

**4.** The nurse is conducting a community presentation on the early detection of colon cancer. Which of the following should the nurse encourage members of the audience to report to their health care providers? Select all that apply.

- 1. Fatigue.
- 2. Unexplained weight loss with adequate nutritional intake.
- 3. Rectal bleeding.
- 4. Bowel changes.
- 5. Positive fecal occult blood testing.

**5.** A client with colon cancer is having a barium enema. The nurse should instruct the client to take which of the following after the procedure is completed?

- 1. Laxative.
- 2. Anticholinergic.
- 3. Antacid.
- 4. Demulcent.

**6.** The client with colon cancer has an abdominal-perineal resection with a colostomy. Which of the following nursing interventions is **most** appropriate for this client in the postoperative period?

- 1. Maintain the client in a semi-Fowler's position.
- 2. Assist the client with warm sitz baths.
- 3. Administer 30 mL of milk of magnesia to stimulate colostomy activity.
- 4. Remove the ostomy pouch as needed so the stoma can be assessed.

**7.** The nurse assesses the client's stoma during the initial postoperative period. Which of the following observations should be reported immediately to the physician?

- 1. The stoma is slightly edematous.
- 2. The stoma is dark red to purple.
- 3. The stoma oozes a small amount of blood.
- 4. The stoma does not expel stool.

**8.** While changing the client's colostomy bag and dressing, the nurse assesses that the client is ready to participate in her care by noting which of the following?

- 1. The client asks what time the doctor will visit that day.
- 2. The client asks about the supplies used during the dressing change.
- 3. The client talks about something she read in the morning newspaper.
- 4. The client complains about the way the night nurse changed the dressing.

**9.** Which of the following skin preparations would be **best** to apply around the client's colostomy?

- 1. Karaya.
- 2. Petroleum jelly.
- 3. Cornstarch.
- 4. Antiseptic cream.

**10.** A client is recovering from an abdominal-perineal resection. Which of the following measures would **most** effectively promote wound healing after the perineal drains have been removed?

- 1. Taking sitz baths.
- 2. Taking daily showers.
- 3. Applying warm, moist dressings to the area.
- 4. Applying a protected heating pad to the area.

**11.** When planning diet teaching for the client with a colostomy, the nurse should develop a plan that emphasizes which of the following dietary instructions?

- 1. Foods containing roughage should not be eaten.
- 2. Liquids are best limited to prevent diarrhea.
- 3. Clients should experiment to find the diet that is best for them.
- 4. A high-fiber diet will produce a regular passage of stool.

**12.** Which of the following would be an expected outcome for a client who is recovering from an abdominal-perineal resection with a colostomy? The client will:

- 1. Maintain a fluid intake of 3,000 mL/day.
- 2. Eliminate fiber from the diet.
- 3. Limit physical activity to light exercise.
- 4. Accept that sexual activity will be diminished.

## The Client with Hemorrhoids

**13.** A 36-year-old female client has been diagnosed with hemorrhoids. Which of the following factors in the client's history would **most** likely be a primary cause of her hemorrhoids?

- 1. Her age.
- 2. Three vaginal delivery pregnancies.
- 3. Her job as a schoolteacher.
- 4. Varicosities in her legs.

**14.** Which position would be **best** for the client in the early postoperative period after a hemorrhoidectomy?

- 1. High Fowler's.
- 2. Supine.
- 3. Side-lying.
- 4. Trendelenburg's.

**15.** The nurse instructs the client who has had a hemorrhoidectomy not to use sitz baths until at least 12 hours postoperatively to avoid inducing which of the following complications?

- 1. Hemorrhage.
- 2. Rectal spasm.
- 3. Urine retention.
- 4. Constipation.

**16.** The nurse teaches the client who has had rectal surgery the proper timing for sitz baths. The nurse knows that the client has understood the teaching when the client states that it is **most** important to take a sitz bath:

- 1. First thing each morning.
- 2. As needed for discomfort.
- 3. After a bowel movement.
- 4. At bedtime.

## The Client with Inflammatory Bowel Disease

**17.** A client has been placed on long-term sulfasalazine (Azulfidine) therapy for treatment of his ulcerative colitis. The nurse should encourage the client to eat which of the following foods to help avoid the nutrient deficiencies that may develop as a result of this medication?

- 1. Citrus fruits.
- 2. Green, leafy vegetables.
- 3. Eggs.
- 4. Milk products.

**18.** The nurse is assigning clients for the evening shift. Which of the following clients are appropriate for the nurse to assign to a licensed practical nurse to provide client care? Select all that apply.

- 1. A client with Crohn's disease who is receiving total parenteral nutrition (TPN).
- 2. A client who underwent inguinal hernia repair surgery 3 hours ago.
- 3. A client with an intestinal obstruction who needs a Cantor tube inserted.
- 4. A client with diverticulitis who needs teaching about his take-home medications.
- 5. A client who is experiencing an exacerbation of his ulcerative colitis.

**19.** A client who has had ulcerative colitis for the past 5 years is admitted to the hospital with an exacerbation of the disease. Which of the following factors was **most** likely of greatest significance in causing an exacerbation of ulcerative colitis?

- 1. A demanding and stressful job.
- 2. Changing to a modified vegetarian diet.
- 3. Beginning a weight-training program.
- 4. Walking 2 miles every day.

**20.** A client who is experiencing an exacerbation of ulcerative colitis is receiving I.V. fluids that are to be infused at 125 mL/hour. The I.V. tubing delivers 15 gtt/mL. How quickly should the nurse infuse the fluids in drops per minute to infuse the fluids at the prescribed rate?

\_\_\_\_\_ gtt/minute.

**21.** When planning care for a client with ulcerative colitis who is experiencing an exacerbation of symptoms, which client care activities can the nurse appropriately delegate to an unlicensed assistant? Select all that apply.

- 1. Assessing the client's bowel sounds.
- 2. Providing skin care following bowel movements.
- 3. Evaluating the client's response to antidiarrheal medications.
- 4. Maintaining intake and output records.
- 5. Obtaining the client's weight.

**22.** Which goal for the client's care should take priority during the first days of hospitalization for an exacerbation of ulcerative colitis?

- 1. Promoting self-care and independence.
- 2. Managing diarrhea.
- 3. Maintaining adequate nutrition.
- 4. Promoting rest and comfort.

**23.** The client with ulcerative colitis is following orders for bed rest with bathroom privileges. When evaluating the effectiveness of this level of activity, the nurse should determine if the client has:

- 1. Conserved energy.
- 2. Reduced intestinal peristalsis.
- 3. Obtained needed rest.
- 4. Minimized stress.

**24.** A client's ulcerative colitis signs and symptoms have been present for longer than 1 week. The nurse should assess the client for signs and symptoms of which of the following complications?

- 1. Heart failure.
- 2. Deep vein thrombosis.
- 3. Hypokalemia.
- 4. Hypocalcemia.

**25.** A client who has ulcerative colitis says to the nurse, "I can't take this anymore! I'm constantly in pain, and I can't leave my room because I need to stay by the toilet. I don't know how to deal with this." Based on these comments, an appropriate nursing diagnosis for this client would be:

- 1. *Impaired physical mobility* related to fatigue.
- 2. *Disturbed thought processes* related to pain.
- 3. *Social isolation* related to chronic fatigue.
- 4. *Ineffective coping* related to chronic abdominal pain.

**26.** A client newly diagnosed with ulcerative colitis who has been placed on steroids asks the nurse why steroids are prescribed. The nurse should tell the client?

- 1. "Ulcerative colitis can be cured by the use of steroids."
- 2. "Steroids are used in severe flare-ups because they can decrease the incidence of bleeding."
- 3. "Long-term use of steroids will prolong periods of remission."
- 4. "The side effects of steroids outweigh their benefits to clients with ulcerative colitis."

**27.** A client who has ulcerative colitis has persistent diarrhea. He is thin and has lost 12 lb since the exacerbation of his ulcerative colitis. Which of the following will be most effective in helping the client meet his nutritional needs?

- 1. Continuous enteral feedings.
- 2. Following a high-calorie, high-protein diet.
- 3. Total parenteral nutrition (TPN).
- 4. Eating six small meals a day.

**28.** A client with ulcerative colitis is to take sulfasalazine (Azulfidine). Which of the following instructions should the nurse provide for the client about taking this medication at home? Select all that apply.

- 1. Drink enough fluids to maintain a urine output of at least 1,200–1,500 mL per day.
- 2. Discontinue therapy if symptoms of acute intolerance develop and notify the health care provider.
- 3. Stop taking the medication if the urine turns orange-yellow.
- 4. Avoid activities that require alertness.
- 5. If dose is missed, skip and continue with the next dose.

**29.** The physician prescribes sulfasalazine (Azulfidine) for the client with ulcerative colitis to continue taking at home. Which instruction should the nurse give the client about taking this medication?

- 1. Avoid taking it with food.
- 2. Take the total dose at bedtime.
- 3. Take it with a full glass (240 mL) of water.
- 4. Stop taking it if urine turns orange-yellow.

**30.** The nurse has an order to administer sulfasalazine (Azulfidine) 2 g. The medication is available in 500-mg tablets. How many tablets should the nurse administer?

\_\_\_\_\_ tablets.

**31.** A client with ulcerative colitis expresses serious concerns about her career as an attorney because of the effects of stress on ulcerative colitis. Which of the following nursing interventions will be **most** helpful to the client?

- 1. Review her current coping mechanisms and develop alternatives, if needed.
- 2. Suggest a less stressful career in which she would still use her education and experience.
- 3. Suggest that she ask her colleagues to help decrease her stress by giving her the easier cases.
- 4. Prepare family members for the fact that she will have to work part-time.

**32.** Which of the following diets would be **most** appropriate for the client with ulcerative colitis?

- 1. High-calorie, low-protein.
- 2. High-protein, low-residue.
- 3. Low-fat, high-fiber.
- 4. Low-sodium, high-carbohydrate.

**33.** A client who has a history of Crohn's disease is admitted to the hospital with fever, diarrhea, cramping, abdominal pain, and weight loss. The nurse should monitor the client for:

- 1. Hyperalbuminemia.
- 2. Thrombocytopenia.
- 3. Hypokalemia.
- 4. Hypercalcemia.

**34.** A client with Crohn's disease has concentrated urine, decreased urinary output, dry skin with decreased turgor, hypotension, and weak, thready pulses. The nurse should do which of the following **first**?

- 1. Encourage the client to drink at least 1,000 mL per day.
- 2. Provide parenteral rehydration therapy ordered by the physician.
- 3. Turn and reposition every 2 hours.
- 4. Monitor vital signs every shift.

**35.** The nurse is developing a plan of care for a client with Crohn's disease who is receiving total parenteral nutrition (TPN). Which of the following interventions should the nurse include? Select all that apply.

- 1. Monitoring vital signs once a shift.
- 2. Weighing the client daily.
- 3. Changing the central venous line dressing daily.
- 4. Monitoring the I.V. infusion rate hourly.
- 5. Taping all I.V. tubing connections securely.

**36.** Which of the following should be a priority focus of care for a client experiencing an exacerbation of Crohn's disease?

- 1. Encouraging regular ambulation.
- 2. Promoting bowel rest.
- 3. Maintaining current weight.
- 4. Decreasing episodes of rectal bleeding.

### The Client with an Intestinal Obstruction

**37.** A nurse is assessing a client who has been admitted with a diagnosis of an obstruction in the small intestine. The nurse should assess the client for? Select all that apply.

- 1. Projectile vomiting.
- 2. Significant abdominal distention.
- 3. Copious diarrhea.
- 4. Rapid onset of dehydration.
- 5. Increased bowel sounds.

**38.** A client is admitted with a bowel obstruction. The client has nausea, vomiting, and crampy abdominal pain. The physician has written orders for the client to be up ad lib, to have narcotics for pain, to have a nasogastric tube inserted if needed, and for I.V. Ringer's Lactate and hyperalimentation fluids. The nurse should do the following in order of priority from first to last:

1. Assist with ambulation to promote peristalsis.

2. Administer Ringer's Lactate.

3. Insert a nasogastric tube.

4. Start an infusion of hyperalimentation fluids.

**39.** The physician orders intestinal decompression with a Cantor tube for a client with an intestinal obstruction. In order to determine effectiveness of intestinal decompression the nurse should evaluate the client to determine if:

- 1. Fluid and gas have been removed from the intestine.
- 2. The client has had a bowel movement.
- 3. The client's urinary output is adequate.
- 4. The client can sit up without pain.

**40.** After insertion of a nasoenteric tube, the nurse should place the client in which position?

- 1. Supine.
- 2. Right side-lying.
- 3. Semi-Fowler's.
- 4. Upright in a bedside chair.

**41.** Which of the following statements about nasoenteric tubes is correct?

- 1. The tube cannot be attached to suction.
- 2. The tube contains a soft rubber bag filled with mercury.
- 3. The tube is taped securely to the client's cheek after insertion.
- 4. The tube can have its placement determined only by auscultation.

**42.** The client with an intestinal obstruction continues to have acute pain even though the nasoenteric tube is patent and draining. Which action by the nurse would be **most** appropriate?

- 1. Reassure the client that the nasoenteric tube is functioning.
- 2. Assess the client for a rigid abdomen.
- 3. Administer an opioid as ordered.
- 4. Reposition the client on the left side.

**43.** Before abdominal surgery for an intestinal obstruction, the nurse monitors the client's urine output and finds that the total output for the past 2 hours was 35 mL. The nurse then assesses the client's total intake and output over the last 24 hours and notes that he had 2,000 mL of I.V. fluid for intake, 500 mL of drainage from the nasogastric tube, and 700 mL of urine for a total output of 1,200 mL. This would indicate which of the following?

- 1. Decreased renal function.
- 2. Inadequate pain relief.
- 3. Extension of the obstruction.
- 4. Inadequate fluid replacement.

## The Client with an Ileostomy

**44.** The nurse is teaching the client how to care for her ileostomy. The client asks the nurse how long she can wear her pouch before changing it. The nurse responds:

- 1. "The pouch is changed only when it leaks."
- 2. "You can wear the pouch for about 4 to 7 days."
- 3. "You should change the pouch every evening before bedtime."
- 4. "It depends on your activity level and your diet."

**45.** A client is scheduled for an ileostomy. Which of the following interventions would be **most** helpful in preparing the client psychologically for the surgery?

- 1. Include family members in preoperative teaching sessions.
- 2. Encourage the client to ask questions about managing an ileostomy.
- 3. Provide a brief, thorough explanation of all preoperative and postoperative procedures.
- 4. Invite a member of the ostomy association to visit the client.

**46.** A client who is scheduled for an ileostomy has an order for oral neomycin (Mycifradin) to be administered before surgery. The intended outcome of administering oral neomycin before surgery is to:

- 1. Prevent postoperative bladder infection.
- 2. Reduce the number of intestinal bacteria.
- 3. Decrease the potential for postoperative hypostatic pneumonia.
- 4. Increase the body's immunologic response to the stressors of surgery.

**47.** A client has returned to the medical surgical unit after having surgery to create an ileostomy. Which goal has the **highest** priority at this time?

- 1. Providing relief from constipation.
- 2. Assisting the client with self-care activities.
- 3. Maintaining fluid and electrolyte balance.
- 4. Minimizing odor formation.

**48.** The client asks the nurse, "Is it really possible to lead a normal life with an ileostomy?" Which action by the nurse would be the **most** effective to address this question?

- 1. Have the client talk with a member of the clergy about these concerns.
- 2. Tell the client to worry about those concerns after surgery.
- 3. Arrange for a person with an ostomy to visit the client preoperatively.
- 4. Notify the surgeon of the client's question.

**49.** Three weeks after the client has had an ileostomy, the nurse is following up with instruction about using a skin barrier around the stoma at all times. The client has been applying the skin barrier correctly when:

- 1. There is no odor from the stoma.
- 2. The client is adequately hydrated.
- 3. There is no skin irritation around the stoma.
- 4. The client only changes the ostomy pouch once a day.

**50.** The nurse should instruct the client with an ileostomy to report which of the following signs and symptoms immediately?

- 1. Passage of liquid stool from the stoma.
- 2. Occasional presence of undigested food in the effluent.
- 3. Absence of drainage from the ileostomy for 6 or more hours.
- 4. Temperature of 99.8° F (37.7° C).

**51.** The nurse finds the client who has had an ileostomy crying. The client explains to the nurse, “I’m upset because I know I won’t be able to have children now that I have an ileostomy.” Which of the following would be the **best** response for the nurse?

- 1. “Many women with ileostomies decide to adopt. Why don’t you consider that option?”
- 2. “Having an ileostomy does not necessarily mean that you can’t bear children. Let’s talk about your concerns.”
- 3. “I can understand your reasons for being upset. Having children must be important to you.”
- 4. “I’m sure you will adjust to this situation with time. Try not to be too upset.”

**52.** The nurse evaluates the client’s understanding of ileostomy care. Which of the following statements indicates that discharge teaching has been effective?

- 1. “I should be able to resume weight lifting in 2 weeks.”
- 2. “I can return to work in 2 weeks.”
- 3. “I need to drink at least 3,000 mL a day of fluid.”
- 4. “I will need to avoid getting my stoma wet while bathing.”

**53.** A client with a well-managed ileostomy calls the nurse to report the sudden onset of abdominal cramps, vomiting, and watery discharge from the ileostomy. The nurse should:

- 1. Tell the client to take an antiemetic.
- 2. Encourage the client to increase fluid intake to 3 L/day to replace fluid lost through vomiting.
- 3. Instruct the client to take 30 mL of milk of magnesia to stimulate a bowel movement.
- 4. Advise the client to notify the physician.

## The Client Receiving Total Parenteral Nutrition

**54.** The nurse is changing the subclavian dressing of a client who is receiving total parenteral nutrition. When assessing the catheter insertion site, the nurse notes the presence of yellow drainage from around the sutures that are anchoring the catheter. Which action should the nurse take **first**?

- 1. Clean the insertion site and redress the area.
- 2. Document assessment findings in the client’s chart.
- 3. Obtain a culture specimen of the drainage.
- 4. Notify the physician.

**55.** Using a sliding-scale schedule, the nurse is preparing to administer an evening dose of regular insulin to a client who is receiving total parenteral nutrition (TPN). Which action is **most** appropriate for the nurse to take to determine the amount of insulin to give?

- 1. Base the dosage on the glucometer reading of the client’s glucose level obtained immediately before administering the insulin.
- 2. Base the dosage on the fasting blood glucose level obtained earlier in the day.
- 3. Calculate the amount of TPN fluid the client has received since the last dose of insulin and adjust the dosage accordingly.
- 4. Assess the client’s dietary intake for the evening meal and snack and adjust the dosage accordingly.

**56.** A client with inflammatory bowel disease is receiving total parenteral nutrition (TPN). The basic component of the client’s TPN solution is **most** likely to be:

- 1. An isotonic dextrose solution.
- 2. A hypertonic dextrose solution.
- 3. A hypotonic dextrose solution.
- 4. A colloidal dextrose solution.

**57.** TPN is ordered for a client with Crohn’s disease. Which of the following indicate the TPN solution is having an intended outcome?

- 1. There is increased cell nutrition.
- 2. The client does not have metabolic acidosis.
- 3. The client is hydrated.
- 4. The client is in a negative nitrogen balance.

**58.** A client is receiving Total Parenteral Nutrition (TPN) solution. The nurse should assess a client’s ability to metabolize the TPN solution adequately by monitoring the client for which of the following signs?

- 1. Tachycardia.
- 2. Hypertension.
- 3. Elevated blood urea nitrogen concentration.
- 4. Hyperglycemia.



**59.** Which of the following interventions should the nurse include in the client's plan of care to prevent complications associated with TPN administered through a central line?

- 1. Use a clean technique for all dressing changes.
- 2. Tape all connections of the system.
- 3. Encourage bed rest.
- 4. Cover the insertion site with a moisture-proof dressing.

**60.** The nurse notes that the sterile, occlusive dressing on the central catheter insertion site of a client receiving total parenteral nutrition (TPN) is moist. The client is breathing easily with no abnormal breath sounds. The nurse should do the following in order of what priority from first to last?

- 1. Change dressing per institutional policy.
- 2. Culture drainage at insertion site.
- 3. Notify physician.
- 4. Position rolled towel under client's back, parallel to the spine.

**61.** The nurse administers fat emulsion solution during TPN as ordered based on the understanding that this type of solution:

- 1. Provides essential fatty acids.
- 2. Provides extra carbohydrates.
- 3. Promotes effective metabolism of glucose.
- 4. Maintains a normal body weight.

**62.** Which of the following should the nurse interpret as an indication of a complication after the first few days of TPN therapy?

- 1. Glycosuria.
- 2. A 1- to 2-pound weight gain.
- 3. Decreased appetite.
- 4. Elevated temperature.

**63.** Which of the following adverse effects would the nurse expect the client to exhibit in the event of too rapid an infusion of TPN solution?

- 1. Negative nitrogen balance.
- 2. Circulatory overload.
- 3. Hypoglycemia.
- 4. Hypokalemia.

### The Client with Diverticular Disease

**64.** Which foods should the nurse encourage a client with diverticulosis to incorporate into the diet? Select all that apply.

- 1. Bran cereal.
- 2. Broccoli.
- 3. Tomato juice.
- 4. Navy beans.
- 5. Cheese.

**65.** Which of the following laboratory findings would the nurse expect to find in a client with diverticulitis?

- 1. Elevated red blood cell count.
- 2. Decreased platelet count.
- 3. Elevated white blood cell count.
- 4. Elevated serum blood urea nitrogen concentration.

**66.** The nurse is aware that the diagnostic tests typically ordered for acute diverticulitis do not include a barium enema. The reason for this is that a barium enema:

- 1. Can perforate an intestinal abscess.
- 2. Would greatly increase the client's pain.
- 3. Is of minimal diagnostic value in diverticulitis.
- 4. Is too lengthy a procedure for the client to tolerate.

**67.** The nurse should teach the client with diverticulitis to integrate which of the following into a daily routine at home?

- 1. Using enemas to relieve constipation.
- 2. Decreasing fluid intake to increase the formed consistency of the stool.
- 3. Eating a high-fiber diet when symptomatic with diverticulitis.
- 4. Refraining from straining and lifting activities.

**68.** After instructing a client with diverticulosis about appropriate self-care activities, which of the following client comments indicate effective teaching? Select all that apply.

- 1. "With careful attention to my diet, my diverticulosis can be cured."
- 2. "Using a cathartic laxative weekly is okay to control bowel movements."
- 3. "I should follow a diet that's high in fiber."
- 4. "It is important for me to drink at least 2,000 mL of fluid every day."
- 5. "I should exercise regularly."

**69.** A client with diverticular disease is receiving psyllium hydrophilic mucilloid (Metamucil). The drug has been effective when the client tells the nurse that he:

- 1. Passes stool without cramping.
- 2. Does not have diarrhea any longer.
- 3. Is not as anxious as he was.
- 4. Does not expel gas like he used to.

**70.** A client with diverticulitis has developed peritonitis following diverticular rupture. The nurse should assess the client to determine which of the following? Select all that apply.

- 1. Percuss the abdomen to note resonance and tympany.
- 2. Percuss the liver to note lack of dullness.
- 3. Monitor the vital signs for fever, tachypnea, and bradycardia.
- 4. Assess presence of polyphagia and polydipsia.
- 5. Auscultate bowel sounds to note frequency.

### The Client with Appendicitis

**71.** A nurse is providing wound care to a client 1 day after the client underwent an appendectomy. A drain was inserted into the incisional site during surgery. Which action should the nurse perform when providing wound care?

- 1. Remove the dressing and leave the incision open to air.
- 2. Remove the drain if wound drainage is minimal.
- 3. Gently irrigate the drain to remove exudate.
- 4. Clean the area around the drain moving away from the drain.

**72.** The nurse is admitting a client with acute appendicitis to the emergency department. The client has abdominal pain of 10 on a pain scale of 1 to 10. The client will be going to surgery as soon as possible. The nurse should:

- 1. Contact the surgeon to request an order for a narcotic for the pain.
- 2. Maintain the client in a recumbent position.
- 3. Place the client on nothing-by-mouth (NPO) status.
- 4. Apply heat to the abdomen in the area of the pain.

**73.** A client with acute appendicitis develops a fever, tachycardia, and hypotension. Based on these assessment findings, the nurse should further assess the client for which of the following complications?

- 1. Deficient fluid volume.
- 2. Intestinal obstruction.
- 3. Bowel ischemia.
- 4. Peritonitis.

**74.** Postoperative nursing care for a client after an appendectomy should include which of the following?

- 1. Administering sitz baths four times a day.
- 2. Noting the first bowel movement after surgery.
- 3. Limiting the client's activity to bathroom privileges.
- 4. Measuring abdominal girth every 2 hours.

**75.** A client who had an appendectomy for a perforated appendix returns from surgery with a drain inserted in the incisional site. The purpose of the drain is to:

- 1. Provide access for wound irrigation.
- 2. Promote drainage of wound exudates.
- 3. Minimize development of scar tissue.
- 4. Decrease postoperative discomfort.

### The Client with an Inguinal Hernia

**76.** A client who has a history of an inguinal hernia is admitted to the hospital with sudden, severe abdominal pain, vomiting, and abdominal distention. The nurse should assess the client further for which of the following complications?

- 1. Peritonitis.
- 2. Incarcerated hernia.
- 3. Strangulated hernia.
- 4. Intestinal perforation.

**77.** A client has just had an inguinal herniorrhaphy. Which of the following instructions would be **most** appropriate to include in his discharge plan?

- 1. Turning, coughing, and deep breathing every 2 hours.
- 2. Applying an ice bag to the scrotum.
- 3. Applying a truss before the client ambulates.
- 4. Maintaining a high Fowler's position while resting.

**78.** After an inguinal herniorrhaphy, the nurse should assess the client carefully for which of the following likely complications?

- 1. Hypostatic pneumonia.
- 2. Deep vein thrombosis.
- 3. Paralytic ileus.
- 4. Urine retention.

### Managing Care Quality and Safety

**79.** The nurse is taking care of a client with *Clostridium difficile* (*C. difficile*). The nurse should do which of the following to prevent the spread of infection? Select all that apply.

- 1. Wear a particulate respirator.
- 2. Wear sterile gloves when providing care.
- 3. Cleanse hands with alcohol-based hand sanitizer.
- 4. Wash hands with soap and water.
- 5. Wear a protective gown when in the client's room.

**80.** The nurse discovers that a client's TPN solution was running at an incorrect rate and is now 2 hours behind schedule. Which action is most appropriate for the nurse to take to correct the problem?

- 1. Readjust the solution to infuse the desired amount.
- 2. Continue the infusion at the current rate, but run the next bottle at an increased rate.
- 3. Double the infusion rate for 2 hours.
- 4. Notify the physician.

**81.** The nurse is to administer Polycillin (ampicillin) 500 mg orally to a client with a ruptured appendix. The nurse checks the capsule in the client's medication box which is located inside of the client's room. The dosage of the medication is not labeled, but the nurse recognizes the color and shape of the capsule. The nurse should next:

- 1. Administer the medication to maintain blood levels of the drug.
- 2. Ask another registered nurse to verify that the capsule is ampicillin.
- 3. Contact the pharmacy to bring a properly labeled medication.
- 4. Notify the unit manager to report the problem.

**82.** On the second day following an abdominal perineal resection, the nurse notes that the wound edges aren't approximated and one half the incision has torn apart. The nurse should immediately take what action?

- 1. Flush the wound with sterile water.
- 2. Apply an abdominal binder.
- 3. Cover the wound with a sterile dressing moistened with normal saline.
- 4. Apply strips of tape.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Cancer of the Colon

**1. 2.** Annual fecal testing for occult blood should begin at age 50. Annual digital rectal examinations are recommended in men beginning at age 50 to screen for prostate cancer. Baseline barium enemas or colonoscopies are recommended at age 50. Baseline barium enemas and colonoscopies are not performed on individuals in their 40s unless they experience signs or symptoms that indicate the need for such diagnostic testing, or are considered to be at high risk.

🔑 CN: Health promotion and maintenance;  
CL: Apply

**2. 4.** It is important for the nurse to recognize that individuals go through a grieving process when adjusting to a colostomy. The nurse should be accepting and provide the client with opportunities to share her concerns and feelings when she is ready. Lecturing the client about the need to learn how to care for the colostomy is not productive, nor is attempting to shame her into caring for the colostomy by implying her husband will have to provide the care if she does not. It is not possible for the nurse to understand what the client is feeling.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**3. 4.** A history of inflammatory bowel disease is a risk factor for colon cancer. Other risk factors include age (older than 40 years), history of familial polyposis, colorectal polyps, and high-fat or low-fiber diet.

🔑 CN: Reduction of risk potential;  
CL: Analyze

**4. 1, 2, 3, 4, 5.** Colorectal cancer may be asymptomatic, or symptoms vary according to the location of the tumor and the extent of involvement. Fatigue, weight loss, and iron deficiency anemia, even without rectal bleeding or bowel changes, should prompt investigation for colorectal cancer. Fecal occult blood testing commonly reveals evidence of carcinoma when the client is otherwise asymptomatic.

🔑 CN: Health promotion and maintenance;  
CL: Create


**5. 1.** After a barium enema, a laxative is ordinarily prescribed. This is done to promote elimination of the barium. Retained barium predisposes the client to constipation and fecal impaction. Anticholinergic drugs decrease gastrointestinal motility. Antacids decrease gastric acid secretion. Demulcents soothe mucous membranes of the gastrointestinal tract and are used to treat diarrhea.

🔑 CN: Reduction of risk potential;  
CL: Synthesize

**6. 2.** Appropriate nursing interventions after an abdominal-perineal resection with a colostomy include assisting the client with warm sitz baths three to four times a day to clean the perineal incision. The client will be more comfortable assuming a side-lying position because of the perineal incision. It would be inappropriate to administer milk of magnesia to stimulate colostomy activity. Stool passage will begin as peristalsis returns. It is not necessary or desirable to change the ostomy pouch daily to assess the stoma. The ostomy pouch should be transparent to allow easy observation of the stoma and drainage.

🔑 CN: Physiological adaptation;  
CL: Synthesize

**7. 2.** A dark red to purple stoma indicates inadequate blood supply. Mild edema and slight oozing of blood are normal in the early postoperative period. The colostomy would typically not begin functioning until 2 to 4 days after surgery.

 CN: Physiological adaptation;  
CL: Analyze


**8. 2.** A client who displays interest in the procedure and asks about supplies used for dressings may be ready to participate in self-care. Inquiring about the physician's visit, discussing news events, and complaining about a dressing change are behaviors that avoid the subject of the colostomy.

 CN: Basic care and comfort; CL: Analyze

**9. 1.** Karaya and Stomahesive are both effective agents for protecting the skin around a colostomy. They keep the skin healthy and prevent skin irritation from stoma drainage. Petroleum jelly, cornstarch, and antiseptic creams do not protect the skin adequately and may prevent an adequate seal between the skin and the colostomy bag.

 CN: Basic care and comfort; CL: Apply


**10. 1.** Sitz baths are an effective way to clean the operative area after an abdominal-perineal resection. Sitz baths bring warmth to the area, improve circulation, and promote healing and cleanliness. Most clients find them comfortable and relaxing. Between sitz baths, the area should be kept clean and dry. A shower will not adequately clean the perineal area. Moist dressings may promote wound contamination and delay healing. A heating pad applied to the area for longer than 20 minutes may cause excessive vasodilation, leading to congestion and discomfort.

 CN: Physiological adaptation;  
CL: Synthesize

**11. 3.** It is best to adjust the diet of a client with a colostomy in a manner that suits the client rather than trying special diets. Severe restriction of roughage is not recommended. The client is encouraged to drink 2 to 3 L of fluid per day. A high-fiber diet may produce loose stools.

 CN: Basic care and comfort; CL: Create

**12. 1.** An expected outcome is that the client will maintain a fluid intake of 3,000 mL/day unless contraindicated. There is no need to eliminate fiber from the diet; the client can eat whatever foods are desired, avoiding those that are bothersome. Physical activity does not need to be limited to light exercise. The client can resume normal activities as tolerated, usually within 6 to 8 weeks. The client's sexual activity may be affected, but it does not need to be diminished.


 CN: Physiological adaptation;  
CL: Evaluate

## The Client with Hemorrhoids

**13. 2.** Hemorrhoids are associated with prolonged sitting or standing, portal hypertension, chronic constipation, and prolonged increased intra-abdominal pressure, as associated with pregnancy and the strain of vaginal delivery. Her job as a schoolteacher does not require prolonged sitting or standing. Age and leg varicosities are not related to the development of hemorrhoids.

 CN: Reduction of risk potential;  
CL: Analyze

**14. 3.** Positioning in the early postoperative phase should avoid stress and pressure on the operative site. The prone and side-lying positions are ideal from a comfort perspective. A high Fowler's or supine position will place pressure on the operative site and is not recommended. There is no need for Trendelenburg's position.

 CN: Physiological adaptation;  
CL: Synthesize

**15. 1.** Applying heat during the immediate postoperative period may cause hemorrhage at the surgical site. Moist heat may relieve rectal spasms after bowel movements. Urine retention caused by reflex spasm may also be relieved by moist heat. Increasing fiber and fluid in the diet can help prevent constipation.


 CN: Physiological adaptation; CL: Apply

**16. 3.** Adequate cleaning of the anal area is difficult but essential. After rectal surgery, sitz baths assist in this process, so the client should take a sitz bath after a bowel movement. Other times are dictated by client comfort.

 CN: Reduction of risk potential;  
CL: Evaluate

## The Client with Inflammatory Bowel Disease

**17. 2.** In long-term sulfasalazine therapy, the client may develop folic acid deficiency. The client can take folic acid supplements, but the nurse should also encourage the client to increase the intake of folic acid in his diet. Green, leafy vegetables are a good source of folic acid. Citrus fruits, eggs, and milk products are not good sources of folic acid.

 CN: Pharmacological and parenteral therapies; CL: Apply

**18. 2, 5.** The nurse should consider client needs and scope of practice when assigning staff to provide care. The client who is recovering from

inguinal hernia repair surgery and the client who is experiencing an exacerbation of his ulcerative colitis are appropriate clients to assign to a licensed practical nurse as the care they require fall within the scope of practice for a licensed practical nurse. It is not within the scope of practice for the licensed practical nurse to administer TPN, insert nasogastric tubes, or provide client teaching related to medications.

 CN: Management of care; CL: Synthesize


**19. 1.** Stressful and emotional events have been clearly linked to exacerbations of ulcerative colitis, although their role in the etiology of the disease has been disproved. A modified vegetarian diet or an exercise program is an unlikely cause of the exacerbation.

 CN: Physiological adaptation; CL: Apply

**20. 31 gtt/minute**

To administer I.V. fluids at 125 mL/hour using tubing that has a drip factor of 15 gtt/mL, the nurse should use the following formula:


$$125 \text{ mL}/60 \text{ minutes} \times 15 \text{ gtt}/1 \text{ mL} = 31 \text{ gtt}/\text{minute}.$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**21. 2, 4, 5.** The nurse can delegate the following basic care activities to the unlicensed assistant: providing skin care following bowel movements, maintaining intake and output records, and obtaining the client's weight. Assessing the client's bowel sounds and evaluating the client's response to medication are registered nurse activities that cannot be delegated.

 CN: Management of care;  
CL: Synthesize

**22. 2.** Diarrhea is the primary symptom in an exacerbation of ulcerative colitis, and decreasing the frequency of stools is the first goal of treatment. The other goals are ongoing and will be best achieved by halting the exacerbation. The client may receive antidiarrheal agents, antispasmodic agents, bulk hydrophilic agents, or anti-inflammatory drugs.

 CN: Physiological adaptation;  
CL: Synthesize


**23. 2.** Although modified bed rest does help conserve energy and promotes comfort, its primary purpose in this case is to help reduce the hypermotility of the colon. Remaining on bed rest does not by itself reduce stress, and if the client is having stress, the nurse can plan with the client to use strategies that will help the client manage the stress.

 CN: Physiological adaptation;  
CL: Evaluate


**24. 3.** Excessive diarrhea causes significant depletion of the body's stores of sodium and potassium as well as fluid. The client should be closely monitored for hypokalemia and hyponatremia. Ulcerative colitis does not place the client at risk for heart failure, deep vein thrombosis, or hypocalcemia.

 CN: Reduction of risk potential;  
CL: Analyze


**25. 4.** It is not uncommon for clients with ulcerative colitis to become apprehensive and upset about the frequency of stools and the presence of abdominal cramping. During these acute exacerbations, clients need emotional support and encouragement to verbalize their feelings about their chronic health concerns and assistance in developing effective coping methods. The client has not expressed feelings of fatigue or isolation or demonstrated disturbed thought processes.

 CN: Psychosocial adaptation;  
CL: Analyze

**26. 2.** Steroids are effective in management of the acute symptoms of ulcerative colitis. Steroids do not cure ulcerative colitis, which is a chronic disease. Long-term use is not effective in prolonging the remission and is not advocated. Clients should be assessed carefully for side effects related to steroid therapy, but the benefits of short-term steroid therapy usually outweigh the potential adverse effects.

 CN: Pharmacological and parenteral therapies; CL: Apply

**27. 3.** Food will be withheld from the client with severe symptoms of ulcerative colitis to rest the bowel. To maintain the client's nutritional status, the client will be started on TPN. Enteral feedings or dividing the diet into six small meals does not allow the bowel to rest. A high-calorie, high-protein diet will worsen the client's symptoms.


 CN: Physiological adaptation;  
CL: Apply

**28. 1, 2, 4.** Sulfasalazine may cause dizziness and the nurse should caution the client to avoid driving or other activities that require alertness until response to medication is known. If symptoms of acute intolerance (cramping, acute abdominal pain, bloody diarrhea, fever, headache, rash) occur, the client should discontinue therapy and notify the health care provider immediately. Fluid intake should be sufficient to maintain a urine output of at least 1,200–1,500 mL daily to prevent crystalluria and stone formation. The nurse can also inform the client that this medication may cause orange-yellow discoloration of urine and

skin, which is not significant and does not require the client to stop taking the medication. The nurse should instruct the client to take missed doses as soon as remembered unless it is almost time for the next dose.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**29. 3.** Adequate fluid intake of at least 8 glasses a day prevents crystalluria and stone formation during sulfasalazine therapy. Sulfasalazine can cause gastrointestinal distress and is best taken after meals and in equally divided doses. Sulfasalazine gives alkaline urine an orange-yellow color, but it is not necessary to stop the drug when this occurs.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

### 30. 4 tablets

To administer 2 g sulfasalazine (Azulfidine), the nurse will need to administer 4 tablets. The following formula is used to calculate the correct dosage: The first step is to convert grams into milligrams:

$$1 \text{ g}/1,000 \text{ mg} = 2 \text{ g}/X \text{ mg}$$

$$X = 2,000 \text{ mg.}$$


Then,

$$2,000 \text{ mg}/X \text{ tablets} = 500 \text{ mg}/1 \text{ tablet}$$

$$X = 4 \text{ tablets.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**31. 1.** A client with ulcerative colitis need not curtail career goals. Self-care is the cornerstone of long-term management, and learning to cope with and modify stressors will enable the client to live with the disease. Giving up a desired career could discourage and even depress the client. Placing the responsibility for minimizing stressors at work in the hands of others leads to a feeling of loss of control and decreases the sense of responsibility needed for sound self-care. Working part-time rather than full-time is unnecessary.

 CN: Psychosocial adaptation;  
CL: Synthesize


**32. 2.** Clients with ulcerative colitis should follow a well-balanced high-protein, high-calorie, low-residue diet, avoiding such high-residue foods as whole-wheat grains, nuts, and raw fruits and vegetables. Clients with ulcerative colitis need more protein for tissue healing and should avoid excess roughage. There is no need for clients with ulcerative colitis to follow low-sodium diets.

 CN: Basic care and comfort; CL: Apply

**33. 3.** Hypokalemia is the most expected laboratory finding owing to the diarrhea. Hypoalbuminemia can also occur in Crohn's disease; however, the client's potassium level is of greater importance at this time because a low potassium level can cause cardiac arrest. Anemia is an expected development, but thrombocytopenia is not. Calcium levels are not affected.

 CN: Physiological adaptation;  
CL: Analyze


**34. 2.** Initially, the extracellular fluid (ECF) volume with isotonic I.V. fluids until adequate circulating blood volume and renal perfusion are achieved. Vital signs should be monitored as parenteral and oral rehydration are achieved. Oral fluid intake should be greater than 1,000 mL/day. Turning and repositioning the client at regular intervals aids in the prevention of skin breakdown, but it is first necessary to rehydrate this client.

 CN: Physiological adaptation;  
CL: Synthesize

**35. 2, 4, 5.** When caring for a client who is receiving TPN, the nurse should plan to weigh the client daily, monitor the I.V. fluid infusion rate hourly (even when using an I.V. fluid pump), and securely tape all I.V. tubing connections to prevent disconnections. Vital signs should be monitored at least every 4 hours to facilitate early detection of complications. It is recommended that the I.V. dressing be changed once or twice per week or when it becomes soiled, loose, or wet.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**36. 2.** A priority goal of care during an acute exacerbation of Crohn's disease is to promote bowel rest. This is accomplished through decreasing activity, encouraging rest, and initially placing client on nothing-by-mouth status while maintaining nutritional needs parenterally. Regular ambulation is important, but the priority is bowel rest. The client will probably lose some weight during the acute phase of the illness. Diarrhea is nonbloody in Crohn's disease, and episodes of rectal bleeding are not expected.

 CN: Physiological adaptation;  
CL: Synthesize

## The Client with an Intestinal Obstruction

**37. 1, 4, 5.** Signs and symptoms of intestinal obstructions in the small intestine may include projectile vomiting and rapidly developing dehydration

and electrolyte imbalances. The client will also have increased bowel sounds, usually high-pitched and tinkling. The client would not normally have diarrhea and would have minimal abdominal distention. Pain is intermittent, being relieved by vomiting. Intestinal obstructions in the large intestine usually evolve slowly, produce persistent pain, and vomiting is less common. Clients with a large-intestine obstruction may develop obstipation and significant abdominal distention.

 CN: Physiological adaptation;  
CL: Analyze

**38.**

1. Assist with ambulation to promote peristalsis.

2. Administer Ringer's Lactate.


3. Insert a nasogastric tube.

4. Start an infusion of hyperalimentation fluids.

The nurse should first help the client ambulate to try to induce peristalsis; this may be effective and require the least amount of invasive procedures. I.V. fluid therapy can be done to correct fluid and electrolyte imbalances (sodium and potassium), and normal saline or Ringer's Lactate to correct interstitial fluid deficit. Nasogastric (NG) decompression of G.I. tract to reduce gastric secretions and nasointestinal tubes may also be used. Hyperalimentation can be used to correct protein deficiency from chronic obstruction, paralytic ileus, or infection.

 CN: Physiological adaptation;  
CL: Synthesize

**39. 1.** Intestinal decompression is accomplished with a Cantor, Harris, or Miller-Abbott tube. These 6- to 10-foot tubes are passed into the small intestine to the obstruction. They remove accumulated fluid and gas, relieving the pressure. The client will not have an adequate bowel movement until the obstruction is removed. The pressure from the distended intestine should not obstruct urinary output. While the client may be able to more easily sit up, and the pain caused by the intestinal pressure will be less, these are not the primary indicators for successful intestinal decompression.

 CN: Physiological adaptation;  
CL: Evaluate

**40. 2.** The client is placed in a right side-lying position to facilitate movement of the mercury-weighted tube through the pyloric sphincter. After the tube is in the intestine, the client is turned from side to side or encouraged to ambulate to facilitate tube movement through the intestinal loops. Placing the client in the supine or semi-Fowler's position,

or having the client sitting out of bed in a chair will not facilitate tube progression.

 CN: Reduction of risk potential;  
CL: Apply

**41. 2.** A nasogastric tube has a small balloon at its tip that is weighted with mercury. The weight of the mercury helps advance the tube by gravity through the intestine. Nasogastric tubes are attached to suction. A nasogastric tube is not taped in position until it has reached the obstruction. Because the tube has a radiopaque strip, its progress through the intestinal tract can be followed by fluoroscopy.

 CN: Reduction of risk potential;  
CL: Apply

**42. 2.** The client's pain may be indicative of peritonitis, and the nurse should assess for signs and symptoms, such as a rigid abdomen, elevated temperature, and increasing pain. Reassuring the client is important, but accurate assessment of the client is essential. The full assessment should occur before pain relief measures are employed. Repositioning the client to the left side will not resolve the pain.


 CN: Reduction of risk potential;  
CL: Synthesize

**43. 4.** Considering that there is usually 1 L of insensible fluid loss, this client's output exceeds his intake (intake, 2,000 mL; output, 2,200 mL), indicating deficient fluid volume. The kidneys are concentrating urine in response to low circulating volume, as evidenced by a urine output of less than 30 mL/hour. This indicates that increased fluid replacement is needed. Decreasing urine output can be a sign of decreased renal function, but the data provided suggest that the client is dehydrated. Pain does not affect urine output. There are no data to suggest that the obstruction has worsened.

 CN: Reduction of risk potential;  
CL: Analyze


## The Client with an Ileostomy

**44. 2.** Unless the pouch leaks, the client can wear her ileostomy pouch for about 4 to 7 days. If leakage occurs, it is important to promptly change the pouch to avoid skin irritation. It is not necessary to change the pouch daily or in the evening. Diet and activity typically do not affect the schedule for changing the pouch.


 CN: Basic care and comfort;  
CL: Synthesize

**45. 3.** Providing explanations of preoperative and postoperative procedures helps the client prepare and understand what to expect. It also provides


an opportunity for the client to share concerns. Including family members in the teaching sessions is beneficial but does not focus on the client's psychological preparation. Encouraging the client to ask questions about managing the ileostomy may be rushing the client psychologically into accepting the change in body image and function. The client may need time to first handle the stress of surgery and then observe the care of the ileostomy by others before it is appropriate to begin discussing self-management. The nurse should gently explore whether the client is ready to ask questions about management throughout the hospitalization. The client should have the opportunity to express concerns and to agree to an ostomy association visitor before an invitation is extended.

 CN: Psychosocial adaptation;  
CL: Synthesize


**46. 2.** The rationale for the administration of oral neomycin is to decrease intestinal bacteria and thereby decrease the potential for peritonitis and wound infection postoperatively. Neomycin will not alter the client's potential for developing a urinary or respiratory infection. Neomycin does not affect the body's immune system.

 CN: Pharmacological and parenteral therapies; CL: Apply

**47. 3.** A high-priority outcome after ileostomy surgery is the maintenance of fluid and electrolyte balance. The client will experience continuous liquid to semiliquid stools. The client should be engaged in self-care activities, and minimizing odor formation is important; however, these goals do not take priority over maintaining fluid and electrolyte balance.

 CN: Physiological adaptation;  
CL: Synthesize

**48. 3.** If the client agrees, having a visit by a person who has successfully adjusted to living with an ileostomy would be the most helpful measure. This would let the client actually see that typical activities of daily living can be pursued postoperatively. Someone who has felt some of the same concerns can answer the client's questions. A visit from the clergy may be helpful to some clients but would not provide this client with the information sought. Disregarding the client's concerns is not helpful. Although the physician should know about the client's concerns, this in itself will not reassure the client about life after an ileostomy.

 CN: Psychosocial adaptation;  
CL: Synthesize

**49. 3.** Because of high concentrations of digestive enzymes, ileostomy effluent is irritating to skin and can cause excoriation and ulceration. Some form of


protection must be used to keep the effluent from contacting the skin. A skin barrier does not decrease odor formation; odor is controlled by diet. The barrier does not affect the client's hydration status, and the nurse can encourage the client to have an adequate daily intake of fluids. Pouches are usually worn for 4 to 7 days before being changed.

 CN: Basic care and comfort; CL: Evaluate


**50. 3.** Any sudden decrease in drainage or onset of severe abdominal pain should be reported to the physician immediately because it could mean that an obstruction has developed. The ileostomy drains liquid stool at frequent intervals throughout the day. Undigested food may be present at times. A temperature of 99.8° F is not necessarily abnormal or a cause for concern.

 CN: Reduction of risk potential;  
CL: Synthesize

**51. 2.** The fact that the client has an ileostomy does not necessarily mean that she cannot get pregnant and bear children. It may be recommended, however, that the number of pregnancies be limited. Women of childbearing age should be encouraged to discuss their concerns with their physician. Discussing their concerns about sexual functioning and pregnancy will help decrease fears and anxiety. Empathizing or telling the woman that she can adopt does not address her concerns. Her current fears may be based on erroneous understanding. Telling the client that she will adjust to the situation ignores her concerns.

 CN: Psychosocial adaptation;  
CL: Synthesize

**52. 3.** To maintain an adequate fluid balance, the client needs to drink at least 3,000 mL/day. Heavy lifting should be avoided; the physician will indicate when the client can participate in sports again. The client will not resume working as soon as 2 weeks after surgery. Water does not harm the stoma, so the client does not have to worry about getting it wet.

 CN: Physiological adaptation;  
CL: Evaluate


**53. 4.** Sudden onset of abdominal cramps, vomiting, and watery discharge with no stool from an ileostomy are likely indications of an obstruction. It is imperative that the physician examine the client immediately. Although the client is vomiting, the client should not take an antiemetic until the physician has examined the client. If an obstruction is present, ingesting fluids or taking milk of magnesia will increase the severity of symptoms. Oral intake is avoided when a bowel obstruction is suspected.

 CN: Reduction of risk potential;  
CL: Synthesize




## The Client Receiving Total Parenteral Nutrition


**54. 3.** The nurse should first obtain a culture specimen. The presence of drainage is a potential indication of an infection and the catheter may need to be removed. A culture specimen should be obtained and sent for analysis so that treatment can be promptly initiated. Since removing the catheter will be required in the presence of an infection, the nurse would not clean and redress the area. After the culture report is obtained, the nurse should notify the physician and document all assessments and client care activities in the client's record.

 CN: Safety and infection control;  
CL: Synthesize


**55. 1.** When using a sliding-scale insulin schedule, the nurse obtains a glucometer reading of the client's blood glucose level immediately before giving the insulin and bases the dosage on those findings. The fasting blood glucose level obtained earlier in the day is not relevant to an evening sliding-scale insulin dosage. The nurse cannot calculate insulin dosage by assessing the amount of TPN intake or dietary intake.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**56. 2.** The TPN solution is usually a hypertonic dextrose solution. The greater the concentration of dextrose in solution, the greater the tonicity. Hypertonic dextrose solutions are used to meet the body's calorie demands in a volume of fluid that will not overload the cardiovascular system. An isotonic dextrose solution (e.g., 5% dextrose in water) or a hypotonic dextrose solution will not provide enough calories to meet metabolic needs. Colloids are plasma expanders and blood products and are not used in TPN.


 CN: Pharmacological and parenteral therapies; CL: Apply

**57. 1.** The goal of TPN is to meet the client's nutritional needs. TPN is not used to treat metabolic acidosis; ketoacidosis can actually develop as a result of administering TPN. TPN is a hypertonic solution containing carbohydrates, amino acids, electrolytes, trace elements, and vitamins. It is not used to meet the hydration needs of clients. TPN is administered to provide a positive nitrogen balance.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**58. 4.** During TPN administration, the client should be monitored regularly for hyperglycemia. The client may require small amounts of insulin to

improve glucose metabolism. The client should also be observed for signs and symptoms of hypoglycemia, which may occur if the body overproduces insulin in response to a high glucose intake or if too much insulin is administered to help improve glucose metabolism. Tachycardia or hypertension is not indicative of the client's ability to metabolize the solution. An elevated blood urea nitrogen concentration is indicative of renal status and fluid balance.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**59. 2.** Complications associated with administration of TPN through a central line include infection and air embolism. To prevent these complications, strict aseptic technique is used for all dressing changes, the insertion site is covered with an air-occlusive dressing, and all connections of the system are taped. Ambulation and activities of daily living are encouraged and not limited during the administration of TPN.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**60. 3, 4, 2, 1.** A potential complication of receiving TPN is leakage or catheter puncture; notify the physician immediately and prepare for changing of the catheter. If pneumothorax is suspected, position a rolled towel under the client's back. If there is drainage at the insertion site, culture the drainage and change the dressing using sterile technique.

 CN: Reduction of risk potential;  
CL: Synthesize


**61. 1.** The administration of fat emulsion solution provides additional calories and essential fatty acids to meet the body's energy needs. Fatty acids are lipids, not carbohydrates. Fatty acids do not aid in the metabolism of glucose. Although they are necessary for meeting the complete nutritional needs of the client, fatty acids do not necessarily help a client maintain normal body weight.

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 4.** An elevated temperature can be an indication of an infection at the insertion site or in the catheter. Vital signs should be taken every 2 to 4 hours after initiation of TPN therapy to detect early signs of complications. Glycosuria is to be expected during the first few days of therapy until the pancreas adjusts by secreting more insulin. A gradual weight gain is to be expected as the client's nutritional status improves. Some clients experience a decreased appetite during TPN therapy.

 CN: Reduction of risk potential;  
CL: Analyze

**63. 2.** Too rapid infusion of a TPN solution can lead to circulatory overload. The client should be assessed carefully for indications of excessive fluid volume. A negative nitrogen balance occurs in nutritionally depleted individuals, not when TPN fluids are administered in excess. When TPN is administered too rapidly the client is at risk for receiving an excess of dextrose and electrolytes. Therefore, the client is at risk for hyperglycemia and hyperkalemia.

 CN: Pharmacological and parenteral therapies; CL: Analyze

### The Client with Diverticular Disease

**64. 1, 2, 4.** Clients with diverticulosis are encouraged to follow a high-fiber diet. Bran, broccoli, and navy beans are foods high in fiber. Tomato juice and cheese are low-residue foods.

 CN: Reduction of risk potential;  
CL: Apply

**65. 3.** Because of the inflammatory nature of diverticulitis, the nurse would anticipate an elevated white blood cell count. The remaining laboratory findings are not associated with diverticulitis. Elevated red blood cell counts occur in clients with polycythemia vera or fluid volume deficit. Decreased platelet counts can occur as a result of aplastic anemias or malignant blood disorders, as an adverse effect of some drugs, and as a result of some heritable conditions. Elevated serum blood urea nitrogen concentration is usually associated with renal conditions.

 CN: Reduction of risk potential;  
CL: Analyze

**66. 1.** Barium enemas and colonoscopies are contraindicated in clients with acute diverticulitis because they can lead to perforation of the colon and peritonitis. A barium enema may be ordered after the client has been treated with antibiotic therapy and the inflammation has subsided. A barium enema is diagnostic in diverticulitis. A barium enema could increase the client's pain; however, that is not a reason for excluding this test. The client may be able to tolerate the procedure but the concern is the potential for perforation of the intestine.

 CN: Reduction of risk potential;  
CL: Apply

**67. 4.** Clients with diverticular disease should refrain from any activities, such as lifting, straining, or coughing, that increase intra-abdominal pressure and may precipitate an attack. Enemas are contraindicated because they increase intestinal pressure. Fluid intake should be increased, rather than


decreased, to promote soft, formed stools. A low-fiber diet is used when inflammation is present.

 CN: Reduction of risk potential;  
CL: Synthesize

**68. 3, 4, 5.** Clients who have diverticulosis should be instructed to maintain a diet high in fiber and, unless contraindicated, should increase their fluid intake to a minimum of 2,000 mL/day. Participating in a regular exercise program is also strongly encouraged. Diverticulosis can be controlled with treatment but cannot be cured. Clients should be instructed to avoid the regular use of cathartic laxatives. Bulk laxatives and stool softeners may be helpful to maintain regularity and decrease straining.

 CN: Reduction of risk potential;  
CL: Evaluate

**69. 1.** Diverticular disease is treated with a high-fiber diet and bulk laxatives such as psyllium hydrophilic mucilloid (Metamucil). Fiber decreases the intraluminal pressure and makes it easier for stool to pass through the colon. Bulk laxatives do not manage diarrhea, anxiety or relieve gas formation.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**70. 1, 2, 5.** Assessment during peritonitis will reveal fever, tachypnea, and tachycardia. The abdomen becomes rigid with rebound tenderness and there will be absent bowel sounds. Percussion will show resonance and tympany indicating paralytic ileus; loss of liver dullness may indicate free air in the abdomen. There is anorexia, nausea, and vomiting as peristalsis decreases.

 CN: Physiological adaptation;  
CL: Analyze

### The Client with Appendicitis

**71. 4.** The nurse should gently clean the area around the drain by moving in a circular motion away from the drain. Doing so prevents the introduction of microorganisms to the wound and drain site. The incision cannot be left open to air as long as the drain is intact. The nurse should note the amount and character of wound drainage, but the surgeon will determine when the drain should be removed. Surgical wound drains are not irrigated.


 CN: Safety and infection control;  
CL: Synthesize

**72. 3.** The nurse should place the client on NPO status in anticipation of surgery. The nurse can initiate pain relief strategies, such as relaxation


techniques, but the surgeon will likely not order narcotic medication prior to surgery. The nurse can place the client in a position that is most comfortable for the client. Heat is contraindicated because it may lead to perforation of the appendix.

 CN: Reduction of risk potential;  
CL: Synthesize


**73. 4.** Complications of acute appendicitis are perforation, peritonitis, and abscess development. Signs of the development of peritonitis include abdominal pain and distention, tachycardia, tachypnea, nausea, vomiting, and fever. Because peritonitis can cause hypovolemic shock, hypotension can develop. Deficient fluid volume would not cause a fever. Intestinal obstruction would cause abdominal distention, diminished or absent bowel sounds, and abdominal pain. Bowel ischemia has signs and symptoms similar to those found with intestinal obstruction.

 CN: Physiological adaptation;  
CL: Analyze

**74. 2.** Noting the client's first bowel movement after surgery is important because this indicates that normal peristalsis has returned. Sitz baths are used after rectal surgery, not appendectomy. Ambulation is started the day of surgery and is not confined to bathroom privileges. The abdomen should be auscultated for bowel sounds and palpated for softness, but there is no need to measure the girth every 2 hours.

 CN: Physiological adaptation;  
CL: Synthesize


**75. 2.** Drains are inserted postoperatively in appendectomies when an abscess was present or the appendix was perforated. The purpose is to promote drainage of exudate from the wound and facilitate healing. A drain is not used for irrigation of the wound. The drain will not minimize scar tissue development or decrease postoperative discomfort.

 CN: Reduction of risk potential;  
CL: Apply


### The Client with an Inguinal Hernia

**76. 3.** The symptoms are indicative of a strangulated hernia. In a strangulated hernia, the hernia cannot be reduced back into the abdominal cavity. The intestinal lumen and the blood supply to the intestine are obstructed, causing an acute intestinal obstruction. Without immediate intervention, necrosis and gangrene may develop. Surgery is required to release the strangulation. Although many of these signs and symptoms are present with peritonitis or perforated bowel, abdominal rigidity, a cardinal sign

of peritonitis and perforated bowel, is not mentioned. Therefore, the nurse would not immediately suspect these conditions. An incarcerated hernia refers to a hernia that is irreducible but has not necessarily resulted in an obstruction.

 CN: Physiological adaptation;  
CL: Analyze

**77. 2.** After inguinal herniorrhaphy, an ice bag to the scrotum will help decrease pain and edema. The client is encouraged to turn and deep-breathe, but coughing is not encouraged, to decrease straining on the surgical area. A truss is not needed for support after surgery. While resting, the client may be most comfortable in a semi-Fowler's position, but there is no need to maintain a high Fowler's position.

 CN: Physiological adaptation;  
CL: Synthesize

**78. 4.** The most common complication after an inguinal hernia repair is the inability to void, especially in men. The nurse should evaluate the client carefully for urine retention. Hypostatic pneumonia, deep vein thrombosis, and paralytic ileus are potential postoperative problems with any surgical client but are not as likely to occur after an inguinal hernia repair as is urine retention.

 CN: Reduction of risk potential;  
CL: Analyze

### Managing Care Quality and Safety


**79. 4, 5.** *Clostridium difficile* is an organism that has developed very resistant and highly morbid strains. Universal precautions, most importantly hand washing, wearing personal protective gear, and modest use of antibiotics, are critical actions for stopping the spread. *C. difficile* is not spread via the respiratory tract, therefore, a mask is not needed. Alcohol-based hand sanitizers do not kill the spores of *C. difficile*; soap and water must be used. Sterile gloves are not needed to provide care; clean gloves may be worn.

 CN: Safety and infection control;  
CL: Synthesize

**80. 4.** When TPN fluids are infused too rapidly or too slowly, the physician should be notified. TPN solutions must be carefully and accurately infused. Rate adjustments should not be made without a written order from the physician. Significant alterations in rate (10% increase or decrease) can result in fluctuations of blood glucose levels. Speeding up the solution can result in too much glucose entering the system.

 CN: Management of care; CL: Synthesize

**81. 3.** The nurse should contact the pharmacy directly and request that a properly labeled medication be provided. The nurse should not administer any drug that is not properly labeled, even if the nurse or another nurse recognizes the medication. It is not necessary to notify the unit manager at this point because the client needs to receive the antibiotic as soon as possible.

 CN: Safety and infection control;  
CL: Apply

**82. 3.** When dehiscence occurs, the nurse should immediately cover the wound with a sterile dressing moistened with normal saline. If the dehiscence is extensive, the incision must be resutured in surgery. Later, after the sutures are removed, additional support may be provided to the incision by applying strips of tape as directed by institutional policy or by the surgeon. An abdominal binder may also be utilized for additional support.

 CN: Reduction of risk potential;  
CL: Synthesize

# TEST 7

## The Client with Biliary Tract Disorders

- The Client with Cholecystitis
- The Client with Pancreatitis
- The Client with Viral Hepatitis
- The Client with Cirrhosis
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Cholecystitis

**1.** A client has undergone a laparoscopic cholecystectomy. Which of the following instructions should the nurse include in the discharge teaching?

- 1. Empty the bile bag daily.
- 2. If you become nauseated, breathe deeply into a paper bag.
- 3. Keep adhesive dressings in place for 6 weeks.
- 4. Report bile-colored drainage from any incision.

**2.** A 40-year-old client is admitted to the hospital with a diagnosis of acute cholecystitis. The nurse should contact the physician to question which of the following orders?

- 1. I.V. fluid therapy of normal saline solution to be infused at 100 mL/hour until further orders.
- 2. Administer morphine sulfate 10 mg I.M. every 4 hours as needed for severe abdominal pain.
- 3. Nothing by mouth (NPO) until further orders.
- 4. Insert a nasogastric tube and connect to low intermittent suction.

**3.** A client is admitted to the hospital with a diagnosis of cholecystitis from cholelithiasis. The client has severe abdominal pain, nausea, and has vomited several times. Based on these data, which nursing diagnosis would have the **highest** priority for intervention at this time?

- 1. *Anxiety* related to severe abdominal discomfort.
- 2. *Deficient fluid volume* related to vomiting.
- 3. *Pain* related to gallbladder inflammation.
- 4. *Imbalanced nutrition: Less than body requirements* related to vomiting.

**4.** A client's stools are light gray in color. The nurse should assess the client further for which of the following? Select all that apply.

- 1. Intolerance to fatty foods.
- 2. Fever.
- 3. Jaundice.
- 4. Respiratory distress.
- 5. Pain at McBurney's point.
- 6. Peptic ulcer disease.

**5.** A client who has been scheduled to have a choledocholithotomy expresses anxiety about having surgery. Which nursing intervention would be the **most** appropriate to achieve the outcome of anxiety reduction?

- 1. Providing the client with information about what to expect postoperatively.
- 2. Telling the client it is normal to be afraid.
- 3. Reassuring the client by telling her that surgery is a common procedure.
- 4. Stressing the importance of following the physician's instructions after surgery.

**6.** A client has an open cholecystectomy with bile duct exploration. Following surgery, the client has a T-tube. To evaluate the effectiveness of the T-tube, the nurse should:

- 1. Irrigate the tube with 20 mL of normal saline every 4 hours.
- 2. Unclamp the T-tube and empty the contents every day.
- 3. Assess the color and amount of drainage every shift.
- 4. Monitor the multiple incision sites for bile drainage.

7. At 8 a.m., the nurse reviews the amount of T-tube drainage for a client who underwent an open cholecystectomy yesterday. After reviewing the output record (see chart), the nurse should:

Output Record	
Date	T-tube
12 pm	50 mL
4 pm	60 mL
8 pm	60 mL
12 am	70 mL
4 am	70 mL
8 am	10 mL

- 1. Report the 24-hour drainage amount at 12 noon.
- 2. Clamp the T-tube.
- 3. Evaluate the tube for patency.
- 4. Irrigate the T-tube.

8. The nurse measures the amount of bile drainage from a T-tube and records it by which one of the following methods?

- 1. Adding it to the client's urine output.
- 2. Charting it separately on the output record.
- 3. Adding it to the amount of wound drainage.
- 4. Subtracting it from the total intake for each day.

9. After a cholecystectomy, the client is to follow a low-fat diet. Which of the following foods would be **most** appropriate to include in a low-fat diet?

- 1. Cheese omelet.
- 2. Peanut butter.
- 3. Ham salad sandwich.
- 4. Roast beef.

10. A client with cholecystitis continues to have severe right upper quadrant pain. The nurse obtains the following vital signs: temperature 38.4° C; pulse 114; respirations 22; blood pressure 142/90. Using the SBAR (Situation-Background-Assessment-Recommendation) technique for communication, the nurse recommends to the primary care provider for the client to receive:

- 1. Hydromorphone (Dilaudid) I.V.
- 2. Diltiazem (Cardizem) PO.
- 3. Meperidine (Demerol) I.M.
- 4. Promethazine (Phenergan).

11. The nurse prepares to administer promethazine (Phenergan) 35 mg I.M. as ordered p.r.n. for a client with cholecystitis complaining of nausea. The ampule label reads that the medication is available in 25 mg/mL. How many milliliters should the nurse administer?

\_\_\_\_\_ mL.

12. A client undergoes a laparoscopic cholecystectomy. Which of the following dietary instructions should the nurse give the client immediately after surgery?

- 1. "You cannot eat or drink anything for 24 hours."
- 2. "You may resume your normal diet the day after your surgery."
- 3. "Drink liquids today and eat lightly for a few days."
- 4. "You can progress from a liquid to a bland diet as tolerated."

13. Which of the following discharge instructions would be appropriate for a client who has had a laparoscopic cholecystectomy?

- 1. Avoid showering for 48 hours after surgery.
- 2. Return to work within 1 week.
- 3. Leave dressings in place until you see the surgeon at the postoperative visit.
- 4. Use acetaminophen (Tylenol) to control any fever.

14. After a client who has had a laparoscopic cholecystectomy receives discharge instructions, which of the following client statements would indicate that the teaching has been successful? Select all that apply.

- 1. "I can resume my normal diet when I want."
- 2. "I need to avoid driving for about 4 weeks."
- 3. "I may experience some pain in my right shoulder."
- 4. "I should spend 2 to 3 days in bed before resuming activity."
- 5. "I can wash the puncture site with mild soap and water."

### The Client with Pancreatitis

15. A client has an amylase level of 450 units/L and lipase level of 659 units/L. The client has mid-epigastric pain with nausea. What assessment helps the nurse to determine severity of the client's condition?

- 1. Ranson's criteria.
- 2. Vital signs.
- 3. Urine output.
- 4. Glasgow Coma Scale.

**16.** The client who has been hospitalized with pancreatitis does not drink alcohol because of her religious convictions. She becomes upset when the physician persists in asking her about alcohol intake. The nurse should explain that the reason for these questions is that:

- 1. There is a strong link between alcohol use and acute pancreatitis.
- 2. Alcohol intake can interfere with the tests used to diagnose pancreatitis.
- 3. Alcoholism is a major health problem, and all clients are questioned about alcohol intake.
- 4. The physician must obtain the pertinent facts, regardless of religious beliefs.

**17.** The nurse monitors the client with pancreatitis for early signs of shock. Which of the following conditions is **primarily** responsible for making it difficult to manage shock in pancreatitis?

- 1. Severity of intestinal hemorrhage.
- 2. Vasodilating effects of kinin peptides.
- 3. Tendency toward heart failure.
- 4. Frequent incidence of acute tubular necrosis.

**18.** A client with acute pancreatitis has a blood pressure of 88/40, heart rate of 128 beats per minute, respirations of 28 per minute, and Grey Turner's sign. What action should the nurse perform **first**?

- 1. Assess the urine output.
- 2. Place an intravenous line.
- 3. Position on the left side.
- 4. Insert a nasogastric tube.

**19.** A client is admitted with acute necrotizing pancreatitis. Lab results have been obtained and a peripheral I.V. has been inserted. Which of the following orders from a health care provider should the nurse question?

- 1. Infuse a 500 mL normal saline bolus.
- 2. Calcium gluconate 90 mg in 100 mL NS.
- 3. Total parenteral nutrition (TPN) at 72 mL/hour.
- 4. Placement of a Foley catheter.

**20.** Which of the following medications would the nurse question for a client with acute pancreatitis?

- 1. Furosemide (Lasix) 20 mg I.V. push.
- 2. Imipenem (Primaxin) 500 mg I.V.
- 3. Morphine Sulfate 2 mg I.V. push.
- 4. Famotidine (Pepcid) 20 mg I.V. push.

**21.** The nurse should monitor the client with acute pancreatitis for which of the following complications?

- 1. Heart failure.
- 2. Duodenal ulcer.
- 3. Cirrhosis.
- 4. Pneumonia.

**22.** When providing care for a client hospitalized with acute pancreatitis who has acute abdominal pain, which of the following nursing interventions would be **most** appropriate for this client? Select all that apply.

- 1. Placing the client in a side-lying position.
- 2. Administering morphine sulfate for pain as needed.
- 3. Maintaining the client on a high-calorie, high-protein diet.
- 4. Monitoring the client's respiratory status.
- 5. Obtaining daily weights.

**23.** The nurse notes that a client with acute pancreatitis occasionally experiences muscle twitching and jerking. How should the nurse interpret the significance of these symptoms?

- 1. The client may be developing hypocalcemia.
- 2. The client is experiencing a reaction to mep-eridine (Demerol).
- 3. The client has a nutritional imbalance.
- 4. The client needs a muscle relaxant to help him rest.

**24.** A client is receiving Propantheline bromide (Pro-Banthine) in the management of acute pancreatitis. Which of the following would indicate that the nurse should withhold the medication?

- 1. Absent bowel sounds.
- 2. Increased urine output.
- 3. Diarrhea.
- 4. Decreased heart rate.

**25.** Which of the following dietary instructions would be appropriate for the nurse to give a client who is recovering from acute pancreatitis?

- 1. Avoid crash dieting.
- 2. Restrict carbohydrate intake.
- 3. Eat six small meals a day.
- 4. Decrease sodium in the diet.

**26.** Pancreatic enzyme replacements are ordered for the client with chronic pancreatitis. When should the nurse instruct the client to take them to obtain the most therapeutic effect?

- 1. Three times daily between meals.
- 2. With each meal and snack.
- 3. In the morning and at bedtime.
- 4. Every 4 hours, at specified times.

**27.** The nurse should teach the client with chronic pancreatitis to monitor the effectiveness of pancreatic enzyme replacement therapy by doing which of the following?

- 1. Monitoring fluid intake.
- 2. Performing regular glucose fingerstick tests.
- 3. Observing stools for steatorrhea.
- 4. Testing urine for ketones.

**28.** The client with chronic pancreatitis should be monitored closely for the development of which of the following disorders?

- 1. Cholelithiasis.
- 2. Hepatitis.
- 3. Irritable bowel syndrome.
- 4. Diabetes mellitus.

### The Client with Viral Hepatitis

**29.** The nurse is assessing a client with chronic hepatitis B who is receiving Lamivudine (Epivir). What information is **most** important to communicate to the physician?

- 1. The client's daily record indicates a 3 kg weight gain over 2 days.
- 2. The client is complaining of nausea.
- 3. The client has a temperature of 99° F orally.
- 4. The client has fatigue.

**30.** The nurse is assessing a client with hepatitis and notices that the AST and ALT lab values have increased. Which of the following statements by the client requires further instruction by the nurse?

- 1. "I require increased periods of rest."
- 2. "I follow a low-fat, high carbohydrate diet."
- 3. "I eat dry toast to relieve my nausea."
- 4. "I take acetaminophen (Tylenol) for arthritis pain."

**31.** College freshman are participating in a study abroad program. When teaching them about hepatitis B, the nurse should instruct the students on:

- 1. Water sanitation.
- 2. Single dormitory rooms.
- 3. Vaccination for hepatitis D.
- 4. Safe sexual practices.

**32.** Which of the following is normal for a client during the icteric phase of viral hepatitis?

- 1. Tarry stools.
- 2. Yellowed sclera.
- 3. Shortness of breath.
- 4. Light, frothy urine.

**33.** The nurse is planning a home visit for a client with hepatitis. In order to prevent transmission the nurse should focus teaching on:

- 1. Proper food handling.
- 2. Insulin syringe disposal.
- 3. Alpha-interferon.
- 4. Use of condoms.

**34.** A client who is recovering from hepatitis A has fatigue and malaise. The client asks the nurse, "When will my strength return?" Which of the following responses by the nurse is **most** appropriate?

- 1. "Your fatigue should be gone by now. We will evaluate you for a secondary infection."
- 2. "Your fatigue is an adverse effect of your drug therapy. It will disappear when your treatment regimen is complete."
- 3. "It is important for you to increase your activity level. That will help decrease your fatigue."
- 4. "It is normal for you to feel fatigued. The fatigue should go away in the next 2 to 4 months."

**35.** The nurse is developing a plan of care for the client with viral hepatitis. The nurse should instruct the client to:

- 1. Obtain adequate bed rest.
- 2. Increase fluid intake.
- 3. Take antibiotic therapy as ordered.
- 4. Drink 8 oz of an electrolyte solution every day.

**36.** When planning care for a client with viral hepatitis, the nurse should review laboratory reports for which of the following abnormal laboratory values?

- 1. Prolonged prothrombin time.
- 2. Decreased blood glucose level.
- 3. Elevated serum potassium level.
- 4. Decreased serum calcium level.

**37.** The nurse should teach the client with viral hepatitis to:

- 1. Limit caloric intake and reduce weight.
- 2. Increase carbohydrates and protein in the diet.
- 3. Avoid contact with others and live separately.
- 4. Intensify routine exercise and increase strength.

**38.** The nurse develops a teaching plan for the client about how to prevent the transmission of hepatitis A. Which of the following discharge instructions is appropriate for the client?

- 1. Spray the house to eliminate infected insects.
- 2. Tell family members to try to stay away from the client.
- 3. Tell family members to wash their hands frequently.
- 4. Disinfect all clothing and eating utensils.



**39.** The nurse assesses that the client with hepatitis is experiencing fatigue, weakness, and a general feeling of malaise. The client tires rapidly during morning care. Based on this information, which of the following would be an appropriate nursing diagnosis?

- 1. *Impaired physical mobility* related to malaise.
- 2. *Self-care deficit* related to fatigue.
- 3. *Ineffective coping* related to long-term illness.
- 4. *Activity intolerance* related to fatigue.

**40.** What would be the nurse's **best** response to the client's expressed feelings of isolation as a result of having hepatitis?

- 1. "Don't worry. It's normal to feel that way."
- 2. "Your friends are probably afraid of contracting hepatitis from you."
- 3. "I'm sure you're imagining that!"
- 4. "Tell me more about your feelings of isolation."

**41.** Interferon alfa-2b (Intron A) has been prescribed to treat a client with chronic hepatitis B. The nurse should assess the client for which of the following adverse effects?

- 1. Retinopathy.
- 2. Constipation.
- 3. Flulike symptoms.
- 4. Hypoglycemia.

**42.** The nurse is preparing a community education program about preventing hepatitis B infection. Which of the following would be appropriate to incorporate into the teaching plan?

- 1. Hepatitis B is relatively uncommon among college students.
- 2. Frequent ingestion of alcohol can predispose an individual to development of hepatitis B.
- 3. Good personal hygiene habits are most effective at preventing the spread of hepatitis B.
- 4. The use of a condom is advised for sexual intercourse.

**43.** Which of the following expected outcomes would be appropriate for a client with viral hepatitis? The client will:

- 1. Demonstrate a decrease in fluid retention related to ascites.
- 2. Verbalize the importance of reporting bleeding gums or bloody stools.
- 3. Limit use of alcohol to two to three drinks per week.
- 4. Restrict activity to within the home to prevent disease transmission.

## The Client with Cirrhosis

**44.** A client with cirrhosis is receiving Lactulose (Cephulac). During the assessment the nurse notes increased confusion and asterixis. The nurse should:

- 1. Assess for GI bleeding.
- 2. Hold the Lactulose (Cephulac).
- 3. Increase protein in the diet.
- 4. Monitor serum bilirubin levels.

**45.** The nurse is assessing a client with cirrhosis who has developed hepatic encephalopathy. The nurse should notify the physician of a decrease in which lab serum that is a potential precipitating factor for hepatic encephalopathy?

- 1. Aldosterone.
- 2. Creatinine.
- 3. Potassium.
- 4. Protein.

**46.** A client has advanced cirrhosis of the liver. The client's spouse asks the nurse why his abdomen is swollen, making it very difficult for him to fasten his pants. How should the nurse respond to provide the **most** accurate explanation of the disease process?

- 1. "He must have been eating too many foods with salt in them. Salt pulls water with it."
- 2. "The swelling in his ankles must have moved up closer to his heart so the fluid circulates better."
- 3. "He must have forgotten to take his daily water pill."
- 4. "Blood is not able to flow readily through the liver now, and the liver cannot make protein to keep fluid inside the blood vessels."

**47.** A nurse is developing a care plan for a client with hepatic encephalopathy. Which of the following are goals for the care for this client? Select all that apply.

- 1. Preventing constipation.
- 2. Administering lactulose (Cephulac).
- 3. Monitoring coordination while walking.
- 4. Checking the pupil reaction.
- 5. Providing food and fluids high in carbohydrate.
- 6. Encouraging physical activity.

**48.** The nurse is assessing a client who is in the early stages of cirrhosis of the liver. Which focused assessment is appropriate?

- 1. Peripheral edema.
- 2. Ascites.
- 3. Anorexia.
- 4. Jaundice.

**49.** A client with cirrhosis begins to develop ascites. Spironolactone (Aldactone) is prescribed to treat the ascites. The nurse should monitor the client closely for which of the following drug-related adverse effects?

- 1. Constipation.
- 2. Hyperkalemia.
- 3. Irregular pulse.
- 4. Dysuria.

**50.** What diet should be implemented for a client who is in the early stages of cirrhosis?

- 1. High-calorie, high-carbohydrate.
- 2. High-protein, low-fat.
- 3. Low-fat, low-protein.
- 4. High-carbohydrate, low-sodium.

**51.** A client with jaundice has pruritis and states that he has areas of irritation from scratching. What measures can the nurse discuss to prevent skin breakdown? Select all that apply.

- 1. Avoid lotions containing calamine.
- 2. Take baking soda baths.
- 3. Keep nails short and clean.
- 4. Rub with knuckles instead of nails.
- 5. Massage skin with alcohol.
- 6. Increase sodium intake in diet.

**52.** Which of the following health promotion activities would be appropriate for the nurse to suggest that the client with cirrhosis add to the daily routine at home?

- 1. Supplement the diet with daily multivitamins.
- 2. Limit daily alcohol intake.
- 3. Take a sleeping pill at bedtime.
- 4. Limit contact with other people whenever possible.

**53.** The nurse is reviewing the chart information for a client with increased ascites. The data include: temperature 37.2° C; heart rate 118; shallow respirations 26; blood pressure 128/76; and SpO<sub>2</sub> 89% on room air. Which action should receive **priority** by the nurse?

- 1. Assess heart sounds.
- 2. Obtain an order for blood cultures.
- 3. Prepare for a paracentesis.
- 4. Raise the head of the bed.

**54.** Which of the following positions would be appropriate for a client with severe ascites?

- 1. Fowler's.
- 2. Side-lying.
- 3. Reverse Trendelenburg.
- 4. Sims.

**55.** The client with cirrhosis receives 100 mL of 25% serum albumin I.V. Which finding would **best** indicate that the albumin is having its desired effect?

- 1. Increased urine output.
- 2. Increased serum albumin level.
- 3. Decreased anorexia.
- 4. Increased ease of breathing.

**56.** The nurse is planning care for a client being admitted with bleeding esophageal varices. Vital signs are: Pulse 100; respiratory rate 22; and blood pressure 100/58. The nurse should prepare the client for which of the following? Select all that apply.

- 1. Administration of intravenous Octreotide (Sandostatin).
- 2. Endoscopy.
- 3. Administration of a blood product.
- 4. Minnesota tube insertion.
- 5. Transjugular intrahepatic portosystemic shunt (TIPS) procedure.
- 6. Immediate endotracheal intubation.

**57.** A client with a Sengstaken-Blakemore tube has a sudden drop in SpO<sub>2</sub> and increase in respiratory rate to 40 breaths/minute. The nurse should do which of the following in order from first to last?

1. Affirm airway obstruction by the tube.

2. Remove the tube.

3. Deflate the tube by cutting with bedside scissors.

4. Apply oxygen via face mask.

**58.** The physician orders oral neomycin (Mycifradin) as well as a neomycin enema for a client with cirrhosis. The expected outcome of this therapy is to:

- 1. Reduce abdominal pressure.
- 2. Prevent straining during defecation.
- 3. Block ammonia formation.
- 4. Reduce bleeding within the intestine.

**59.** The nurse monitors a client with cirrhosis for the development of hepatic encephalopathy. Which of the following would be an indication that hepatic encephalopathy is developing?

- 1. Decreased mental status.
- 2. Elevated blood pressure.
- 3. Decreased urine output.
- 4. Labored respirations.

**60.** A client's serum ammonia level is elevated, and the physician orders 30 mL of lactulose (Cephulac). Which of the following is an adverse effect of this drug?

- 1. Increased urine output.
- 2. Improved level of consciousness.
- 3. Increased bowel movements.
- 4. Nausea and vomiting.

**61.** The nurse has an order to administer 2 oz of lactulose (Cephulac) to a client who has cirrhosis. How many milliliters of lactulose should the nurse administer?

\_\_\_\_\_ mL.

**62.** A client is to be discharged with a prescription for lactulose (Cephulac). The nurse teaches the client and the client's spouse how to administer this medication. Which of the following statements would indicate that the client has understood the information?

- 1. "I'll take it with Maalox."
- 2. "I'll mix it with apple juice."
- 3. "I'll take it with a laxative."
- 4. "I'll mix the crushed tablets in some gelatin."

**63.** The nurse is providing discharge instructions for a client with cirrhosis. Which of the following statements **best** indicates that the client has understood the teaching?

- 1. "I should eat a high-protein, high-carbohydrate diet to provide energy."
- 2. "It is safer for me to take acetaminophen (Tylenol) for pain instead of aspirin."
- 3. "I should avoid constipation to decrease chances of bleeding."
- 4. "If I get enough rest and follow my diet, it is possible for my cirrhosis to be cured."

**64.** The nurse is preparing a client for a paracentesis. The nurse should:

- 1. Have the client void immediately before the procedure.
- 2. Place the client in a side-lying position.
- 3. Initiate an I.V. line to administer sedatives.
- 4. Place the client on nothing-by-mouth (NPO) status 6 hours before the procedure.

**65.** Which of the following interventions should the nurse anticipate incorporating into the client's plan of care when hepatic encephalopathy initially develops?

- 1. Inserting a nasogastric (NG) tube.
- 2. Restricting fluids to 1,000 mL/day.
- 3. Administering I.V. salt-poor albumin.
- 4. Implementing a low-protein diet.

**66.** A client with ascites and peripheral edema is at risk for impaired skin integrity. To prevent skin breakdown, the nurse should:

- 1. Institute range-of-motion (ROM) exercise every 4 hours.
- 2. Massage the abdomen once a shift.
- 3. Use an alternating air pressure mattress.
- 4. Elevate the lower extremities.

### Managing Care Quality and Safety

**67.** The nurse is planning a staff development program on how to care for clients with hepatitis A. Which of the following precautions should the nurse indicate as essential when caring for clients with hepatitis A?

- 1. Gowning when entering a client's room.
- 2. Wearing a mask when providing care.
- 3. Assigning the client to a private room.
- 4. Wearing gloves when giving direct care.

**68.** The nurse's assignment consists of the following four clients. From highest to lowest priority, in which order should the nurse assess the clients after receiving morning report?

1. The client with cirrhosis who became confused and disoriented during the night.

2. The client with acute pancreatitis who is requesting pain medication.

3. The client who is 1 day postoperative following a cholecystectomy and has a T-tube inserted.

4. The client with hepatitis B who has questions about his discharge instructions.

**69.** The nurse should institute which of the following measures to prevent transmission of the hepatitis C virus to health care personnel?

- 1. Administering hepatitis C vaccine to all health care personnel.
- 2. Decreasing contact with blood and blood-contaminated fluids.
- 3. Wearing gloves when emptying the bedpan.
- 4. Wearing a gown and mask when providing direct care.

**70.** The nurse is taking care of a client who has an I.V. infusion pump. The pump alarm rings. What should the nurse do in order from first to last?

1. Silence the pump alarm.

2. Determine if the infusion pump is plugged into an electrical outlet.

3. Assess the client's access site for infiltration or inflammation.

4. Assess the tubing for hindrances to flow of solution.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Cholecystitis

**1. 4.** There should be no bile-colored drainage coming from any of the incisions postoperatively. A laparoscopic cholecystectomy does not involve a bile bag. Breathing deeply into a paper bag will prevent

a person from passing out due to hyperventilation; it does not alleviate nausea. If the adhesive dressings have not already fallen off, they are removed by the surgeon in 7 to 10 days, not 6 weeks.

🔑 CN: Management of care; CL: Create

**2. 2.** A nurse should question the order for morphine sulfate because it is believed to cause biliary spasm. Thus, the preferred opioid analgesic to treat cholecystitis is meperidine (Demerol). Elderly clients should not be given meperidine because of the risk of acute confusion and seizures in this population. An alternative pain medication will be necessary. I.V. fluid therapy is used to maintain fluid and electrolyte balance that may result from NPO status and gastric suctioning. NPO status and gastric decompression prevent further gallbladder stimulation.

🔑 CN: Safety and infection control; CL: Synthesize

**3. 3.** The priority for nursing care at this time is to decrease the client's severe abdominal pain. The pain, which is frequently accompanied by nausea and vomiting, is caused by biliary spasm. Opioid analgesics are given to relieve the severe pain and spasm of cholecystitis. Relief of pain may decrease nausea and vomiting and thereby decrease the client's likelihood of developing further complications, such as deficient fluid volume and imbalanced nutrition. There are no data to suggest that the client is anxious.

🔑 CN: Physiological adaptation; CL: Analyze


**4. 1, 2, 3.** Bile is created in the liver, stored in the gallbladder, and released into the duodenum giving stool its brown color. A bile duct obstruction can cause pale colored stools. Other symptoms associated with cholelithiasis are right upper quadrant tenderness, fever from inflammation or infection, jaundice from elevated serum bilirubin levels, and nausea or right upper quadrant pain after a fatty meal. Pain at McBurney's point lies between the umbilicus and right iliac crest and is associated with appendicitis. A bleeding ulcer produces black, tarry stools. Respiratory distress is not a symptom of cholelithiasis.

🔑 CN: Physiological adaptation; CL: Analyze

**5. 1.** Providing information can help to answer the client's questions and decrease anxiety. Fear of the unknown can increase anxiety. Telling the client not to be afraid, that the procedure is common, or to follow her physician's orders will not necessarily decrease anxiety.

🔑 CN: Psychosocial adaptation; CL: Synthesize

**6. 3.** A T-tube is inserted in the common bile duct to maintain patency until edema from the duct exploration subsides. The bile color should be gold to dark green and the amount of drainage should be closely monitored to ensure tube patency. Irrigation is not routinely done, unless ordered using a smaller volume of fluid. The T-tube is not clamped in the early post-op period to allow for continuous drainage. An open cholecystectomy has one right subcostal incision, whereas a laparoscopic cholecystectomy has multiple small incisions.

 CN: Physiological adaptation;  
CL: Evaluate


**7. 3.** The T-tube should drain approximately 300 to 500 mL in the first 24 hours and after 3 to 4 days the amount should decrease to less than 200 mL in 24 hours. With the sudden decrease in drainage at 8 a.m., the nurse should immediately assess the tube for obstruction of flow that can be caused by kinks in the tube or the client lying on the tube. Drainage color must also be assessed for signs of bleeding. The tube should not be irrigated or clamped without an order.

 CN: Physiological adaptation;  
CL: Synthesize

**8. 2.** T-tube bile drainage is recorded separately on the output record. Adding the T-tube drainage to the urine output or wound drainage makes it difficult to accurately determine the amounts of bile, urine, or drainage. The client's total intake will be incorrect if drainage is subtracted from it.


 CN: Reduction of risk potential;  
CL: Apply

**9. 4.** Lean meats, such as beef, lamb, veal, and well-trimmed lean ham and pork, are low in fat. Rice, pasta, and vegetables are low in fat when not served with butter, cream, or sauces. Fruits are low in fat. The amount of fat allowed in a client's diet after a cholecystectomy will depend on the client's ability to tolerate fat. Typically, the client does not require a special diet but is encouraged to avoid excessive fat intake. A cheese omelet and peanut butter have high fat content. Ham salad is high in fat from the fat in salad dressing.

 CN: Basic care and comfort;  
CL: Apply

**10. 1.** Dilaudid should be considered for pain management. It should be administered intravenously for rapid action to address the severe pain the client is experiencing. Intramuscular injections are painful and slower acting. Since meperidine's toxic metabolite can cause seizures, it is no longer the treatment choice for pain. Diltiazem, a calcium channel blocker, is not indicated. Elevation of heart

rate and blood pressure are likely due to pain and fever. Phenergan is used to treat nausea.

 CN: Pharmacological and parenteral therapies;  
CL: Synthesize


### 11. 1.4 mL.

The following formula is used to calculate the correct dosage:

$$\begin{aligned} 35 \text{ mg}/X \text{ mL} &= 25 \text{ mg}/1 \text{ mL} \\ X &= 1.4 \text{ mL.} \end{aligned}$$

 CN: Pharmacological and parenteral therapies;  
CL: Apply

**12. 3.** Immediately after surgery, the client will drink liquids. A light diet can be resumed the day after surgery. There is no need for the client to remain on nothing-by-mouth status after surgery because peristaltic bowel activity should not be affected. The client will probably not be able to tolerate a full meal comfortably the day after surgery. There is no need for the client to stay on a bland diet after a laparoscopic cholecystectomy. The client should, however, avoid excessive fats.

 CN: Physiological adaptation;  
CL: Synthesize

**13. 3.** After a laparoscopic cholecystectomy, the client should not remove dressings from the puncture sites but should wait until visiting the surgeon. The client may shower the day after surgery. A client can return to work within 1 week, but only if approved by the surgeon and no strenuous activity is involved. The client should report any fever, which could be an indication of a complication.

 CN: Reduction of risk potential;  
CL: Synthesize


**14. 1, 3, 5.** Following a laparoscopic cholecystectomy, the client can resume a normal diet as tolerated. The client may experience right shoulder pain from the gas that was used to inflate the abdomen during surgery. The puncture site should be cleansed daily with mild soap and water. Driving can usually be resumed in 3 to 4 days following surgery and there is no need for the client to maintain bed rest in the days following surgery. Light exercise such as walking can be resumed immediately.

 CN: Physiological adaptation;  
CL: Evaluate

## The Client with Pancreatitis

**15. 1.** The elevated amylase and lipase and symptoms suggest acute pancreatitis. Ranson's criteria is a clinical predictor scale used to assess the severity of acute pancreatitis and prognosis. Vital signs are used to evaluate hemodynamic stability.


Urine output is monitored for assessment of fluid volume status. Glasgow Coma Scale (GCS) is a neurological scale to assess the level of consciousness.

 CN: Physiological adaptation;  
CL: Analyze


**16. 1.** Alcoholism is a major cause of acute pancreatitis in the United States. Because some clients are reluctant to discuss alcohol use, staff may inquire about it in several ways. Generally, alcohol intake does not interfere with the tests used to diagnose pancreatitis. Recent ingestion of large amounts of alcohol, however, may cause an increased serum amylase level. Large amounts of ethyl and methyl alcohol may produce an elevated urinary amylase concentration. All clients are asked about alcohol and drug use on hospital admission, but this information is especially pertinent for clients with pancreatitis. Physicians do need to seek facts, but this can be done while respecting the client's religious beliefs. Respecting religious beliefs is important in providing holistic client care.

 CN: Health promotion and maintenance;  
CL: Apply

**17. 2.** Life-threatening shock is a potential complication of pancreatitis. Kinin peptides activated by the trapped trypsin cause vasodilation and increased capillary permeability. These effects exacerbate shock and are not easily reversed with pharmacologic agents such as vasopressors. Hemorrhage may occur into the pancreas, but not in the intestines. Systemic complications include pulmonary complications, but not heart failure or acute tubular necrosis.


 CN: Physiological adaptation;  
CL: Analyze

**18. 2.** Grey Turner's sign is a bluish discoloration in the flank area caused by retroperitoneal bleeding. The vital signs are showing hemodynamic instability. I.V. access should be obtained to provide immediate volume replacement. The urine output will provide information on the fluid status. A nasogastric tube is indicated for clients with uncontrolled nausea and vomiting or gastric distension. Repositioning the client may be considered for pain management once the client's vital signs are stable.


 CN: Physiological adaptation;  
CL: Synthesize

**19. 3.** Clients with acute necrotizing pancreatitis should remain NPO with early enteral feeding via the jejunum to maintain bowel integrity and immune function. TPN is considered if enteral feedings are contraindicated. Access is also needed for TPN, preferably via a central line. Hemodynamic instability can result from fluid volume loss and bleeding and requires fluid and electrolyte

replacement. Fat necrosis occurring with acute pancreatitis can cause hypocalcemia requiring calcium replacement. A Foley catheter provides accurate output assessment to monitor for prerenal acute renal failure that can occur from hypovolemia.

 CN: Physiological adaptation;  
CL: Synthesize

**20. 1.** Furosemide (Lasix) can cause pancreatitis. Additionally, hypovolemia can develop with acute pancreatitis and Lasix will further delete fluid volume. Imipenem is indicated in the treatment of acute pancreatitis with necrosis and infection. Research no longer supports Meperidine (Demerol) over other opiates. Morphine and Dilaudid are opiates of choice in acute pancreatitis to get pain under control. Famotidine is a Histamine 2 receptor antagonist used to decrease acid secretion and prevent stress or peptic ulcers.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**21. 4.** The client with acute pancreatitis is prone to complications associated with the respiratory system. Pneumonia, atelectasis, and pleural effusion are examples of respiratory complications that can develop as a result of pancreatic enzyme exudate. Pancreatitis does not cause heart failure, ulcer formation, or cirrhosis.

 CN: Reduction of risk potential;  
CL: Analyze

**22. 1, 4, 5.** The client with acute pancreatitis usually experiences acute abdominal pain. Placing the client in a side-lying position relieves the tension on the abdominal area and promotes comfort. A semi-Fowler's position is also appropriate. The nurse should also monitor the client's respiratory status because clients with pancreatitis are prone to develop respiratory complications. Daily weights are obtained to monitor the client's nutritional and fluid volume status. While the client will likely need opioid analgesics to treat the pain, morphine sulfate is not appropriate as it stimulates spasm of the sphincter of Oddi, thus increasing the client's discomfort. During the acute phase of the illness while the client is experiencing pain, the pancreas is rested by withholding food and drink. When the diet is reintroduced, it is a high-carbohydrate, low-fat, bland diet.


 CN: Physiological adaptation;  
CL: Synthesize

**23. 1.** Hypocalcemia develops in severe cases of acute pancreatitis. The exact cause is unknown. Signs and symptoms of hypocalcemia include jerking and muscle twitching, numbness of fingers and lips, and irritability. Meperidine (Demerol) may cause tremors or seizures as an adverse effect, but not muscle twitching. Muscle twitching is not


caused by a nutritional deficit, nor does it indicate that the client needs a muscle relaxant.

 CN: Reduction of risk potential;  
CL: Analyze


**24. 1.** Propantheline is an anticholinergic, anti-spasmodic medication that decreases vagal stimulation and pancreatic secretions. It is contraindicated in paralytic ileus, therefore the nurse should be concerned with the absent bowel sounds. Side effects are urinary retention, constipation, and tachycardia.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**25. 1.** Crash dieting or bingeing may cause an acute attack of pancreatitis and should be avoided. Carbohydrate intake should be increased because carbohydrates are less stimulating to the pancreas. There is no need to maintain a dietary pattern of six meals a day; the client can eat whenever desired. There is no need to place the client on a sodium-restricted diet because pancreatitis does not promote fluid retention.

 CN: Physiological adaptation;  
CL: Synthesize

**26. 2.** In chronic pancreatitis, destruction of pancreatic tissue requires pancreatic enzyme replacement. Pancreatic enzymes are prescribed to facilitate the digestion of proteins and fats and should be taken in conjunction with every meal and snack. Specified hours or limited times for administration are ineffective because the enzymes must be taken in conjunction with food ingestion.

 CN: Pharmacological and parenteral therapies; CL: Apply

**27. 3.** If the dosage and administration of pancreatic enzymes are adequate, the client's stool will be relatively normal. Any increase in odor or fat content would indicate the need for dosage adjustment. Stable body weight would be another indirect indicator. Fluid intake does not affect enzyme replacement therapy. If diabetes has developed, the client will need to monitor glucose levels. However, glucose and ketone levels are not affected by pancreatic enzyme therapy and would not indicate effectiveness of the therapy.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**28. 4.** Clients with chronic pancreatitis are likely to develop diabetes as a result of the pancreatic fibrosis that occurs. The pancreas becomes unable to secrete insulin. Cholelithiasis, hepatitis, and irritable bowel syndrome are not caused by chronic pancreatitis.

 CN: Reduction of risk potential;  
CL: Analyze

## The Client with Viral Hepatitis

**29. 1.** The fluid weight gain is of concern since the drug should be used with caution with impaired renal function. Dosage adjustment may be needed with renal insufficiency since the drug is excreted in the urine. Nausea, mild temperature elevation, and fatigue are symptoms that should be monitored, but are associated with hepatitis.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**30. 4.** Acetaminophen is toxic to the liver and should be avoided in a client with liver dysfunction. Increased periods of rest allow for liver regeneration. A low-fat, high carbohydrate diet and dry toast to relieve nausea are appropriate.

 CN: Health promotion and maintenance;  
CL: Evaluate

**31. 4.** Hepatitis B is considered a sexually transmitted disease and students should observe safe sex practices. Poor sanitary conditions in underdeveloped countries relate to spread of hepatitis A and E. Focusing on routes of transmission and avoidance of infection can prevent the spread of hepatitis; isolation in single rooms is not required. There is no vaccine for hepatitis D.

 CN: Reduction of risk potential;  
CL: Synthesize

**32. 2.** Liver inflammation and obstruction block the normal flow of bile. Excess bilirubin turns the skin and sclera yellow and the urine dark and frothy. Profound anorexia is also common. Tarry stools are indicative of gastrointestinal bleeding and would not be expected in hepatitis. Light- or clay-colored stools may occur in hepatitis owing to bile duct obstruction. Shortness of breath would be unexpected.

 CN: Physiological adaptation;  
CL: Analyze

**33. 1.** The main route of transmission for hepatitis A is the oral-fecal route, rarely parenteral. Good hand washing before eating or preparing food[AF1]. Percutaneous transmission is seen with hepatitis B, C, and D. Alpha-interferon is used for treatment of chronic hepatitis B and C.


 CN: Safety and infection control;  
CL: Synthesize

**34. 4.** During the convalescent or posticteric stage of hepatitis, fatigue and malaise are the most common complaints. These symptoms usually disappear within 2 to 4 months. Fatigue and malaise are not evidence of a secondary infection. Hepatitis A

is not treated by drug therapy. It is important that the client continue to balance activity with periods of rest.

 CN: Reduction of risk potential;  
CL: Synthesize

**35. 1.** Treatment of hepatitis consists primarily of bed rest with bathroom privileges. Bed rest is maintained during the acute phase to reduce metabolic demands on the liver, thus increasing its blood supply and promoting liver cell regeneration. When activity is gradually resumed, the client should be taught to rest before becoming overly tired. Although adequate fluid intake is important, it is not necessary to force fluids to treat hepatitis. Antibiotics are not used to treat hepatitis. Electrolyte imbalances are not typical of hepatitis.

 CN: Basic care and comfort;  
CL: Synthesize


**36. 1.** The prothrombin time may be prolonged because of decreased absorption of vitamin K and decreased production of prothrombin by the liver. The client should be assessed carefully for bleeding tendencies. Blood glucose and serum potassium and calcium levels are not affected by hepatitis.

 CN: Reduction of risk potential;  
CL: Analyze

**37. 2.** Low-fat, high protein, high carbohydrate diet is encouraged for a client with hepatitis to promote liver rejuvenation. Nutrition intake is important because clients may be anorexic and experience weight loss. Activity should be modified and adequate rest obtained to promote hepatocyte. Social isolation should be avoided and education on preventing transmission should be provided.


 CN: Health promotion and maintenance;  
CL: Synthesize

**38. 3.** The hepatitis A virus is transmitted via the fecal-oral route. It spreads through contaminated hands, water, and food, especially shellfish growing in contaminated water. Certain animal handlers are at risk for hepatitis A, particularly those handling primates. Frequent hand washing is probably the single most important preventive action. Insects do not transmit hepatitis A. Family members do not need to stay away from the client with hepatitis. It is not necessary to disinfect food and clothing.


 CN: Safety and infection control;  
CL: Synthesize

**39. 4.** The most appropriate diagnosis for this client is *Activity intolerance* related to fatigue. The major goal of care for the client with hepatitis is to increase activity gradually as tolerated. Periods of alternating rest and activity should be included in


the plan of care. There is no evidence that the client is physically immobile, unable to provide self-care, or coping ineffectively.

 CN: Basic care and comfort;  
CL: Analyze


**40. 4.** The nurse should encourage the client to further verbalize feelings of isolation. Instead of dismissing these feelings or making assumptions about the cause of isolation, the nurse should allow clients to verbalize their fears and provide education on how to prevent infection transmission.

 CN: Psychosocial adaptation;  
CL: Synthesize

**41. 3.** Interferon alfa-2b (Intron A) most commonly causes flulike adverse effects, such as myalgia, arthralgia, headache, nausea, fever, and fatigue. Retinopathy is a potential adverse effect, but not a common one. Diarrhea may develop as an adverse effect. Clients are advised to administer the drug at bedtime and get adequate rest. Medications may be prescribed to treat the symptoms. The drug may also cause hematologic changes; therefore, laboratory tests such as a complete blood count and differential should be conducted monthly during drug therapy. Blood glucose laboratory values should be monitored for the development of hyperglycemia.

 CN: Pharmacological and parenteral therapies;  
CL: Analyze


**42. 4.** Hepatitis B is spread through exposure to blood or blood products and through high-risk sexual activity. Hepatitis B is considered to be a sexually transmitted disease. High-risk sexual activities include sex with multiple partners, unprotected sex with an infected individual, male homosexual activity, and sexual activity with I.V. drug users. The Centers for Disease Control and Prevention recommends immunization of all newborns and adolescents. College students are at high risk for development of hepatitis B and are encouraged to be immunized. Alcohol intake by itself does not predispose an individual to hepatitis B, but it can lead to high-risk behaviors such as unprotected sex. Good personal hygiene alone will not prevent the transmission of hepatitis B.

 CN: Safety and infection control;  
CL: Create

**43. 2.** The client should be able to verbalize the importance of reporting any bleeding tendencies that could be the result of a prolonged prothrombin time. Ascites is not typically a clinical manifestation of hepatitis; it is associated with cirrhosis. Alcohol use should be eliminated for at least 1 year after the diagnosis of hepatitis to allow the liver time to fully recover. There is no need




for a client to be restricted to the home because hepatitis is not spread through casual contact between individuals.


 CN: Physiological adaptation;  
CL: Evaluate

## The Client with Cirrhosis


**44. 1.** Clients with cirrhosis can develop hepatic encephalopathy caused by increased ammonia levels. Asterixis, a flapping tremor, is a characteristic symptom of increased ammonia levels. Bacterial action on increased protein in the bowel will increase ammonia levels and cause the encephalopathy to worsen. GI bleeding and protein consumed in the diet increases protein in the intestine and can elevate ammonia levels. Lactulose is given to reduce ammonia formation in the intestine and should not be held since neurological symptoms are worsening. Bilirubin is associated with jaundice.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**45. 3.** Hypokalemia is a precipitating factor in hepatic encephalopathy. A decrease in creatinine results from muscle atrophy; an increase in creatinine would indicate renal insufficiency. With liver dysfunction increased aldosterone levels are seen. A decrease in serum protein will decrease colloid osmotic pressure and promote edema.

 CN: Physiological adaptation;  
CL: Synthesize

**46. 4.** Portal hypertension and hypoalbuminemia as a result of cirrhosis cause a fluid shift into the peritoneal space causing ascites. In a cardiac or kidney problem, not cirrhosis, sodium can promote edema formation and subsequent decreased urine output. Edema does not migrate upward toward the heart to enhance its circulation. Although diuretics promote the excretion of excess fluid, occasionally forgetting or omitting a dose will not yield the ascites found in cirrhosis of the liver.


 CN: Physiological adaptation;  
CL: Synthesize

**47. 1, 2, 3, 4, 5.** Constipation leads to increased ammonia production. Lactulose (Cephulac) is a hyperosmotic laxative that reduces blood ammonia by acidifying the colon contents, which retards diffusion of nonionic ammonia from the colon to the blood while promoting its migration from the blood to the colon. Hepatic encephalopathy is considered a toxic or metabolic condition that causes cerebral edema; it affects a person's coordination and pupil reaction to light and accommodation. Food and flu-


ids high in carbohydrates should be given because the liver is not synthesizing and storing glucose. Because exercise produces ammonia as a byproduct of metabolism, physical activity should be limited, not encouraged.

 CN: Management of care; CL: Create

**48. 3.** Early clinical manifestations of cirrhosis are subtle and usually include gastrointestinal symptoms, such as anorexia, nausea, vomiting, and changes in bowel patterns. These changes are caused by the liver's altered ability to metabolize carbohydrates, proteins, and fats. Peripheral edema, ascites, and jaundice are later signs of liver failure and portal hypertension.

 CN: Physiological adaptation;  
CL: Analyze

**49. 2.** Spironolactone (Aldactone) is a potassium-sparing diuretic; therefore, clients should be monitored closely for hyperkalemia. Other common adverse effects include abdominal cramping, diarrhea, dizziness, headache, and rash. Constipation and dysuria are not common adverse effects of spironolactone. An irregular pulse is not an adverse effect of spironolactone but could develop if serum potassium levels are not closely monitored.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**50. 1.** For clients who have cirrhosis without complications, a high-calorie, high-carbohydrate diet is preferred to provide an adequate supply of nutrients. In the early stages of cirrhosis, there is no need to restrict fat, protein, or sodium.

 CN: Physiological adaptation; CL: Apply


**51. 2, 3, 4.** Baking soda baths can decrease pruritis. Keeping nails short and rubbing with knuckles can decrease breakdown when scratching cannot be resisted, such as during sleep. Calamine lotions help relieve itching. Alcohol will increase skin dryness. Sodium in the diet will increase edema and weaken skin integrity.

 CN: Basic care and comfort; CL: Create


**52. 1.** General health promotion measures include maintaining good nutrition, avoiding infection, and abstaining from alcohol. Rest and sleep are essential, but an impaired liver may not be able to detoxify sedatives and barbiturates. Such drugs must be used cautiously, if at all, by clients with cirrhosis. The client does not need to limit contact with others but should exercise caution to stay away from ill people.

 CN: Health promotion and maintenance;  
CL: Synthesize


**53. 4.** Elevating the head of the bed will allow for increased lung expansion by decreasing the ascites pressing on the diaphragm. The client requires reassessment. A paracentesis is reserved for symptomatic clients with ascites with impaired respiration or abdominal pain not responding to other measures such as sodium restriction and diuretics. There is no indication for blood cultures. Heart sounds are assessed with the routine physical assessment.

 CN: Physiological adaptation;  
CL: Synthesize

**54. 1.** Ascites can compromise the action of the diaphragm and increase the client's risk of respiratory problems. Ascites also greatly increases the risk of skin breakdown. Frequent position changes are important, but the preferred position is Fowler's. Placing the client in Fowler's position helps facilitate the client's breathing by relieving pressure on the diaphragm. The other positions do not relieve pressure on the diaphragm.

 CN: Reduction of risk potential;  
CL: Synthesize

**55. 1.** Normal serum albumin is administered to reduce ascites. Hypoalbuminemia, a mechanism underlying ascites formation, results in decreased colloid osmotic pressure. Administering serum albumin increases the plasma colloid osmotic pressure, which causes fluid to flow from the tissue space into the plasma. Increased urine output is the best indication that the albumin is having the desired effect. An increased serum albumin level and increased ease of breathing may indirectly imply that the administration of albumin is effective in relieving the ascites. However, it is not as direct an indicator as increased urine output. Anorexia is not affected by the administration of albumin.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**56. 1, 2, 3.** The management of bleeding esophageal varices involves endoscopic therapy and drug therapy with octreotide, vasopressin, nitroglycerin, or beta blockers to lower portal hypertension and decompress the varices. I.V. access is needed for octreotide and potential blood product administration due to blood loss or altered clotting factors. A patent airway should be maintained, but intubation is not needed for clients with adequate ventilation and oxygenation. Balloon tamponade is used if variceal hemorrhage cannot be controlled by endoscopy. A TIPS procedure may be considered after a second major bleed to redirect portal blood flow away from the varices.

 CN: Physiological adaptation;  
CL: Synthesize

**57.**

1. Affirm airway obstruction by the tube.

3. Deflate the tube by cutting with bedside scissors.


2. Remove the tube.

4. Apply oxygen via face mask.


The nurse should first assess the client to determine if the tube is obstructing the airway; assessment is done by assessing air flow. Once obstruction is established, the tube should be deflated and then quickly removed. A set of scissors should always be at the bedside to allow for emergency deflation of the balloon. Oxygen via face mask should then be applied once the tube is removed.

 CN: Safety and infection control;  
CL: Synthesize


**58. 3.** Neomycin (Mycifradin) is administered to decrease the bacterial action on protein in the intestines, which results in ammonia production. This ammonia, if not detoxified by the liver, can result in hepatic encephalopathy and coma. The antibiotic does not reduce abdominal pressure, prevent straining during defecation, or decrease hemorrhaging within the intestine.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**59. 1.** The client should be monitored closely for changes in mental status. Ammonia has a toxic effect on central nervous system tissue and produces an altered level of consciousness, marked by drowsiness and irritability. If this process is unchecked, the client may lapse into coma. Increasing ammonia levels are not detected by changes in blood pressure, urine output, or respirations.

 CN: Physiological adaptation;  
CL: Analyze

**60. 3.** Lactulose (Cephulac) increases intestinal motility, thereby trapping and expelling ammonia in the feces. An increase in the number of bowel movements is expected as an adverse effect. Lactulose does not affect urine output. Any improvements in mental status would be the result of increased ammonia elimination, not an adverse effect of the drug. Nausea and vomiting are not common adverse effects of lactulose.

 CN: Pharmacological and parenteral therapies; CL: Apply


**61. 60 mL**

$$30 \text{ mL} = 1 \text{ oz}$$


The following formula is used to calculate the correct dosage:

$$30 \text{ mL}/1 \text{ oz} = X \text{ mL}/2 \text{ oz}$$

$$X = 60 \text{ mL.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 2.** The taste of lactulose (Cephulac) is a problem for some clients. Mixing it with fruit juice, water, or milk can make it more palatable. Lactulose should not be given with antacids, which may inhibit its action. Lactulose should not be taken with a laxative because diarrhea is an adverse effect of the drug. Lactulose comes in the form of syrup for oral or rectal administration.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**63. 3.** Clients with cirrhosis should be instructed to avoid constipation and straining at stool to prevent hemorrhage. The client with cirrhosis has bleeding tendencies because of the liver's inability to produce clotting factors. A low-protein and high-carbohydrate diet is recommended. Clients with cirrhosis should not take acetaminophen (Tylenol), which is potentially hepatotoxic. Aspirin also should be avoided if esophageal varices are present. Cirrhosis is a chronic disease.

 CN: Reduction of risk potential; CL: Evaluate

**64. 1.** Immediately before a paracentesis, the client should empty the bladder to prevent perforation. The client will be placed in a high Fowler's position or seated on the side of the bed for the procedure. I.V. sedatives are not usually administered. The client does not need to be NPO.

 CN: Reduction of risk potential; CL: Synthesize

**65. 4.** When hepatic encephalopathy develops, measures are taken to reduce ammonia formation. Protein is restricted in the diet. An NG tube is not inserted initially but may be necessary as the disease progresses. Fluid restriction and salt-poor albumin are incorporated into the treatment of ascites, but not hepatic encephalopathy.

 CN: Physiological adaptation; CL: Synthesize


**66. 3.** Edematous tissue is easily traumatized and must receive meticulous care. An alternating air pressure mattress will help decrease pressure on the edematous tissue. ROM exercises are important to maintain joint function, but they do not necessarily prevent skin breakdown. When abdominal skin is

stretched taut due to ascites, it must be cleaned very carefully. The abdomen should not be massaged. Elevation of the lower extremities promotes venous return and decreases swelling.

 CN: Reduction of risk potential; CL: Synthesize

## Managing Care Quality and Safety

**67. 4.** Contact precautions are recommended for clients with hepatitis A. This includes wearing gloves for direct care. These recommendations are made by the Centers for Disease Control and Prevention. A gown is not required unless substantial contact with the client is anticipated. It is not necessary to wear a mask. The client does not need a private room unless incontinent of stool.

 CN: Safety and infection control; CL: Create

**68.**

1. The client with cirrhosis who became confused and disoriented during the night.

3. The client with acute pancreatitis who is requesting pain medication.

2. The client who is 1 day postoperative following a cholecystectomy and has a T-tube inserted.


4. The client with hepatitis B who has questions about his discharge instructions.

The nurse should first assess the client with cirrhosis to ensure the client's safety and to assess the client for the onset of hepatic encephalopathy. The nurse should then assess the client with acute pancreatitis who is requesting pain medication and administer the needed medication. The nurse should next assess the client who underwent a cholecystectomy and is 1 day postoperative to make sure that the T-tube is draining and that the client is performing postoperative breathing exercises. This client's safety is not at risk and the client is not indicating that he is in pain, so his care is a lower priority. The nurse can speak last with the client with hepatitis B who has questions about his discharge instructions because this client's issues are not urgent.

 CN: Management of care; CL: Synthesize

**69. 2.** Hepatitis C is usually transmitted through blood exposure or needles. A hepatitis C vaccine is currently under development, but it is not

available for use. The first line of defense against hepatitis B is the hepatitis B vaccine. Hepatitis C is not transmitted through feces or urine. Wearing a gown and mask will not prevent transmission of the hepatitis C virus if the caregiver comes in contact with infected blood or needles.

 CN: Safety and infection control;  
CL: Apply

### 70.

1. Silence the pump alarm.
2. Determine if the infusion pump is plugged into an electrical outlet.
3. Assess the client's access site for infiltration or inflammation.
4. Assess the tubing for hindrances to flow of solution.

Silencing the alarm will eliminate a stress to the client and allow the nurse to focus on the task at hand. The nurse should then assess the access site to note if the needle is inserted in the vein or if there is tissue trauma, infiltration, or inflammation. Next, the nurse should check for kinks in the tubing. Finally, the nurse can plug the pump into the wall to allow the battery to become recharged.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

TEST  
8

## The Client with Endocrine Health Problems

- The Client with Thyrotoxicosis
- The Client with Diabetes Mellitus
- The Client with Pituitary Adenoma
- The Client with Addison's Disease
- The Client with Cushing's Disease
- The Female Client with Perimenopausal or Menopausal Syndrome
- The Client with Pheochromocytoma
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with Thyrotoxicosis

1. The nurse is completing a health assessment of a 42-year-old female with suspected Graves' disease. The nurse should assess this client for:

- 1. Anorexia.
- 2. Tachycardia.
- 3. Weight gain.
- 4. Cold skin.

2. When conducting a health history with a female client with thyrotoxicosis, the nurse should ask about which of the following changes in the menstrual cycle?

- 1. Dysmenorrhea.
- 2. Metrorrhagia.
- 3. Oligomenorrhea.
- 4. Menorrhagia.

3. A 34-year-old female is diagnosed with hypothyroidism. The nurse should assess the client for which of the following? Select all that apply.

- 1. Rapid pulse.
- 2. Decreased energy and fatigue.
- 3. Weight gain of 10 lb.
- 4. Fine, thin hair with hair loss.
- 5. Constipation.
- 6. Menorrhagia.

4. Propylthiouracil (PTU) is prescribed for a client with Graves' disease. The nurse should teach the client to immediately report which of the following?

- 1. Sore throat.
- 2. Painful, excessive menstruation.
- 3. Constipation.
- 4. Increased urine output.

5. A client with thyrotoxicosis says to the nurse, "I am so irritable. I am having problems at work because I lose my temper very easily." Which of the following responses by the nurse would give the client the **most** accurate explanation of her behavior?

- 1. "Your behavior is caused by temporary confusion brought on by your illness."
- 2. "Your behavior is caused by the excess thyroid hormone in your system."
- 3. "Your behavior is caused by your worrying about the seriousness of your illness."
- 4. "Your behavior is caused by the stress of trying to manage a career and cope with illness."

6. Serum concentrations of thyroid hormones and thyroid-stimulating hormone (TSH) are tests ordered for the client with thyrotoxicosis. Which of the following laboratory values are indicative of thyrotoxicosis?

- 1. Elevated thyroid hormone concentrations and normal TSH.
- 2. Elevated TSH and normal thyroid hormone concentrations.
- 3. Decreased thyroid hormone concentrations and elevated TSH.
- 4. Elevated thyroid hormone concentrations and decreased TSH.

7. The nurse should teach the client to prevent corneal irritation from mild exophthalmos by:

- 1. Massaging the eyes at regular intervals.
- 2. Instilling an ophthalmic anesthetic as ordered.
- 3. Wearing dark-colored glasses.
- 4. Covering both eyes with moistened gauze pads.

**8.** A client with Graves' disease is treated with radioactive iodine (RAI) in the form of sodium iodide  $^{131}\text{I}$ . Which of the following statements by the nurse will explain to the client how the drug works?

- 1. "The radioactive iodine stabilizes the thyroid hormone levels before a thyroidectomy."
- 2. "The radioactive iodine reduces uptake of thyroxine and thereby improves your condition."
- 3. "The radioactive iodine lowers the levels of thyroid hormones by slowing your body's production of them."
- 4. "The radioactive iodine destroys thyroid tissue so that thyroid hormones are no longer produced."

**9.** After treatment with radioactive iodine (RAI) in the form of sodium iodide  $^{131}\text{I}$ , the nurse teaches the client to:

- 1. Monitor for signs and symptoms of hyperthyroidism.
- 2. Rest for 1 week to prevent complications of the medication.
- 3. Take thyroxine replacement for the remainder of the client's life.
- 4. Assess for hypertension and tachycardia resulting from altered thyroid activity.

**10.** A client with a large goiter is scheduled for a subtotal thyroidectomy to treat thyrotoxicosis. Saturated solution of potassium iodide (SSKI) is prescribed preoperatively for the client. The **primary** reason for using this drug is that it helps:

- 1. Slow progression of exophthalmos.
- 2. Reduce the vascularity of the thyroid gland.
- 3. Decrease the body's ability to store thyroxine.
- 4. Increase the body's ability to excrete thyroxine.

**11.** The nurse is administering a saturated solution of potassium iodide (SSKI). The nurse should:

- 1. Pour the solution over ice chips.
- 2. Mix the solution with an antacid.
- 3. Dilute the solution with water, milk, or fruit juice and have the client drink it with a straw.
- 4. Disguise the solution in a pureed fruit or vegetable.

**12.** The nurse asks the client to state her name as soon as she regains consciousness postoperatively after a subtotal thyroidectomy and at each assessment. The nurse does this to monitor for signs of which of the following?

- 1. Internal hemorrhage.
- 2. Decreasing level of consciousness.
- 3. Laryngeal nerve damage.
- 4. Upper airway obstruction.

**13.** A client who has undergone a subtotal thyroidectomy is subject to complications in the first 48 hours after surgery. The nurse should obtain and keep at the bedside equipment to:

- 1. Begin total parenteral nutrition.
- 2. Start a cutdown infusion.
- 3. Administer tube feedings.
- 4. Perform a tracheotomy.

**14.** Which of the following symptoms might indicate that a client was developing tetany after a subtotal thyroidectomy?

- 1. Pains in the joints of the hands and feet.
- 2. Tingling in the fingers.
- 3. Bleeding on the back of the dressing.
- 4. Tension on the suture line.

**15.** Which of the following medications should be available to provide emergency treatment if a client develops tetany after a subtotal thyroidectomy?

- 1. Sodium phosphate.
- 2. Calcium gluconate.
- 3. Echothiophate iodide.
- 4. Sodium bicarbonate.

**16.** A 60-year-old female is diagnosed with hypothyroidism. The nurse should assess the client for which of the following?

- 1. Tachycardia.
- 2. Weight gain.
- 3. Diarrhea.
- 4. Nausea.

**17.** Appropriate nursing diagnoses for a client with hypothyroidism would include which of the following?

- 1. *Risk for injury* (corneal abrasion) related to incomplete closure of the eyelid.
- 2. *Imbalanced nutrition: Less than body requirements* related to hypermetabolism.
- 3. *Deficient fluid volume* related to diarrhea.
- 4. *Activity intolerance* related to fatigue associated with the disorder.

**18.** When discussing recent onset of feelings of sadness and depression in a client with hypothyroidism, the nurse should inform the client that these feelings are:

- 1. The effects of thyroid hormone replacement therapy and will diminish over time.
- 2. Related to thyroid hormone replacement therapy and will not diminish over time.
- 3. A normal part of having a chronic illness.
- 4. Most likely related to low thyroid hormone levels and will improve with treatment.

## The Client with Diabetes Mellitus

**19.** The nurse is teaching a diabetic client using an empowerment approach. The nurse should initiate teaching by asking which of the following?

- 1. “How much does your family need to be involved in learning about your condition?”
- 2. “What is required for your family to manage your symptoms?”
- 3. “What activities are most important for you to be able to maintain control of your diabetes?”
- 4. “What do you know about your medications and condition?”

**20.** A nurse is participating in a diabetes screening program. Who of the following is (are) at risk for developing type 2 diabetes? Select all that apply.

- 1. A 32-year-old female who delivered a 9½-lb infant.
- 2. A 44-year-old Native American Indian who has a body mass index (BMI) of 32.
- 3. An 18-year-old Hispanic who jogs four times a week.
- 4. A 55-year-old Asian American who has hypertension and two siblings with type 2 diabetes.
- 5. A 12-year-old who is overweight.

**21.** A 57-year-old with diabetes insipidus is hospitalized for care. Which finding should the nurse report to the physician?

- 1. Urine output of 350 mL in 8 hours.
- 2. Urine specific gravity of 1.001.
- 3. Potassium of 4.0 mEq.
- 4. Weight gain.

**22.** The nurse is checking the laboratory results on a 52-year-old client with type 1 diabetes (see chart). What laboratory result indicates a problem that should be managed?

- 1. Blood glucose.
- 2. Total cholesterol.
- 3. Hemoglobin.
- 4. Low-density lipoprotein (LDL) cholesterol.

### Laboratory Results

Test	Result
Blood glucose	192 mg/dL
Total cholesterol	250 mg/dL
Hemoglobin	12.3 mg/dL
Low-density lipoprotein cholesterol	125 mg/dL

**23.** A client with type 1 diabetes mellitus has diabetic ketoacidosis. Which of the following findings has the **greatest** effect on fluid loss?

- 1. Hypotension.
- 2. Decreased serum potassium level.
- 3. Rapid, deep respirations.
- 4. Warm, dry skin.

**24.** A client is to receive glargine (Lantus) insulin in addition to a dose of aspart (NovoLog). When the nurse checks the blood glucose level at the bedside, it is greater than 200 mg/dL. How should the nurse administer the insulins?

- 1. Put air into the glargine insulin vial, and then air into the aspart insulin vial, and draw up the correct dose of aspart insulin first.
- 2. Roll the glargine insulin vial, then roll the aspart insulin vial. Draw up the longer-acting glargine insulin first.
- 3. Shake both vials of insulin before drawing up each dose in separate insulin syringes.
- 4. Put air into the glargine insulin vial, and draw up the correct dose in an insulin syringe; then, with a different insulin syringe, put air into the aspart vial and draw up the correct dose.

**25.** An adult client with type 2 diabetes is taking metformin (Glucophage) 1,000 mg two times every day. After the nurse provides instructions regarding the interaction of alcohol and metformin, the nurse evaluates that the client understands the instructions when the client says:

- 1. “If I know I’ll be having alcohol, I must not take metformin; I could develop lactic acidosis.”
- 2. “If my physician approves, I may drink alcohol with my metformin.”
- 3. “Adverse effects I should watch for are feeling excessively energetic, unusual muscle stiffness, low back pain, and a rapid heartbeat.”
- 4. “If I feel bloated, I should call my physician.”

**26.** A client has recently been diagnosed with type 2 diabetes mellitus and is to take tolbutamide (Orinase). When teaching the client about the drug, the nurse explains that tolbutamide is believed to lower the blood glucose level by which of the following actions?

- 1. Potentiating the action of insulin.
- 2. Lowering the renal threshold of glucose.
- 3. Stimulating insulin release from functioning beta cells in the pancreas.
- 4. Combining with glucose to render it inert.

**27.** Which information should the nurse include when developing a teaching plan for a client newly diagnosed with type 2 diabetes mellitus. Select all that apply.

- 1. A major risk factor for complications is obesity and central abdominal obesity.
- 2. Supplemental insulin is mandatory for controlling the disease.
- 3. Exercise increases insulin resistance.
- 4. The primary nutritional source requiring monitoring in the diet is carbohydrates.
- 5. Annual eye and foot examinations are recommended by the American Diabetes Association (ADA).

**28.** When teaching the diabetic client about foot care, the nurse should instruct the client to do which of the following?

- 1. Avoid going barefoot.
- 2. Buy shoes a half size larger.
- 3. Cut toenails at angles.
- 4. Use heating pads for sore feet.

**29.** A client with diabetes mellitus asks the nurse to recommend something to remove corns from his toes. The nurse should advise the client to:

- 1. Apply a high-quality corn plaster to the area.
- 2. Consult a physician or podiatrist about removing the corns.
- 3. Apply iodine to the corns before peeling them off.
- 4. Soak the feet in borax solution to peel off the corns.

**30.** A client with diabetes mellitus comes to the clinic for a regular 3-month follow-up appointment. The nurse notes several small bandages covering cuts on the client's hands. The client says, "I'm so clumsy. I'm always cutting my finger cooking or burning myself on the iron." Which of the following responses by the nurse would be **most** appropriate?

- 1. "Wash all wounds in isopropyl alcohol."
- 2. "Keep all cuts clean and covered."
- 3. "Why don't you have your children do the cooking and ironing?"
- 4. "You really should be fine as long as you take your daily medication."

**31.** The client with diabetes mellitus says, "If I could just avoid what you call carbohydrates in my diet, I guess I would be okay." The nurse should base the response to this comment on the knowledge that diabetes affects metabolism of which of the following?

- 1. Carbohydrates only.
- 2. Fats and carbohydrates only.
- 3. Protein and carbohydrates only.
- 4. Proteins, fats, and carbohydrates.

**32.** A client with type 1 diabetes mellitus is admitted to the emergency department. Which of the following respiratory patterns requires immediate action?

- 1. Deep, rapid respirations with long expirations.
- 2. Shallow respirations alternating with long expirations.
- 3. Regular depth of respirations with frequent pauses.
- 4. Short expirations and inspirations.

**33.** Which of the following findings should the nurse report to the client's physician for a client with unstable type 1 diabetes mellitus? Select all that apply.

- 1. Systolic blood pressure, 145 mm Hg.
- 2. Diastolic blood pressure, 87 mm Hg.
- 3. High-density lipoprotein (HDL), 30 mg/dL.
- 4. Glycosylated hemoglobin (HbA<sub>1c</sub>), 10.2%.
- 5. Triglycerides, 425 mg/dL.
- 6. Urine ketones, negative.

**34.** The nurse should caution the client with diabetes mellitus who is taking a sulfonylurea that alcoholic beverages should be avoided while taking these drugs because they can cause which of the following?

- 1. Hypokalemia.
- 2. Hyperkalemia.
- 3. Hypocalcemia.
- 4. Disulfiram (Antabuse)-like symptoms.

**35.** Which of the following conditions is the **most** significant risk factor for the development of type 2 diabetes mellitus?

- 1. Cigarette smoking.
- 2. High-cholesterol diet.
- 3. Obesity.
- 4. Hypertension.

**36.** Which of the following indicates a potential complication of diabetes mellitus?

- 1. Inflamed, painful joints.
- 2. Blood pressure of 160/100 mm Hg.
- 3. Stooped appearance.
- 4. Hemoglobin of 9 g/dL.

**37.** The nurse is teaching the client about home blood glucose monitoring. Which of the following blood glucose measurements indicates hypoglycemia?

- 1. 59 mg/dL.
- 2. 75 mg/dL.
- 3. 108 mg/dL.
- 4. 119 mg/dL.

**38.** Assessment of the diabetic client for common complications should include examination of the:

- 1. Abdomen.
- 2. Lymph glands.
- 3. Pharynx.
- 4. Eyes.

**39.** The client with type 1 diabetes mellitus is taught to take isophane insulin suspension NPH (Humulin N) at 5 p.m. each day. The client should be instructed that the **greatest** risk of hypoglycemia will occur at about what time?

- 1. 11 a.m., shortly before lunch.
- 2. 1 p.m., shortly after lunch.
- 3. 6 p.m., shortly after dinner.
- 4. 1 a.m., while sleeping.



**40.** A nurse is teaching a client with type 1 diabetes mellitus who jogs daily about the preferred sites for insulin absorption. What is the **most** appropriate site for a client who jogs?

- 1. Arms.
- 2. Legs.
- 3. Abdomen.
- 4. Iliac crest.

**41.** A client with diabetes is taking insulin lispro (Humalog) injections. The nurse should advise the client to eat:

- 1. Within 10 to 15 minutes after the injection.
- 2. 1 hour after the injection.
- 3. At any time, because timing of meals with lispro injections is unnecessary.
- 4. 2 hours before the injection.

**42.** The **best** indicator that the client has learned how to give an insulin self-injection correctly is when the client can:

- 1. Perform the procedure safely and correctly.
- 2. Critique the nurse's performance of the procedure.
- 3. Explain all steps of the procedure correctly.
- 4. Correctly answer a posttest about the procedure.

**43.** The nurse is instructing the client on insulin administration. The client is performing a return demonstration for preparing the insulin. The client's morning dose of insulin is 10 units of regular and 22 units of NPH. The nurse checks the dose accuracy with the client. The nurse determines that the client has prepared the correct dose when the syringe reads how many units?

\_\_\_\_\_ units.

**44.** Angiotensin-converting enzyme (ACE) inhibitors may be prescribed for the client with diabetes mellitus to reduce vascular changes and possibly prevent or delay development of:

- 1. Chronic obstructive pulmonary disease.
- 2. Pancreatic cancer.
- 3. Renal failure.
- 4. Cerebrovascular accident.

**45.** The nurse should teach the diabetic client that which of the following is the **most** common symptom of hypoglycemia?

- 1. Nervousness.
- 2. Anorexia.
- 3. Kussmaul's respirations.
- 4. Bradycardia.

**46.** The nurse is assessing the client's use of medications. Which of the following medications may cause a complication with the treatment plan of a client with diabetes?

- 1. Aspirin.
- 2. Steroids.
- 3. Sulfonylureas.
- 4. Angiotensin-converting enzyme (ACE) inhibitors.

**47.** A client with type 1 diabetes mellitus has influenza. The nurse should instruct the client to:

- 1. Increase the frequency of self-monitoring (blood glucose testing).
- 2. Reduce food intake to diminish nausea.
- 3. Discontinue that dose of insulin if unable to eat.
- 4. Take half of the normal dose of insulin.

**48.** Which of the following is a priority nursing diagnosis for the diabetic client who is taking insulin and has nausea and vomiting from a viral illness or influenza?

- 1. *Imbalanced nutrition: Less than body requirements.*
- 2. *Ineffective health maintenance* related to ineffective coping skills.
- 3. *Acute pain.*
- 4. *Activity intolerance.*

**49.** During a home visit, a diabetic client begins to cry and says, "I just cannot stand the thought of having to give myself a shot every day." Which of the following would be the **best** response by the nurse?

- 1. "If you do not give yourself your insulin shots, you will die."
- 2. "We can teach your daughter to give the shots so you will not have to do it."
- 3. "I can arrange to have a home care nurse give you the shots every day."
- 4. "What is it about giving yourself the insulin shots that bothers you?"

## The Client with Pituitary Adenoma

**50.** Galactorrhea is caused by overproduction of which hormone?

- 1. Prolactin.
- 2. Adrenocorticotropic hormone (ACTH).
- 3. Growth hormone (GH).
- 4. Thyroid-stimulating hormone (TSH).

**51.** Which of the following signs and symptoms are common in male clients with prolactin-secreting tumors?

- 1. Severe lethargy and fatigue.
- 2. Decreased libido and impotence.
- 3. Bony proliferation of the hands, jaw, and feet.
- 4. Deepening or coarsening of the voice.

**52.** A client is to have a transsphenoidal hypophysectomy to remove a large, invasive pituitary tumor. The nurse should instruct the client that the surgery will be performed through an incision in the:

- 1. Back of the mouth.
- 2. Nose.
- 3. Sinus channel below the right eye.
- 4. Upper gingival mucosa in the space between the upper gums and lip.

**53.** To help minimize the risk of postoperative respiratory complications after a hypophysectomy, during preoperative teaching, the nurse should instruct the client how to:

- 1. Use blow bottles.
- 2. Turn in bed.
- 3. Take deep breaths.
- 4. Cough.

**54.** Following a transsphenoidal hypophysectomy, the nurse should assess the client for:

- 1. Cerebrospinal fluid (CSF) leak.
- 2. Fluctuating blood glucose levels.
- 3. Cushing's syndrome.
- 4. Cardiac arrhythmias.

**55.** A client expresses concern about how a hypophysectomy will affect his sexual function. Which of the following statements provides the **most** accurate information about the physiologic effects of hypophysectomy?

- 1. Removing the source of excess hormone should restore the client's libido, erectile function, and fertility.
- 2. Potency will be restored, but the client will remain infertile.
- 3. Fertility will be restored, but impotence and decreased libido will persist.
- 4. Exogenous hormones will be needed to restore erectile function after the adenoma is removed.

**56.** Before undergoing a transsphenoidal hypophysectomy for pituitary adenoma, the client asks the nurse how the surgeon will close the incision made in the dura. The nurse should respond based on the knowledge that:

- 1. Dissolvable sutures are used to close the dura.
- 2. Nasal packing provides pressure until normal wound healing occurs.
- 3. A patch is made with a piece of fascia.
- 4. A synthetic mesh is placed to facilitate healing.

**57.** Initial treatment for a cerebrospinal fluid (CSF) leak after transsphenoidal hypophysectomy would **most** likely involve:

- 1. Repacking the nose.
- 2. Returning the client to surgery.
- 3. Enforcing bed rest with the head of the bed elevated.
- 4. Administering high-dose corticosteroid therapy.

**58.** To provide oral hygiene for a client recovering from transsphenoidal hypophysectomy, the nurse should instruct the client to:

- 1. Rinse the mouth with saline solution.
- 2. Perform frequent toothbrushing.
- 3. Clean the teeth with an electric toothbrush.
- 4. Floss the teeth thoroughly.

**59.** The nurse teaches the client to report signs and symptoms of which potential complication after hypophysectomy?

- 1. Acromegaly.
- 2. Cushing's disease.
- 3. Diabetes mellitus.
- 4. Hypopituitarism.

**60.** After pituitary surgery, the nurse should assess the client for which of the following?

- 1. Urine specific gravity less than 1.010.
- 2. Urine output between 1 and 2 L/day.
- 3. Blood glucose level higher than 300 mg/dL.
- 4. Urine negative for glucose and ketones.

**61.** Vasopressin (Pitressin) is administered to the client with diabetes insipidus because it:

- 1. Decreases blood pressure.
- 2. Increases tubular reabsorption of water.
- 3. Increases release of insulin from the pancreas.
- 4. Decreases glucose production within the liver.

**62.** Which of the following indicates that the client with diabetes insipidus understands how to manage care?

- 1. The client will maintain normal fluid and electrolyte balance.
- 2. The client will select American Diabetes Association diet correctly.
- 3. The client will state dietary restrictions.
- 4. The client will exhibit serum glucose level within normal range.

### The Client with Addison's Disease

**63.** The nurse is instructing a young adult with Addison's disease how to adjust the dose of glucocorticoids. The nurse should explain that the client may need an increased dosage of glucocorticoids in which of the following situations?

- 1. Completing the spring semester of school.
- 2. Gaining 4 pounds.
- 3. Becoming engaged.
- 4. Undergoing a root canal.

**64.** Which of the following is the **priority** for a client in Addisonian crisis?

- 1. Controlling hypertension.
- 2. Preventing irreversible shock.
- 3. Preventing infection.
- 4. Relieving anxiety.

**65.** Which of the following would be an expected finding in a client with adrenal crisis (addisonian crisis)?

- 1. Fluid retention.
- 2. Pain.
- 3. Peripheral edema.
- 4. Hunger.

**66.** The client is receiving an I.V. infusion of 5% dextrose in normal saline running at 125 mL/hour. When hanging a new bag of fluid, the nurse notes swelling and hardness at the infusion site. The nurse should **first**:

- 1. Discontinue the infusion.
- 2. Apply a warm soak to the site.
- 3. Stop the flow of solution temporarily.
- 4. Irrigate the needle with normal saline.

**67.** The client's wife asks the nurse whether the I.V. infusion is meeting her husband's nutritional needs because he has vomited several times. The nurse's response should be based on the knowledge that 1 L of 5% dextrose in normal saline solution delivers:

- 1. 170 calories.
- 2. 250 calories.
- 3. 340 calories.
- 4. 500 calories.

**68.** A client with Addison's disease is admitted to the medical unit. The nurse diagnoses the client with *Deficient fluid volume* related to inadequate fluid intake and to fluid loss secondary to inadequate adrenal hormone secretion. As the client's oral intake increases, which of the following fluids would be **most** appropriate?

- 1. Milk and diet soda.
- 2. Water and eggnog.
- 3. Bouillon and juice.
- 4. Coffee and milkshakes.

**69.** After stabilization of Addison's disease, the nurse teaches the client about stress management. The nurse should instruct the client to:

- 1. Remove all sources of stress from daily life.
- 2. Use relaxation techniques such as music.
- 3. Take anti-anxiety drugs daily.
- 4. Avoid discussing stressful experiences.

**70.** When teaching a client newly diagnosed with primary Addison's disease, the nurse should explain that the disease results from:

- 1. Insufficient secretion of growth hormone (GH).
- 2. Dysfunction of the hypothalamic pituitary.
- 3. Idiopathic atrophy of the adrenal gland.
- 4. Oversecretion of the adrenal medulla.

**71.** The nurse is conducting discharge education with a client newly diagnosed with Addison's disease. Which information should be included in the client and family teaching plan? Select all that apply.

- 1. Addison's disease will resolve over a few weeks, requiring no further treatment.
- 2. Avoiding stress and maintaining a balanced lifestyle will minimize risk for exacerbations.
- 3. Fatigue, weakness, dizziness, and mood changes need to be reported to the physician.
- 4. A medical identification bracelet should be worn.
- 5. Family members need to be informed about the warning signals of adrenal crisis.
- 6. Dental work or surgery will require adjustment of daily medication.

**72.** The nurse should assess a client with Addison's disease for which of the following?

- 1. Weight gain.
- 2. Hunger.
- 3. Lethargy.
- 4. Muscle spasms.

**73.** A nurse is assessing a client with Addison's disease. The nurse should review laboratory reports for which condition?

- 1. Hypokalemia.
- 2. Hypernatremia.
- 3. Hypoglycemia.
- 4. Decreased blood urea nitrogen (BUN) level.

**74.** The client with Addison's disease is taking glucocorticoids at home. Which of the following statements indicate that the client understands how to take the medication?

- 1. "Various circumstances increase the need for glucocorticoids, so I will need to adjust the dosage."
- 2. "My need for glucocorticoids will stabilize and I will be able to take a predetermined dose once a day."
- 3. "Glucocorticoids are cumulative, so I will take a dose every third day."
- 4. "I must take a dose every 6 hours to ensure consistent blood levels of glucocorticoids."

**75.** Cortisone acetate (Cortone) and fludrocortisone acetate (Florinef Acetate) are prescribed as replacement therapy for a client with Addison's disease. What administration schedule should be followed for this therapy?

- 1. Take both drugs three times a day.
- 2. Take the entire dose of both drugs first thing in the morning.
- 3. Take all the fludrocortisone acetate and two-thirds of the cortisone acetate in the morning, and take the remaining cortisone acetate in the afternoon.
- 4. Take half of each drug in the morning and the remaining half of each drug at bedtime.

**76.** The nurse should tell the client to do which of the following when teaching the client about taking oral glucocorticoids?

- 1. "Take your medication with a full glass of water."
- 2. "Take your medication on an empty stomach."
- 3. "Take your medication at bedtime to increase absorption."
- 4. "Take your medication with meals or with an antacid."

**77.** Which of the following is the **best** indicator for determining whether a client with Addison's disease is receiving the correct amount of glucocorticoid replacement?

- 1. Skin turgor.
- 2. Temperature.
- 3. Thirst.
- 4. Daily weight.

**78.** Which of the following signs and symptoms would probably indicate that the client with Addison's disease is receiving too much glucocorticoid replacement?

- 1. Anorexia.
- 2. Dizziness.
- 3. Rapid weight gain.
- 4. Poor skin turgor.

**79.** Which of the following is a priority outcome for the client with Addison's disease?

- 1. Maintenance of medication compliance.
- 2. Avoidance of normal activities with stress.
- 3. Adherence to a 2-g sodium diet.
- 4. Prevention of hypertensive episodes.

**80.** The client with Addison's disease should anticipate the need for increased glucocorticoid supplementation in which of the following situations?

- 1. Returning to work after a weekend.
- 2. Going on vacation.
- 3. Having oral surgery.
- 4. Having a routine medical checkup.

**81.** The nurse should teach the client with Addison's disease that the adverse effect of bronze-colored skin is thought to be caused by which of the following?

- 1. Hypersensitivity to sun exposure.
- 2. Increased serum bilirubin level.
- 3. Adverse effects of the glucocorticoid therapy.
- 4. Increased secretion of adrenocorticotropic hormone (ACTH).

## The Client with Cushing's Disease

**82.** A client reports that she has gained weight and that her face and body are "rounder," while her legs and arms have become thinner. A tentative diagnosis of Cushing's disease is made. When examining this client, the nurse would expect to find:

- 1. Orthostatic hypotension.
- 2. Muscle hypertrophy in the extremities.
- 3. Bruised areas on the skin.
- 4. Decreased body hair.

**83.** Signs and symptoms of Cushing's disease include:

- 1. Weight loss.
- 2. Thin, fragile skin.
- 3. Hypotension.
- 4. Abdominal pain.

**84.** Cushing's disease is manifested by the excessive secretion of corticosteroids. The hormones involved are:

- 1. Glucocorticoids and aldosterone.
- 2. Adrenocorticotropic hormone (ACTH).
- 3. Glucocorticoids, aldosterone, and androgens.
- 4. Catecholamines.

**85.** The nurse should monitor the client with Cushing's disease for which of the following?

- 1. Postprandial hypoglycemia.
- 2. Hypokalemia.
- 3. Hyponatremia.
- 4. Decreased urine calcium level.

**86.** A client with Cushing's disease tells the nurse that the physician said the morning serum cortisol level was within normal limits. The client asks, "How can that be? I'm not imagining all these symptoms!" The nurse's response will be based on which of the following concepts?

- 1. Some clients are very sensitive to the effects of cortisol and develop symptoms even with normal levels.
- 2. A single random blood test cannot provide reliable information about endocrine levels.
- 3. The excessive cortisol levels seen in Cushing's disease commonly result from loss of the normal diurnal secretion pattern.
- 4. Tumors tend to secrete hormones irregularly, and the hormones are generally not present in the blood.

**87.** The client with Cushing's disease needs to modify dietary intake to control symptoms. In addition to increasing protein, which strategy would be **most** appropriate?

- 1. Increase calories.
- 2. Restrict sodium.
- 3. Restrict potassium.
- 4. Reduce fat to 10%.

**88.** Bone resorption is a possible complication of Cushing's disease. Which of the following interventions should the nurse recommend to help the client prevent this complication?

- 1. Increase the amount of potassium in the diet.
- 2. Maintain a regular program of weight-bearing exercise.
- 3. Limit dietary vitamin D intake.
- 4. Perform isometric exercises.

**89.** A client has an adrenal tumor and is scheduled for a bilateral adrenalectomy. During preoperative teaching, the nurse teaches the client how to do deep breathing exercises after surgery by telling the client to:

- 1. "Sit in an upright position and take a deep breath."
- 2. "Hold your abdomen firmly with a pillow and take several deep breaths."
- 3. "Tighten your stomach muscles as you inhale and breathe normally."
- 4. "Raise your shoulders to expand your chest."

**90.** A priority in the first 24 hours after a bilateral adrenalectomy is:

- 1. Beginning oral nutrition.
- 2. Promoting self-care activities.
- 3. Preventing adrenal crisis.
- 4. Ambulating in the hallway.

**91.** A client undergoing a bilateral adrenalectomy has postoperative orders for hydromorphone hydrochloride (Dilaudid) 2 mg to be given subcutaneously every 4 hours p.r.n. for pain. This drug is administered in relatively small doses **primarily** because it is:

- 1. Less likely to cause dependency in small doses.
- 2. Less irritating to subcutaneous tissues in small doses.
- 3. As potent as most other analgesics in larger doses.
- 4. Excreted before accumulating in toxic amounts in the body.

**92.** Adrenal function is affected by the drug ketoconazole (Nizoral), an antifungal agent used to treat severe fungal infections. How is this effect manifested?

- 1. Ketoconazole suppresses adrenal steroid secretion.
- 2. Ketoconazole destroys adrenocortical cells, resulting in a "medical" adrenalectomy.
- 3. Ketoconazole increases adrenocorticotrophic hormone (ACTH)-induced corticosteroid serum levels.
- 4. Ketoconazole decreases duration of adrenal suppression when administered with corticosteroids.

**93.** In the early postoperative period after a bilateral adrenalectomy, the client has an increased temperature. The nurse should assess the client further for signs of:

- 1. Dehydration.
- 2. Poor lung expansion.
- 3. Wound infection.
- 4. Urinary tract infection.

**94.** A client who is recovering from a bilateral adrenalectomy has a patient-controlled analgesia (PCA) system with morphine sulfate. Which of the following actions is a priority nursing intervention for the client?

- 1. Observing the client at regular intervals for opioid addiction.
- 2. Encouraging the client to reduce analgesic use and tolerate the pain.
- 3. Evaluating pain control at least every 2 hours.
- 4. Increasing the amount of morphine if the client does not administer the medication.

**95.** After surgery for bilateral adrenalectomy, the client is kept on bed rest for several days to stabilize the body's need for steroids postoperatively. Which of the following exercises will be most effective for preparing a client for ambulation after a period of bed rest?

- 1. Alternately flexing and extending the knees.
- 2. Alternately abducting and adducting the legs.
- 3. Alternately stretching the Achilles tendons.
- 4. Alternately flexing and relaxing the quadriceps femoris muscles.

**96.** As the nurse assists the postoperative client out of bed, the client reports having gas pains in the abdomen. Which of the following is the **most** effective nursing intervention to relieve this discomfort?

- 1. Encourage the client to ambulate.
- 2. Insert a rectal tube.
- 3. Insert a nasogastric (NG) tube.
- 4. Encourage the client to drink carbonated liquids.

**97.** Because of steroid excess after a bilateral adrenalectomy, the nurse should assess the client for:

- 1. Postoperative confusion.
- 2. Delayed wound healing.
- 3. Emboli.
- 4. Malnutrition.

**98.** The client who has undergone a bilateral adrenalectomy is ready to return home. She tells the nurse that she is concerned about persistent body changes and the fact that her moods are still so unpredictable. She says, "I thought surgery was supposed to fix all that." The nurse should tell the client that:

- 1. The body changes are permanent and the client will not be the same as before this condition.
- 2. The body and mood will gradually return to normal.
- 3. The physical changes are permanent, but the mood swings will disappear.
- 4. The physical changes are temporary, but the mood swings are permanent.

**99.** After a bilateral adrenalectomy for Cushing's disease, the client will receive periodic testosterone injections. The expected outcome of these injections is:

- 1. Balanced reproductive cycle.
- 2. Restored sodium and potassium balance.
- 3. Stimulated protein metabolism.
- 4. Stabilized mood swings.

**100.** Which of the following should the nurse include in the teaching plan of a female client with bilateral adrenalectomy?

- 1. Emphasizing that the client will need steroid replacement for the rest of her life.
- 2. Instructing the client about the importance of tapering steroid medication carefully to prevent crisis.
- 3. Informing the client that steroids will be required only until her body can manufacture sufficient quantities.
- 4. Emphasizing that the client will need to take steroids whenever her life involves physical or emotional stress.

### The Female Client with Perimenopausal or Menopausal Syndrome

**101.** The client with perimenopausal or menopausal syndrome is **primarily** experiencing a deficiency of the hormone:

- 1. Progesterone.
- 2. Estrogen.
- 3. Prolactin.
- 4. Oxytocin.

**102.** A woman with perimenopausal syndrome asks the nurse why she is having irregular periods. The nurse explains that she has a deficiency of estrogen caused by decreased function of the:

- 1. Ovarian follicle.
- 2. Pituitary gland.
- 3. Adrenal cortex.
- 4. Thyroid.

**103.** A menopausal woman with an intact uterus is taking a combined estrogen and progesterone replacement medication, Prempro 0.625 mg/2.5 mg, for severe hot flashes. Combined hormonal therapy is given because estrogen alone:

- 1. Would not be effective for hot flashes.
- 2. Could be a risk factor for endometrial cancer.
- 3. Would not be sufficient to maintain libido.
- 4. Could be a risk factor for ovarian cancer.

**104.** A woman in menopause is a good candidate for hormone replacement therapy (HRT) if she:

- 1. Has a family history of breast cancer.
- 2. Had breast cancer a year ago.
- 3. Has severe hot flashes.
- 4. Had an estrogen-dependent dysplasia.

**105.** The nurse teaches the postmenopausal client prescribed hormone replacement therapy (HRT) to contact her health care provider immediately if she experiences which of the following?

- 1. Hot flashes.
- 2. Irregular vaginal bleeding.
- 3. Vaginal dryness.
- 4. Vaginal pH changes.

### The Client with Pheochromocytoma

**106.** A client is admitted with pheochromocytoma. The nurse assesses the client's blood pressure frequently because pheochromocytoma of the adrenal medulla releases excessive amounts of:

- 1. Renin.
- 2. Aldosterone.
- 3. Catecholamines.
- 4. Glucocorticoids.

**107.** The **primary** feature of pheochromocytoma's effect on blood pressure is:

- 1. Systolic hypertension.
- 2. Diastolic hypertension.
- 3. Hypertension that is resistant to treatment with drugs.
- 4. Widening pulse pressure.

**108.** The client with pheochromocytoma is scheduled for surgical resection of the tumor in the adrenal medulla. The nurse should monitor the client postoperatively for which of the following potential complications?

- 1. Orthostatic hypotension.
- 2. Hemorrhage.
- 3. Hypoglycemia.
- 4. Hypertensive crisis.

**109.** The client with pheochromocytoma should be instructed to avoid activities that precipitate hypertensive crises or paroxysms, such as:

- 1. Jogging.
- 2. The Valsalva maneuver.
- 3. Anxiety.
- 4. Hypoglycemia.

**110.** Which of the following therapeutic classes of drugs is used to treat tachycardia and angina in a client with pheochromocytoma?

- 1. Angiotensin-converting enzyme (ACE) inhibitors.
- 2. Calcium channel blockers.
- 3. Beta blockers.
- 4. Diuretics.

### Managing Care Quality and Safety

**111.** The nurse is reviewing the postoperative orders (see chart) just written by a physician for a client with insulin-dependent diabetes who has returned to the surgery floor from the recovery room following surgery for a left hip replacement. The client has pain of 5 on a scale of 1 to 10. The hand-off report from the nurse in the recovery room indicated that the vital signs have been stable for the last 30 minutes. After obtaining the client's glucose level, the nurse should do which of the following **first**?

- 1. Administer the morphine.
- 2. Contact the physician to report the glucose level and rewrite the insulin order.
- 3. Administer oxygen per nasal canula at 2 L/minute.
- 4. Take the vital signs.

#### Physician Order

Vital signs every 15 minutes for 4 hours, then every hour for 8 hours.  
 Oxygen 2 L/minute per nasal canula.  
 1000 mL NS every 8 hours.  
 10 mg morphine intramuscularly every 4 hours as needed.  
 10 u regular insulin stat.

**112.** A client with type 1 diabetes is admitted to the emergency department with dehydration following the flu. The client has a blood glucose level of 325 mg/dL and a serum potassium level of 3.5 mEq. The physician has ordered 1,000 mL 5% dextrose in water to be infused every 8 hours. Prior to implementing the physician orders, the nurse should contact the physician, explain the situation, provide background information, report the current assessment of the client, and:

- 1. Suggest adding potassium to the fluids.
- 2. Request an increase in the volume of intravenous fluids.
- 3. Verify the order for 5% dextrose in water.
- 4. Determine if the client should be placed in isolation.

**113.** Glulisine (Apidra) insulin is ordered to be administered to a client before each meal. To assist the day-shift nurse who is receiving the report, the night-shift nurse gives the morning dose of glulisine. When the day-shift nurse goes to the room of the client who requires glulisine, the nurse finds that the client is not in the room. The client's roommate tells the nurse that the client "went for a test." What should the nurse do next?

- 1. Bring a small glass of juice, and locate the client.
- 2. Call the client's physician.
- 3. Check the computerized care plan to determine what test was scheduled.
- 4. Send the nurse's assistant to the X-ray department to bring the client back to his room.

**114.** A young adult client has been diagnosed with type 1 diabetes. He has an insulin drip to aid in lowering the serum blood glucose level of 600 mg/dL. He is also receiving ciprofloxacin (Cipro) I.V. The physician orders discontinuation of the insulin drip. The nurse should next?

- 1. Discontinue the insulin drip, as ordered.
- 2. Hang the next I.V. dose of antibiotic before discontinuing the insulin drip.
- 3. Inform the physician that the client has not received any subcutaneous insulin yet.
- 4. Add glargine (Lantus) to the insulin drip before discontinuing it.

## Answers, Rationales, and Test Taking Strategies


The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Thyrotoxicosis

**1. 2.** Graves' disease, the most common type of thyrotoxicosis, is a state of hypermetabolism. The increased metabolic rate generates heat and produces tachycardia and fine muscle tremors. Anorexia is associated with hypothyroidism. Loss of weight, despite a good appetite and adequate caloric intake, is a common feature of hyperthyroidism. Cold skin is associated with hypothyroidism.

🔑 CN: Physiological adaptation;  
 CL: Analyze


**2. 3.** A change in the menstrual interval, diminished menstrual flow (oligomenorrhea), or even the absence of menstruation (amenorrhea) may result from the hormonal imbalances of thyrotoxicosis. Oligomenorrhea in women and decreased libido and impotence in men are common features of thyrotoxicosis. Dysmenorrhea is painful menstruation. Metrorrhagia, blood loss between menstrual periods, is a symptom of hypothyroidism. Menorrhagia, excessive bleeding during menstrual periods, is a symptom of hypothyroidism.

 CN: Physiological adaptation;  
CL: Analyze


**3. 2, 3, 5, 6.** Clients with hypothyroidism exhibit symptoms indicating a lack of thyroid hormone. Bradycardia, decreased energy and lethargy, memory problems, weight gain, coarse hair, constipation, and menorrhagia are common signs and symptoms of hypothyroidism.

 CN: Physiological adaptation;  
CL: Analyze


**4. 1.** The most serious adverse effects of PTU are leukopenia and agranulocytosis, which usually occur within the first 3 months of treatment. The client should be taught to promptly report to the health care provider signs and symptoms of infection, such as a sore throat and fever. Clients complaining of a sore throat and fever should have an immediate white blood cell count and differential performed, and the drug must be withheld until the results are obtained. Painful menstruation, constipation, and increased urine output are not associated with PTU therapy.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**5. 2.** A typical sign of thyrotoxicosis is irritability caused by the high levels of circulating thyroid hormones in the body. This symptom decreases as the client responds to therapy. Thyrotoxicosis does not cause confusion. The client may be worried about her illness, and stress may influence her mood; however, irritability is a common symptom of thyrotoxicosis and the client should be informed of that fact rather than blamed.

 CN: Psychosocial adaptation;  
CL: Synthesize


**6. 4.** Elevated serum concentrations of thyroid hormones and suppressed serum TSH are the features of thyrotoxicosis. Decreased or absent serum TSH is a very accurate indicator of thyrotoxicosis. Increased levels of circulating thyroid hormones cause the feedback mechanism to the brain to suppress TSH secretion.

 CN: Physiological adaptation;  
CL: Analyze


**7. 3.** Treatment of mild ophthalmopathy that may accompany thyrotoxicosis includes measures such as wearing sunglasses to protect the eyes from corneal irritation. Treatment of ophthalmopathy should be performed in consultation with an ophthalmologist. Massaging the eyes will not help to protect the cornea. An ophthalmic anesthetic is used to examine and possibly treat a painful eye, not protect the cornea. Covering the eyes with moist gauze pads is not a satisfactory nursing measure to protect the eyes of a client with exophthalmos because treatment is not focused on moisture to the eye but rather on protecting the cornea and optic nerve. In exophthalmos, the retrobulbar connective tissues and extraocular muscle volume are expanded because of fluid retention. The pressure is also increased.

 CN: Reduction of risk potential;  
CL: Synthesize


**8. 4.** Sodium iodide  $^{131}\text{I}$  destroys the thyroid follicular cells, and thyroid hormones are no longer produced. RAI is commonly recommended for clients with Graves' disease, especially the elderly. The treatment results in a "medical thyroidectomy." RAI is given in lieu of surgery, not before surgery. RAI does not reduce uptake of thyroxine. The outcome of giving RAI is the destruction of the thyroid follicular cells. It is possible to slow the production of thyroid hormones with RAI.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**9. 3.** The client needs to be educated about the need for lifelong thyroid hormone replacement. Permanent hypothyroidism is the major complication of RAI  $^{131}\text{I}$  treatment. Lifelong medical follow-up and thyroid replacement are warranted. The client needs to monitor for signs and symptoms of hypothyroidism, not hyperthyroidism. Resting for 1 week is not necessary. Hypertension and tachycardia are signs of hyperthyroidism, not hypothyroidism.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**10. 2.** SSKI is frequently administered before a thyroidectomy because it helps decrease the vascularity of the thyroid gland. A highly vascular thyroid gland is very friable, a condition that presents a hazard during surgery. Preparation of the client for surgery includes depleting the gland of thyroid hormone and decreasing vascularity. SSKI does not decrease the progression of exophthalmos, and it does not decrease the body's ability to store thyroxine or increase the body's ability to excrete thyroxine.

 CN: Pharmacological and parenteral therapies; CL: Apply



**11. 3.** SSKI should be diluted well in milk, water, juice, or a carbonated beverage before administration to help disguise the strong, bitter taste. Also, this drug is irritating to mucosa if taken undiluted. The client should sip the diluted preparation through a drinking straw to help prevent staining of the teeth. Pouring the solution over ice chips will not sufficiently dilute the SSKI or cover the taste. Antacids are not used to dilute or cover the taste of SSKI. Mixing in a puree would put the SSKI in contact with the teeth.

 CN: Pharmacological and parenteral therapies; CL: Apply

**12. 3.** Laryngeal nerve damage is a potential complication of thyroid surgery because of the proximity of the thyroid gland to the recurrent laryngeal nerve. Asking the client to speak helps assess for signs of laryngeal nerve damage. Persistent or worsening hoarseness and weak voice are signs of laryngeal nerve damage and should be reported to the physician immediately. Internal hemorrhage is detected by changes in vital signs. The client's level of consciousness can be partially assessed by asking her to speak, but that is not the primary reason for doing so in this situation. Upper airway obstruction is detected by color and respiratory rate and pattern.


 CN: Reduction of risk potential; CL: Analyze

**13. 4.** Equipment for an emergency tracheotomy should be kept in the room, in case tracheal edema and airway occlusion occur. Laryngeal nerve damage can result in vocal cord spasm and respiratory obstruction. A tracheostomy set, oxygen and suction equipment, and a suture removal set (for respiratory distress from hemorrhage) make up the emergency equipment that should be readily available. Total parenteral nutrition is not anticipated for the client undergoing thyroidectomy. Intravenous infusion via a cutdown is not an expected possible treatment after thyroidectomy. Tube feedings are not anticipated emergency care.


 CN: Reduction of risk potential; CL: Synthesize

**14. 2.** Tetany may occur after thyroidectomy if the parathyroid glands are accidentally injured or removed during surgery. This would cause a disturbance in serum calcium levels. An early sign of tetany is numbness and tingling of the fingers or toes and in the circumoral region. Tetany may occur from 1 to 7 days postoperatively. Late signs and symptoms of tetany include seizures, contraction of the glottis, and respiratory obstruction. Pains in the joints of the hands and feet are not early symptoms


of tetany. Bleeding on the back of the dressing is related to possible incisional complications. Tension on the suture line may indicate swelling, infection, or internal bleeding, but it is not related to tetany.

 CN: Physiological adaptation; CL: Analyze


**15. 2.** The client with tetany is suffering from hypocalcemia, which is treated by administering an I.V. preparation of calcium, such as calcium gluconate or calcium chloride. Oral calcium is then necessary until normal parathyroid function returns. Sodium phosphate is a laxative. Echothiophate iodide is an eye preparation used as a miotic for an antiglaucoma effect. Sodium bicarbonate is a potent systemic antacid.

 CN: Pharmacological and parenteral therapies; CL: Apply


**16. 2.** Typical signs and symptoms of hypothyroidism include weight gain, fatigue, decreased energy, apathy, brittle nails, dry skin, cold intolerance, hair loss, constipation, and numbness and tingling in the fingers. Tachycardia is a sign of hyperthyroidism, not hypothyroidism. Diarrhea and nausea are not symptoms of hypothyroidism.

 CN: Physiological adaptation; CL: Analyze

**17. 4.** A major problem for the person with hypothyroidism is fatigue. Other signs and symptoms include lethargy, personality changes, generalized edema, impaired memory, slowed speech, cold intolerance, dry skin, muscle weakness, constipation, weight gain, and hair loss. Incomplete closure of the eyelids, hypermetabolism, and diarrhea are associated with hyperthyroidism.

 CN: Basic care and comfort; CL: Analyze

**18. 4.** Hypothyroidism may contribute to sadness and depression. It is good practice for clients with newly diagnosed depression to be monitored for hypothyroidism by checking serum thyroid hormone and thyroid-stimulating hormone levels. This client needs to know that these feelings may be related to her low thyroid hormone levels and may improve with treatment. Replacement therapy does not cause depression. Depression may accompany chronic illness, but it is not "normal."

 CN: Psychosocial adaptation; CL: Analyze

## The Client with Diabetes Mellitus

**19. 3.** Empowerment is an approach to clinical practice that emphasizes helping people discover and use their innate abilities to gain mastery over their own condition. Empowerment means that individuals with a health problem have the tools, such as knowledge, control, resources, and experience, to implement and evaluate their self-management practices. Involvement of others, such as asking the client about family involvement, implies that the others will provide the direct care needed rather than the client. Asking the client what the client needs to know implies that the nurse will be the one to provide the information. Telling the client what is required does not provide the client with options or lead to empowerment.

 CN: Health promotion and maintenance;  
CL: Synthesize

**20. 1, 2, 4, 5.** The risk factors for developing type 2 diabetes include giving birth to an infant weighing more than 9 lb; obesity (BMI over 30); ethnicity of Asian, African American, or Native American Indian; age greater than 45 years; hypertension; and family history in parents or siblings. Childhood obesity is also a risk factor for type 2 diabetes. Maintaining an ideal weight, eating a low-fat diet, and exercising regularly decrease the risk of type 2 diabetes.

 CN: Reduction of risk potential;  
CL: Analyze

**21. 2.** Diabetes insipidus is caused by a deficiency of antidiuretic hormone, which results in excretion of a large volume of dilute urine. Therefore, a urine specific gravity of less than 1.005 should be reported. Urine output should be 30 to 50 mL/hour; thus, 350 mL is a normal urinary output over 8 hours. The potassium level is normal. Weight loss, not weight gain, should be monitored as a sign of dehydration.

 CN: Reduction of risk potential;  
CL: Synthesize

**22. 1.** The elevated blood glucose level indicates hyperglycemia. The hemoglobin is normal. The client's cholesterol and LDL levels are both normal. The nurse should determine if there are standing orders for the hyperglycemia or notify the physician.


 CN: Reduction of risk potential;  
CL: Analyze

**23. 3.** Due to the rapid, deep respirations, the client is losing fluid from vaporization from the lungs and skin (insensible fluid loss). Normally, about 900 mL of fluid is lost per day through vaporization.


Decreased serum potassium level has no effect on insensible fluid loss. Hypotension occurs due to polyurea and inadequate fluid intake. It may decrease the flow of blood to the skin, causing skin to be warm and dry.

 CN: Reduction of risk potential;  
CL: Analyze


**24. 4.** Glargine (Lantus) is a long-acting recombinant human insulin analog. Glargine should not be mixed with any other insulin product. Insulins should not be shaken; instead, if the insulin is cloudy, roll the vial or insulin pen between the palms of the hands.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**25. 1.** A rare but serious adverse effect of metformin (Glucophage) is lactic acidosis; half the cases are fatal. Ideally, one should stop metformin for 2 days before and 2 days after drinking alcohol. Signs and symptoms of lactic acidosis are weakness, fatigue, unusual muscle pain, dyspnea, unusual stomach discomfort, dizziness or light-headedness, and bradycardia or cardiac arrhythmias. Bloating is not an adverse effect of metformin.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**26. 3.** Oral hypoglycemic agents of the sulfonylurea group, such as tolbutamide (Orinase), lower the blood glucose level by stimulating functioning beta cells in the pancreas to release insulin. These agents also increase insulin's ability to bind to the body's cells. They may also act to increase the number of insulin receptors in the body. Tolbutamide does not potentiate the action of insulin. Tolbutamide does not lower the renal threshold of glucose, which would not be a factor in the treatment of diabetes in any case. Tolbutamide does not combine with glucose to render it inert.

 CN: Pharmacological and parenteral therapies; CL: Apply

**27. 1, 5.** Being overweight and having a large waist-hip ratio (central abdominal obesity) increase insulin resistance, making control of diabetes more difficult. The ADA recommends a yearly referral to an ophthalmologist and podiatrist. Exercise and weight management decrease insulin resistance. Insulin is not always needed for type 2 diabetes; diet, exercise, and oral medications are the first-line treatment. The client must monitor all nutritional sources for a balanced diet—fats, carbohydrates, and protein.

 CN: Reduction of risk potential;  
CL: Create

**28. 1.** The client with diabetes is prone to serious foot injuries secondary to peripheral neuropathy and decreased circulation. The client should be taught to avoid going barefoot to prevent injury. Shoes that do not fit properly should not be worn because they will cause blisters that can become nonhealing, serious wounds for the diabetic client. Toenails should be cut straight across. A heating pad should not be used because of the risk of burns due to insensitivity to temperature.

 CN: Reduction of risk potential;  
CL: Synthesize

**29. 2.** A client with diabetes should be advised to consult a physician or podiatrist for corn removal because of the danger of traumatizing the foot tissue and potential development of ulcers. The diabetic client should never self-treat foot problems but should consult a physician or podiatrist.

 CN: Reduction of risk potential;  
CL: Synthesize


**30. 2.** Proper and careful first-aid treatment is important when a client with diabetes has a skin cut or laceration. The skin should be kept supple and as free of organisms as possible. Washing and bandaging the cut will accomplish this. Washing wounds with alcohol is too caustic and drying to the skin. Having the children help is an unrealistic suggestion and does not educate the client about proper care of wounds. Tight control of blood glucose levels through adherence to the medication regimen is vitally important; however, it does not mean that careful attention to cuts can be ignored.

 CN: Reduction of risk potential;  
CL: Synthesize

**31. 4.** Diabetes mellitus is a multifactorial, systemic disease associated with problems in the metabolism of all food types. The client's diet should contain appropriate amounts of all three nutrients, plus adequate minerals and vitamins.

 CN: Basic care and comfort; CL: Apply

**32. 1.** Deep, rapid respirations with long expirations is indicative of Kussmaul's respirations, which occur in metabolic acidosis. The respirations increase in rate and depth, and the breath has a "fruity" or acetone-like odor. This breathing pattern is the body's attempt to blow off carbon dioxide and acetone, thus compensating for the acidosis. The other breathing patterns listed are not related to ketoacidosis and would not compensate for the acidosis.

 CN: Physiological adaptation;  
CL: Analyze

**33. 1, 2, 3, 4, 5.** The client with unstable diabetes mellitus is at risk for many microvascular and macrovascular complications. Heart disease is the leading cause of mortality in clients with diabetes. The goal blood pressure for diabetics is less than 130/80 mm Hg. Therefore, the nurse would need to report any findings greater than 130/80 mm Hg. The goal of HbA<sub>1c</sub> is less than 7%; thus, a level of 10.2% must be reported. HDL less than 40 mg/dL and triglycerides greater than 150 mg/dL are risk factors for heart disease. The nurse would need to report the client's HDL and triglyceride levels. The urine ketones are negative, but this is a late sign of complications when there is a profound insulin deficiency.

 CN: Reduction of risk potential;  
CL: Analyze

**34. 4.** A client with diabetes who takes any first- or second-generation sulfonylurea should be advised to avoid alcohol intake. Sulfonylureas in combination with alcohol can cause serious disulfiram (Antabuse)-like reactions, including flushing, angina, palpitations, and vertigo. Serious reactions, such as seizures and possibly death, may also occur. Hypokalemia, hyperkalemia, and hypocalcemia do not result from taking sulfonylureas in combination with alcohol.

 CN: Physiological adaptation; CL: Apply


**35. 3.** The most important factor predisposing to the development of type 2 diabetes mellitus is obesity. Insulin resistance increases with obesity. Cigarette smoking is not a predisposing factor, but it is a risk factor that increases complications of diabetes mellitus. A high-cholesterol diet does not necessarily predispose to diabetes mellitus, but it may contribute to obesity and hyperlipidemia. Hypertension is not a predisposing factor, but it is a risk factor for developing complications of diabetes mellitus.

 CN: Health promotion and maintenance;  
CL: Apply

**36. 2.** The client with diabetes mellitus is especially prone to hypertension due to atherosclerotic changes, which leads to problems of the microvascular and macrovascular systems. This can result in complications in the heart, brain, and kidneys. Heart disease and stroke are twice as common among people with diabetes mellitus than among people without the disease. Painful, inflamed joints accompany rheumatoid arthritis. A stooped appearance accompanies osteoporosis with narrowing of the vertebral column. A low hemoglobin concentration accompanies anemia, especially iron deficiency anemia and anemia of chronic disease.

 CN: Reduction of risk potential;  
CL: Analyze


**37. 1.** Although some individual variation exists, when the blood glucose level decreases to less than 70 mg/dL, the client experiences or is at risk for hypoglycemia. Hypoglycemia can occur in both type 1 and type 2 diabetes mellitus, although it is more common when the client is taking insulin. The nurse should instruct the client on the prevention, detection, and treatment of hypoglycemia.

 CN: Physiological adaptation;  
CL: Analyze


**38. 4.** Diabetic retinopathy, cataracts, and glaucoma are common complications in diabetics, necessitating eye assessment and examination. The feet should also be examined at each client encounter, monitoring for thickening, fissures, or breaks in the skin; ulcers; and thickened nails. Although assessments of the abdomen, pharynx, and lymph glands are included in a thorough examination, they are not pertinent to common diabetic complications.

 CN: Reduction of risk potential;  
CL: Analyze


**39. 4.** The client with diabetes mellitus who is taking NPH insulin (Humulin N) in the evening is most likely to become hypoglycemic shortly after midnight because this insulin peaks in 6 to 8 hours. The client should eat a bedtime snack to help prevent hypoglycemia while sleeping.

 CN: Pharmacological and parenteral therapies; CL: Apply


**40. 3.** If the client engages in an activity or exercise that focuses on one area of the body, that area may cause inconsistent absorption of insulin. A good regimen for a jogger is to inject the abdomen for 1 week and then rotate to the buttock. A jogger may have inconsistent absorption in the legs or arms with strenuous running. The iliac crest is not an appropriate site due to a lack of loose skin and subcutaneous tissue in that area.

 CN: Pharmacological and parenteral therapies; CL: Apply

**41. 1.** Insulin lispro (Humalog) begins to act within 10 to 15 minutes and lasts approximately 4 hours. A major advantage of Humalog is that the client can eat almost immediately after the insulin is administered. The client needs to be instructed regarding the onset, peak, and duration of all insulin, as meals need to be timed with these parameters. Waiting 1 hour to eat may precipitate hypoglycemia. Eating 2 hours before the insulin lispro could cause hyperglycemia if the client does not have circulating insulin to metabolize the carbohydrate.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**42. 1.** The nurse should judge that learning has occurred from evidence of a change in the client's behavior. A client who performs a procedure safely and correctly demonstrates that he has acquired a skill. Evaluation of this skill acquisition requires performance of that skill by the client with observation by the nurse. The client must also demonstrate cognitive understanding, as shown by the ability to critique the nurse's performance. Explaining the steps demonstrates acquisition of knowledge at the cognitive level only. A posttest does not indicate the degree to which the client has learned a psychomotor skill.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

### 43. 32 units

Clients commonly need to mix insulin, requiring careful mixing and calculation. The total dosage is 10 units plus 22 units, for a total of 32 units.

 CN: Pharmacological and parenteral therapies; CL: Apply


**44. 3.** Renal failure frequently results from the vascular changes associated with diabetes mellitus. ACE inhibitors increase renal blood flow and are effective in decreasing diabetic nephropathy. Chronic obstructive pulmonary disease is not a complication of diabetes, nor is it prevented by ACE inhibitors. Pancreatic cancer is neither prevented by ACE inhibitors nor considered a complication of diabetes. Cerebrovascular accident is not directly prevented by ACE inhibitors, although management of hypertension will decrease vascular disease.

 CN: Pharmacological and parenteral therapies; CL: Apply

**45. 1.** The four most commonly reported signs and symptoms of hypoglycemia are nervousness, weakness, perspiration, and confusion. Other signs and symptoms include hunger, incoherent speech, tachycardia, and blurred vision. Anorexia and Kussmaul's respirations are clinical manifestations of hyperglycemia or ketoacidosis. Bradycardia is not associated with hypoglycemia; tachycardia is.

 CN: Reduction of risk potential;  
CL: Apply


**46. 2.** Steroids can cause hyperglycemia because of their effects on carbohydrate metabolism, making diabetic control more difficult. Aspirin is not known to affect glucose metabolism. Sulfonylureas are oral hypoglycemic agents used in the treatment of diabetes mellitus. ACE inhibitors are not known to affect glucose metabolism.

 CN: Pharmacological and parenteral therapies; CL: Apply


**47. 1.** Colds and influenza present special challenges to the client with diabetes mellitus because the body's need for insulin increases during illness. Therefore, the client must take the prescribed insulin dose, increase the frequency of blood glucose testing, and maintain an adequate fluid intake to counteract the dehydrating effect of hyperglycemia. Clear fluids, juices, and Gatorade are encouraged. Not taking insulin when sick, or taking half the normal dose, may cause the client to develop ketoacidosis.

 CN: Reduction of risk potential;  
CL: Synthesize

**48. 1.** *Imbalanced nutrition: Less than body requirements* is a priority nursing diagnosis for the client with diabetes mellitus who is experiencing vomiting with influenza. The diabetic client should eat small, frequent meals of 50 g of carbohydrate or food equal to 200 calories every 3 to 4 hours. If the client cannot eat the carbohydrates or take fluids, the health care provider should be called or the client should go to the emergency department. The diabetic client is in danger of complications with dehydration, electrolyte imbalance, and ketoacidosis. Increasing the client's coping skills is important to lifestyle behaviors, but it is not a priority during this acute illness of influenza. Pain relief may be a need for this client, but it is not the priority at this time; neither is intolerance for activity.

 CN: Basic care and comfort;  
CL: Analyze

**49. 4.** The best response is to allow the client to verbalize her fears about giving herself a shot each day. Tactics that increase fear are not effective in changing behavior. If possible, the client needs to be responsible for her own care, including giving self-injections. It is unlikely that the client's insurance company will pay for home-care visits if the client is capable of self-administration.


 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Pituitary Adenoma

**50. 1.** Galactorrhea, or abnormal flow of breast milk, results from overproduction of prolactin. Pituitary tumors are almost always secreting tumors, and they are classified by the specific hormone secreted. Pituitary tumors can cause oversecretion of ACTH, GH, or TSH. Overproduction of ACTH results in Cushing's disease. Overproduction of GH results in gigantism. Overproduction of TSH results in hyperthyroidism.

 CN: Physiological adaptation; CL: Apply

**51. 2.** Excessive prolactin secretion in men results in decreased libido and impotence; these are often the only significant signs and symptoms until the tumor becomes large. Signs and symptoms of pituitary tumors result from both the presence of a space-occupying mass in the cranium and the excess secretion of hormones. Lethargy and fatigue are associated with hypothyroidism or Addisonian crisis. Bony proliferation and voice changes are associated with excessive growth hormone.

 CN: Physiological adaptation;  
CL: Analyze

**52. 4.** With transsphenoidal hypophysectomy, the sella turcica is entered from below, through the sphenoid sinus. There is no external incision; the incision is made between the upper lip and gums.

 CN: Reduction of risk potential;  
CL: Apply


**53. 3.** Deep breathing is the best choice for helping prevent atelectasis. The client should be placed in the semi-Fowler's position (or as ordered) and taught deep breathing, sighing, mouth breathing, and how to avoid coughing. Blow bottles are not effective in preventing atelectasis because they do not promote sustained alveolar inflation to maximal lung capacity. Frequent position changes help loosen lung secretions, but deep breathing is most important in preventing atelectasis. Coughing is contraindicated because it increases intracranial pressure and can cause cerebrospinal fluid to leak from the point at which the sella turcica was entered.

 CN: Reduction of risk potential;  
CL: Synthesize


**54. 1.** A major focus of nursing care after transsphenoidal hypophysectomy is prevention of and monitoring for a CSF leak. CSF leakage can occur if the patch or incision is disrupted. The nurse should monitor for signs of infection, including elevated temperature, increased white blood cell count, rhinorrhea, nuchal rigidity, and persistent headache. Hypoglycemia and adrenocortical insufficiency may occur. Monitoring for fluctuating blood glucose levels is not related specifically to transsphenoidal hypophysectomy. The client will be given I.V. fluids postoperatively to supply carbohydrates. Cushing's disease results from adrenocortical excess, not insufficiency. Monitoring for cardiac arrhythmias is important, but arrhythmias are not anticipated following a transsphenoidal hypophysectomy.

 CN: Reduction of risk potential;  
CL: Analyze

**55. 1.** The client's sexual problems are directly related to the excessive prolactin level. Removing the source of excessive hormone secretion should allow the client to return gradually to a normal physiologic pattern. Fertility will return, and erectile function and sexual desire will return to baseline as hormone levels return to normal.

 CN: Physiological adaptation;  
CL: Apply


**56. 3.** The dural opening is typically repaired with a patch of muscle or fascia taken from the abdomen or thigh. The client should be prepared preoperatively for the presence of this additional incision in the abdomen or thigh. The client will need the patch of muscle or fascia to replace the dura. Disposable sutures alone will not provide an intact suture line. Nasal packing will not provide closure for the dural opening. A synthetic mesh is not the tissue of choice for surgical repair of the dura.

 CN: Reduction of risk potential;  
CL: Apply

**57. 3.** If CSF leakage is suspected or confirmed, the client is treated initially with bed rest with the head of the bed elevated to decrease pressure on the graft site. Most leaks heal spontaneously, but occasionally surgical repair of the site in the sella turcica is needed. Repacking the nose will not heal the leak at the graft site in the dura. The client will not be returned to surgery immediately because most leaks heal spontaneously. High-dose corticosteroid therapy is not effective in healing a CSF leak.


 CN: Physiological adaptation;  
CL: Apply

**58. 1.** After transsphenoidal surgery, the client must be careful not to disturb the suture line while healing occurs. Frequent oral care should be provided with rinses of saline, and the teeth may be gently cleaned with Toothettes. Frequent or vigorous toothbrushing or flossing is contraindicated because it may disturb or cause tension on the suture line.


 CN: Physiological adaptation;  
CL: Synthesize

**59. 4.** Most clients who undergo adenoma removal experience a gradual return of normal pituitary secretion and do not experience complications. However, hypopituitarism can cause growth hormone, gonadotropin, thyroid-stimulating hormone, and adrenocorticotrophic hormone deficits. The client should be taught to monitor for change in mental


status, energy level, muscle strength, and cognitive function. In adults, changes in sexual function, impotence, or decreased libido should be reported. Acromegaly and Cushing's disease are conditions of hypersecretion. Diabetes mellitus is related to the function of the pancreas and is not directly related to the function of the pituitary.

 CN: Reduction of risk potential;  
CL: Analyze


**60. 1.** Pituitary diabetes insipidus is a potential complication after pituitary surgery because of possible interference with the production of antidiuretic hormone (ADH). One major manifestation of diabetes insipidus is polyuria because lack of ADH results in insufficient water reabsorption by the kidneys. The polyuria leads to a decreased urine specific gravity (between 1.001 and 1.010). The client may drink and excrete 5 to 40 L of fluid daily. Diabetes insipidus does not affect metabolism. A blood glucose level higher than 300 mg/dL is associated with impaired glucose metabolism or diabetes mellitus. Urine negative for sugar and ketones is normal.

 CN: Reduction of risk potential;  
CL: Analyze

**61. 2.** The major characteristic of diabetes insipidus is decreased tubular reabsorption of water due to insufficient amounts of antidiuretic hormone (ADH). Vasopressin (Pitressin) is administered to the client with diabetes insipidus because it has pressor and ADH activities. Vasopressin works to increase the concentration of the urine by increasing tubular reabsorption, thus preserving up to 90% water. Vasopressin is administered to the client with diabetes insipidus because it is a synthetic ADH. The administration of vasopressin results in increased tubular reabsorption of water, and it is effective for emergency treatment or daily maintenance of mild diabetes insipidus. Vasopressin does not decrease blood pressure or affect insulin production or glucose metabolism, nor is insulin production a factor in diabetes insipidus.

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 1.** Because diabetes insipidus involves excretion of large amounts of fluid, maintaining normal fluid and electrolyte balance is a priority for this client. Special dietary programs or restrictions are not indicated in treatment of diabetes insipidus. Serum glucose levels are priorities in diabetes mellitus but not in diabetes insipidus.


 CN: Physiological adaptation;  
CL: Evaluate

## The Client with Addison's Disease


**63. 4.** Adrenal crisis can occur with physical stress, such as surgery, dental work, infection, flu, trauma, and pregnancy. In these situations, glucocorticoid and mineralocorticoid dosages are increased. Weight loss, not gain, occurs with adrenal insufficiency. Psychological stress has less effect on corticosteroid need than physical stress.

 CN: Reduction of risk potential;  
CL: Synthesize


**64. 2.** Addison's disease is caused by a deficiency of adrenal corticosteroids and can result in severe hypotension and shock because of uncontrolled loss of sodium in the urine and impaired mineralocorticoid function. This results in loss of extracellular fluid and dangerously low blood volume. Glucocorticoids must be administered to reverse hypotension. Preventing infection is not an appropriate goal of care in this life-threatening situation. Relieving anxiety is appropriate when the client's condition is stabilized, but the calm, competent demeanor of the emergency department staff will be initially reassuring.

 CN: Physiological adaptation;  
CL: Synthesize


**65. 2.** Adrenal hormone deficiency can cause profound physiologic changes. The client may experience severe pain (headache, abdominal pain, back pain, or pain in the extremities). Inhibited gluconeogenesis commonly produces hypoglycemia, and impaired sodium retention causes decreased, not increased, fluid volume. Edema would not be expected. Gastrointestinal disturbances, including nausea and vomiting, are expected findings in Addison's disease, not hunger.

 CN: Physiological adaptation;  
CL: Analyze

**66. 1.** Signs of infiltration include slowing of the infusion and swelling, pain, hardness, pallor, and coolness of the skin at the site. If these signs occur, the I.V. line should be discontinued and restarted at another infusion site. The new anatomic site, time, and type of cannula used should be documented. The nurse may apply a warm soak to the site, but only after the I.V. line is discontinued. Parenteral administration of fluids should not be stopped intermittently. Stopping the flow does not treat the problem, nor does it address the client's needs for fluid replacement. Infiltrated I.V. sites should not be irrigated; doing so will only cause more swelling and pain.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**67. 1.** Each liter of 5% dextrose in normal saline solution contains 170 calories. The nurse should consult with the physician and dietitian when a client is on I.V. therapy or is on nothing-by-mouth status for an extended period because further electrolyte supplementation or alimentation therapy may be needed.

 CN: Pharmacological and parenteral therapies; CL: Apply


**68. 3.** Electrolyte imbalances associated with Addison's disease include hypoglycemia, hyponatremia, and hyperkalemia. Salted bouillon and fruit juices provide glucose and sodium to replenish these deficits. Diet soda does not contain sugar. Water could cause further sodium dilution. Coffee's diuretic effect would aggravate the fluid deficit. Milk contains potassium and sodium.

 CN: Basic care and comfort; CL: Apply

**69. 2.** Finding alternative methods of dealing with stress, such as relaxation techniques, is a cornerstone of stress management. Removing all sources of stress from one's life is not possible. Anti-anxiety drugs are prescribed for temporary management during periods of major stress, and they are not an intervention in stress management classes. Avoiding discussion of stressful situations will not necessarily reduce stress.

 CN: Psychosocial adaptation;  
CL: Synthesize


**70. 3.** Primary Addison's disease refers to a problem in the gland itself that results from idiopathic atrophy of the glands. The process is believed to be autoimmune in nature. The most common causes of primary adrenocortical insufficiency are autoimmune destruction (70%) and tuberculosis (20%). Insufficient secretion of GH causes dwarfism or growth delay. Hyposecretion of glucocorticoids, aldosterone, and androgens occur with Addison's disease. Pituitary dysfunction can cause Addison's disease, but this is not a primary disease process. Oversecretion of the adrenal medulla causes pheochromocytoma.

 CN: Physiological adaptation; CL: Apply

**71. 2, 3, 4, 5, 6.** Addison's disease occurs when the client does not produce enough steroids from the adrenal cortex. Lifetime steroid replacement is needed. The client should be taught lifestyle management techniques to avoid stress and maintain rest periods. A medical identification bracelet should be worn and the family should be taught signs and symptoms that indicate an impending adrenal crisis, such as fatigue, weakness, dizziness, or mood changes. Dental work, infections, and surgery commonly require an adjusted dosage of steroids.

 CN: Physiological adaptation; CL: Create


**72. 3.** Although many of the disease signs and symptoms are vague and nonspecific, most clients experience lethargy and depression as early symptoms. Other early signs and symptoms include mood changes, emotional lability, irritability, weight loss, muscle weakness, fatigue, nausea, and vomiting. Most clients experience a loss of appetite. Muscles become weak, not spastic, because of adrenocortical insufficiency.

 CN: Physiological adaptation;  
CL: Analyze


**73. 3.** Decreased hepatic gluconeogenesis and increased tissue glucose uptake cause hypoglycemia in clients with Addison's disease. Hyperkalemia and hyponatremia are characteristic of Addison's disease. There is decreased renal perfusion and excretion of waste products, which causes an elevated BUN level.

 CN: Reduction of risk potential;  
CL: Analyze

**74. 1.** The need for glucocorticoids changes with circumstances. The basal dose is established when the client is discharged, but this dose covers only normal daily needs and does not provide for additional stressors. As the manager of the medication schedule, the client needs to know signs and symptoms of excessive and insufficient dosages. Glucocorticoid needs fluctuate. Glucocorticoids are not cumulative and must be taken daily. They must never be discontinued suddenly; in the absence of endogenous production, Addisonian crisis could result. Two-thirds of the daily dose should be taken at about 8 a.m. and the remainder at about 4 p.m. This schedule approximates the diurnal pattern of normal secretion, with highest levels between 4 a.m. and 6 a.m. and lowest levels in the evening.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**75. 3.** Fludrocortisone acetate (Florinef Acetate) can be administered once a day, but cortisone acetate (Cortone) administration should follow the body's natural diurnal pattern of secretion. Greater amounts of cortisol are secreted during the day to meet increased demand of the body. Typically, baseline administration of cortisone acetate is 25 mg in the morning and 12.5 mg in the afternoon. Taking it three times a day would result in an excessive dose. Taking the drug only in the morning would not meet the needs of the body later in the day and evening.


 CN: Pharmacological and parenteral therapies; CL: Apply

**76. 4.** Oral steroids can cause gastric irritation and ulcers and should be administered with meals, if possible, or otherwise with an antacid. Only


instructing the client to take the medication with a full glass of water will not help prevent gastric complications from steroids. Steroids should never be taken on an empty stomach. Glucocorticoids should be taken in the morning, not at bedtime.

 CN: Pharmacological and parenteral therapies; CL: Apply

**77. 4.** Measuring daily weight is a reliable, objective way to monitor fluid balance. Rapid variations in weight reflect changes in fluid volume, which suggests insufficient control of the disease and the need for more glucocorticoids in the client with Addison's disease. Nurses should instruct clients taking oral steroids to weigh themselves daily and to report any unusual weight loss or gain. Skin turgor testing does supply information about fluid status, but daily weight monitoring is more reliable. Temperature is not a direct measurement of fluid balance. Thirst is a nonspecific and very late sign of weight loss.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**78. 3.** Rapid weight gain, because it reflects excess fluids, is a warning sign that the client is receiving too much hormone replacement. It may be difficult to individualize the correct dosage for a client taking glucocorticoids, and the therapeutic range between underdosage and overdosage is narrow. Maintaining the client on the lowest dose that provides satisfactory clinical response is always the goal of pharmacotherapeutics. Fluid balance is an important indicator of the adequacy of hormone replacement. Anorexia is not present with glucocorticoid therapy because these drugs increase the appetite. Dizziness is not specific to the effects of glucocorticoid therapy. Poor skin turgor is a late sign of fluid volume deficit.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**79. 1.** Medication compliance is an essential part of the self-care required to manage Addison's disease. The client must learn to adjust the glucocorticoid dose in response to the normal and unexpected stresses of daily living. The nurse should instruct the client never to stop taking the drug without consulting the health care provider to avoid an Addisonian crisis. Regularity in daily habits makes adjustment easier, but the client should not be encouraged to withdraw from normal activities to avoid stress. The client does not need to restrict sodium. The client is at risk for hyponatremia. Hypotension, not hypertension, is more common with Addison's disease.

 CN: Reduction of risk potential;  
CL: Evaluate



**80. 3.** Illness or surgery places tremendous stress on the body, necessitating increased glucocorticoid dosage. Extreme emotional or psychological stress also necessitates dosage adjustment. Increased dosages are needed in times of stress to prevent drug-induced adrenal insufficiency. Returning to work after the weekend, going on a vacation, or having a routine checkup usually will not alter glucocorticoid dosage needs.


 CN: Reduction of risk potential;  
CL: Synthesize

**81. 4.** Bronzing, or general deepening of skin pigmentation, is a classic sign of Addison's disease and is caused by melanocyte-stimulating hormone produced in response to increased ACTH secretion. The hyperpigmentation is typically found in the distal portion of extremities and in areas exposed to sun. Additionally, areas that may not be exposed to sun, such as the nipples, genitalia, tongue, and knuckles, become bronze-colored. Treatment of Addison's disease usually reverses the hyperpigmentation. Bilirubin level is not related to the pathophysiology of Addison's disease. Hyperpigmentation is not related to the effects of the glucocorticoid therapy.


 CN: Physiological adaptation; CL: Apply

### The Client with Cushing's Disease

**82. 3.** Skin bruising from increased skin and blood vessel fragility is a classic sign of Cushing's disease. Hyperpigmentation and bruising are caused by the hypersecretion of glucocorticoids. Fluid retention causes hypertension, not hypotension. Muscle wasting occurs in the extremities. Hair on the head thins, while body hair increases.

 CN: Physiological adaptation;  
CL: Analyze

**83. 2.** In Cushing's disease, excessive cortisol secretion causes rapid protein catabolism, depleting the collagen support of the skin. The skin becomes thin and fragile and susceptible to easy bruising. The typical "cushingoid" appearance of the client includes a moon face, buffalo hump, central obesity, and thin musculature. Weight gain, mood swings, and slow wound healing are other signs and symptoms of Cushing's disease. Hypertension, not hypotension, is a sign of Cushing's disease. Abdominal pain is not a symptom of Cushing's disease.

 CN: Physiological adaptation;  
CL: Analyze

**84. 3.** Excessive levels of glucocorticoids, aldosterone, and androgens secreted from the adrenal cortex result in the constellation of symptoms known as Cushing's disease. Cushing's disease can be caused

by a tumor, overstimulation from the pituitary, or the use of prescription steroid drugs. Androgens are also secreted in excess. ACTH is only one hormone that is abnormal in Cushing's disease. Excessive secretion of catecholamines accompanies pheochromocytoma, a disease of the adrenal medulla.

 CN: Physiological adaptation; CL: Apply


**85. 2.** Sodium retention is typically accompanied by potassium depletion. Hypertension, hypokalemia, edema, and heart failure may result from the hypersecretion of aldosterone. The client with Cushing's disease exhibits postprandial or persistent hyperglycemia. Clients with Cushing's disease have hypernatremia, not hyponatremia. Bone resorption of calcium increases the urine calcium level.

 CN: Reduction of risk potential;  
CL: Analyze

**86. 3.** Cushing's disease is commonly caused by loss of the diurnal cortisol secretion pattern. The client's random morning cortisol level may be within normal limits, but secretion continues at that level throughout the entire day. Cortisol levels should normally decrease after the morning peak. Analysis of a 24-hour urine specimen is often useful in identifying the cumulative excess. Clients will not have symptoms with normal cortisol levels. Hormones are present in the blood.

 CN: Reduction of risk potential;  
CL: Apply

**87. 2.** A primary dietary intervention is to restrict sodium, thereby reducing fluid retention. Increased protein catabolism results in loss of muscle mass and necessitates supplemental protein intake. The client may be asked to restrict total calories to reduce weight. The client should be encouraged to eat potassium-rich foods because serum levels are typically depleted. Although reducing fat intake as part of an overall plan to restrict calories is appropriate, fat intake of less than 20% of total calories is not recommended.

 CN: Basic care and comfort;  
CL: Synthesize


**88. 2.** Osteoporosis is a serious outcome of prolonged cortisol excess because calcium is resorbed out of the bone. Regular daily weight-bearing exercise (e.g., brisk walking) is an effective way to drive calcium back into the bones. The client should also be instructed to have a dietary or supplemental intake of calcium of 1,500 mg daily. Potassium levels are not relevant to prevention of bone resorption. Vitamin D is needed to aid in the absorption of calcium. Isometric exercises condition muscle tone but do not build bones.

 CN: Reduction of risk potential;  
CL: Synthesize


**89. 2.** Effective splinting for a high incision reduces stress on the incision line, decreases pain, and increases the client's ability to deep-breathe effectively. Deep breathing should be done hourly by the client after surgery. Sitting upright ignores the need to splint the incision to prevent pain. Tightening the stomach muscles is not an effective strategy for promoting deep breathing. Raising the shoulders is not a feature of deep-breathing exercises.

 CN: Physiological adaptation; CL: Apply


**90. 3.** The priority in the first 24 hours after adrenalectomy is to identify and prevent adrenal crisis. Monitoring of vital signs is the most important evaluation measure. Hypotension, tachycardia, orthostatic hypotension, and arrhythmias can be indicators of pending vascular collapse and hypovolemic shock that can occur with adrenal crisis. Beginning oral nutrition is important, but not necessarily in the first 24 hours after surgery, and it is not more important than preventing adrenal crisis. Promoting self-care activities is not as important as preventing adrenal crisis. Ambulating in the hallway is not a priority in the first 24 hours after adrenalectomy.

 CN: Physiological adaptation;  
CL: Synthesize

**91. 3.** Hydromorphone hydrochloride (Dilaudid) is about five times more potent than morphine sulfate, from which it is prepared. Therefore, it is administered only in small doses. Hydromorphone hydrochloride can cause dependency in any dose; however, fear of dependency developing in the postoperative period is unwarranted. The dose is determined by the client's need for pain relief. Hydromorphone hydrochloride is not irritating to subcutaneous tissues. As with opioid analgesics, excretion depends on normal liver function.

 CN: Pharmacological and parenteral therapies; CL: Apply

**92. 1.** Ketoconazole (Nizoral) suppresses adrenal steroid secretion and may cause acute hypoadrenalism. The adverse effect should reverse when the drug is discontinued. Ketoconazole does not destroy adrenal cells; mitotane (Lysodren) destroys the cells and may be used to obtain a medical adrenalectomy. Ketoconazole decreases, not increases, ACTH-induced serum corticosteroid levels. It increases the duration of adrenal suppression when given with steroids.


 CN: Pharmacological and parenteral therapies; CL: Apply

**93. 2.** Poor lung expansion from bed rest, pain, and retained anesthesia is a common cause of slight postoperative temperature elevation. Nursing care


includes turning the client and having the client cough and deep-breathe every 1 to 2 hours, or more frequently as ordered. The client will have postoperative I.V. fluid replacement ordered to prevent dehydration. Wound infections typically appear 4 to 7 days after surgery. Urinary tract infections would not be typical with this surgery.

 CN: Physiological adaptation;  
CL: Analyze

**94. 3.** Pain control should be evaluated at least every 2 hours for the client with a PCA system. Addiction is not a common problem for the postoperative client. A client should not be encouraged to tolerate pain; in fact, other nursing actions besides PCA should be implemented to enhance the action of opioids. One of the purposes of PCA is for the client to determine frequency of administering the medication; the nurse should not interfere unless the client is not obtaining pain relief. The nurse should ensure that the client is instructed on the use of the PCA control button and that the button is always within reach.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**95. 4.** Alternately flexing and relaxing the quadriceps femoris muscles helps prepare the client for ambulation. This exercise helps maintain the strength in the quadriceps, which is the major muscle group used when walking. The other exercises listed do not increase a client's readiness for walking.

 CN: Basic care and comfort;  
CL: Synthesize

**96. 1.** Decreased mobility is one of the most common causes of abdominal distention related to retained gas in the intestines. Peristalsis has been inhibited by the general anesthesia, analgesics, and inactivity during the immediate postoperative period. Ambulation increases peristaltic activity and helps move gas. Walking can prevent the need for a rectal tube, which is a more invasive procedure. An NG tube is also a more invasive procedure and requires a physician's order. It is not a preferred treatment for gas postoperatively. Walking should prevent the need for further interventions. Carbonated liquids can increase gas formation.


 CN: Reduction of risk potential;  
CL: Synthesize

**97. 2.** Persistent cortisol excess undermines the collagen matrix of the skin, impairing wound healing. It also carries an increased risk of infection and of bleeding. The wound should be observed and documentation performed regarding the status of healing. Confusion and emboli are not expected complications after adrenalectomy. Malnutrition

also is not an expected complication after adrenalectomy. Nutritional status should be regained postoperatively.

 CN: Reduction of risk potential;  
CL: Analyze


**98. 2.** As the body readjusts to normal cortisol levels, mood and physical changes will gradually return to a normal state. The body changes are not permanent, and the mood swings should level off.

 CN: Physiological adaptation;  
CL: Synthesize

**99. 3.** Testosterone is an androgen hormone that is responsible for protein metabolism as well as maintenance of secondary sexual characteristics; therefore, it is needed by both males and females. Removal of both adrenal glands necessitates replacement of glucocorticoids and androgens. Testosterone does not balance the reproductive cycle, stabilize mood swings, or restore sodium and potassium balance.

 CN: Physiological adaptation; CL: Apply

**100. 1.** Bilateral adrenalectomy requires lifelong adrenal hormone replacement therapy. If unilateral surgery is performed, most clients gradually reestablish a normal secretion pattern. The client and family will require extensive teaching and support to maintain self-care management at home. Information on dosing, adverse effects, what to do if a dose is missed, and follow-up examinations is needed in the teaching plan. Although steroids are tapered when given for an intermittent or one-time problem, they are not discontinued when given to clients who have undergone bilateral adrenalectomy because the clients will not regain the ability to manufacture steroids. Steroids must be taken on a daily basis, not just during periods of physical or emotional stress.


 CN: Physiological adaptation;  
CL: Synthesize

### The Female Client with Perimenopausal or Menopausal Syndrome


**101. 2.** Deficiency of estrogen causes the major characteristics of perimenopause and menopause. As estrogen decreases, many physiologic changes occur with perimenopause. Although many of the changes occur in the female reproductive system, other organs and systems are affected as well. Progesterone is the hormone responsible for maintaining pregnancy. Prolactin is one of the hormones responsible for lactation. Oxytocin is secreted by the posterior pituitary and is responsible for labor.

 CN: Physiological adaptation; CL: Apply


**102. 1.** As the ovarian follicle ceases to produce estrogen, menopause occurs. The endocrine changes that occur in menopause due to cessation of the ovarian follicle include hot flashes, headaches, and mood changes with irritability and anxiety.

 CN: Physiological adaptation;  
CL: Apply

**103. 2.** Unopposed estrogen in a woman with an intact uterus can cause overgrowth of the endometrium, or endometrial hyperplasia. This hyperplasia can be a precursor to endometrial cancer. Estrogen is effective in the control of hot flashes. If libido is a major problem, testosterone is usually deficient. Hormone replacement therapy (HRT) is not known to be related to the incidence of ovarian cancer but it is considered a risk factor for breast cancer. HRT should be used at the lowest dosage for the shortest period of time to control hot flashes.

 CN: Pharmacological and parenteral therapies; CL: Apply

**104. 3.** A woman with severe hot flashes is a candidate for HRT for a short time in the lowest dosage possible. A family or personal history of breast cancer or a history of estrogen-dependent dysplasia is an absolute contraindication for HRT.


 CN: Pharmacological and parenteral therapies; CL: Apply

**105. 2.** Endometrial or uterine cancer is a potential complication for postmenopausal women on HRT. Unfortunately, no signs or symptoms except irregular vaginal bleeding are evident in endometrial or uterine cancer. A menopausal or postmenopausal woman with irregular bleeding requires a biopsy to rule out endometrial or uterine cancer. Hot flashes may occur but are not a danger sign. Vaginal dryness, a common complaint during menopause, can be treated with vaginal lubricants. However, this condition is not life-threatening. Changes in vaginal pH may occur but need not be reported.

 CN: Reduction of risk potential;  
CL: Analyze

### The Client with Pheochromocytoma

**106. 3.** Pheochromocytomas release catecholamines, both epinephrine and norepinephrine. The excessive hormone secretion can be constant or episodic, producing constant or episodic severe hypertension. The pheochromocytoma does not cause release of renin, aldosterone, or glucocorticoids.

 CN: Physiological adaptation;  
CL: Apply

**107. 3.** The release of catecholamines, epinephrine and norepinephrine, causes hypertension that is resistant to treatment. Although pheochromocytoma accounts for fewer than 1% of the cases of hypertension, it is important to diagnose so the client may be correctly treated. The hypertension occurs with both systolic and diastolic pressures, and the pressures may be very labile. Widening pulse pressure is not related to pheochromocytoma.

 CN: Reduction of risk potential;  
CL: Apply


**108. 4.** Postoperative management is directed at maintaining a normal blood pressure because the client may be hypertensive immediately after surgery. The nurse must monitor blood pressure frequently and report abnormalities. Clients in hypertensive crisis should be in an intensive care unit for cardiac, blood pressure, and neurologic monitoring. Orthostatic hypotension may be a concern for clients on prolonged bed rest or with fluid deficits. Although hemorrhage may accompany surgery, it is unlikely with this surgery. Elevated blood glucose concentrations, not hypoglycemia, occur with pheochromocytoma.

 CN: Reduction of risk potential;  
CL: Analyze

**109. 2.** Bending, lifting, and the Valsalva maneuver can precipitate hypertensive crises or paroxysms. These activities increase transabdominal pressure and may cause cardiac-stimulating effects. The blood pressure is very labile with these activities, and paroxysms may be accompanied by tachycardia, palpitations, angina, or electrocardiographic changes. Jogging, anxiety, and hypoglycemia are not triggers for hypertensive crises or paroxysms.

 CN: Management of care; CL: Synthesize

**110. 3.** A beta blocker such as propranolol (Inderal) is administered to block the cardiac-stimulating effects of epinephrine. ACE inhibitors and calcium channel blockers do not block sympathetic activity as beta blockers do. Diuretics decrease fluid volume and peripheral resistance, but they do not block sympathetic activity.

 CN: Pharmacological and parenteral therapies; CL: Apply

## Managing Care Quality and Safety

**111. 2.** Insulin is on the list of error-prone medications and the nurse should ask the physician to rewrite the order to spell out the word “units” and to indicate the route the drug is to be administered. The nurse should contact the physician immediately as the nurse is to administer the insulin now. The nurse can then also report the most current glucose level. While waiting for the insulin order to be rewritten, the nurse can administer the pain medication if needed, start the oxygen, and check the client’s vital signs.

 CN: Safety and infection control;  
CL: Synthesize

**112. 3.** The client needs fluid volume replacement due to the dehydration. However, the nurse should verify the order for I.V. dextrose with the physician due to the risk of hyperglycemia that dextrose would present when administered to a client with diabetes. The potassium level is within normal limits. The client does not have restrictions on oral fluids and the nurse can encourage the client to drink fluids. The client does not need to be placed in isolation at this time.

 CN: Management of care; CL: Synthesize

**113. 3.** Glulisine (Apidra) is a rapid-acting insulin with an action onset of 15 minutes. The client could experience hypoglycemia with the insulin in the bloodstream and no breakfast. It is not necessary to call the client’s physician; the nurse should determine what test was scheduled and then locate the client and provide either breakfast or 4 oz of fruit juice. To bring the client back to the room would be wasting valuable time needed to prevent or correct hypoglycemia.

 CN: Management of care; CL: Synthesize

**114. 3.** Because subcutaneous administration of insulin has a slower rate of absorption than I.V. insulin, there must be an adequate level of insulin in the bloodstream before discontinuing the insulin drip; otherwise, the glucose level will rise. Adding an I.V. antibiotic has no influence on the insulin drip; it should not be piggy-backed into the insulin drip. Gargine (Lantus) cannot be administered I.V., and should not be mixed with other insulins or solutions.

 CN: Management of care; CL: Synthesize

**TEST**  
**9**

# The Client with Urinary Tract Health Problems

- The Client with Cancer of the Bladder
- The Client with Renal Calculi
- The Client with Acute Renal Failure
- The Client with Urinary Tract Infection
- The Client with Pyelonephritis
- The Client with Chronic Renal Failure
- The Client with Urinary Incontinence
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Cancer of the Bladder

**1.** A client has undergone a cystectomy and an ileal conduit diversion. What should the nurse incorporate into the discharge instructions? Select all that apply.

- 1. Drink at least 3,000 mL of fluid each day.
- 2. Minimize daily activities.
- 3. Keep urine alkaline to prevent urinary tract infections.
- 4. Avoid odor-producing foods, such as onions, fish, eggs, and cheese.
- 5. Wear snug clothing over the stoma to encourage urine flow into the drainage bag.

**2.** A nurse is caring for a client with an ileal conduit. When assessing the stoma, which of the following outcomes are undesirable? Select all that apply.

- 1. Dermatitis.
- 2. Bleeding.
- 3. Fungal infection.
- 4. Flow of adhesive solvent into the stoma.
- 5. Partial obstruction of the stoma from skin cement.

**3.** The nurse should assess the client with bladder cancer for which of the following?

- 1. Suprapubic pain.
- 2. Dysuria.
- 3. Painless hematuria.
- 4. Urine retention.

**4.** A client is to have a cystoscopy to rule out cancer of the bladder. Which of the following indicate that the client has developed a complication after the cystoscopy?

- 1. Dizziness.
- 2. Chills.
- 3. Pink-tinged urine.
- 4. Bladder spasms.

**5.** If the client develops lower abdominal pain after a cystoscopy, the nurse should instruct the client to do which of the following?

- 1. Apply an ice pack to the pubic area.
- 2. Massage the abdomen gently.
- 3. Ambulate as much as possible.
- 4. Sit in a tub of warm water.

**6.** A client who has been diagnosed with bladder cancer is scheduled for an ileal conduit. Preoperatively, the nurse reinforces the client's understanding of the surgical procedure by explaining that an ileal conduit:

- 1. Is a temporary procedure that can be reversed later.
- 2. Diverts urine into the sigmoid colon, where it is expelled through the rectum.
- 3. Conveys urine from the ureters to a stoma opening on the abdomen.
- 4. Creates an opening in the bladder that allows urine to drain into an external pouch.

**7.** After surgery for an ileal conduit, the nurse should closely assess the client for the occurrence of which of the following complications related to pelvic surgery?

- 1. Peritonitis.
- 2. Thrombophlebitis.
- 3. Ascites.
- 4. Inguinal hernia.

**8.** The nurse is assessing the urine of a client who has had an ileal conduit and notes that the urine is yellow with a moderate amount of mucus. Based on the data, the nurse should?

- 1. Change the appliance bag.
- 2. Notify the physician.
- 3. Obtain a urine specimen for culture.
- 4. Encourage a high fluid intake.

**9.** When teaching the client to care for an ileal conduit, the nurse instructs the client to empty the appliance frequently. Which of the following indicate that the client is following instructions?

- 1. The skin around the stoma is red.
- 2. The urine is a deep yellow.
- 3. There is no odor present.
- 4. The seal around the stoma is intact.

**10.** The nurse should teach the client with an ileal conduit to prevent urine leakage when changing the appliance by using which of the following procedures?

- 1. Insert a gauze wick into the stoma.
- 2. Close the opening temporarily with a cellophane seal.
- 3. Suction the stoma before changing the appliance.
- 4. Avoid oral fluids for several hours before changing the appliance.

**11.** The client with an ileal conduit will be using a reusable appliance at home. The nurse should teach the client to clean the appliance routinely with which product?

- 1. Baking soda.
- 2. Soap.
- 3. Hydrogen peroxide.
- 4. Alcohol.

**12.** The nurse is evaluating the discharge teaching for a client who has an ileal conduit. Which of the following statements indicates that the client has correctly understood the teaching? Select all that apply.

- 1. "If I limit my fluid intake, I will not have to empty my ostomy pouch as often."
- 2. "I can place an aspirin tablet in my pouch to decrease odor."
- 3. "I can usually keep my ostomy pouch on for 3 to 7 days before changing it."
- 4. "I must use a skin barrier to protect my skin from urine."
- 5. "I should empty my ostomy pouch of urine when it is full."

**13.** A client has an ileal conduit. Which of the following solutions will be useful to help control odor in the urine collecting bag after it has been cleaned?

- 1. Salt water.
- 2. Vinegar.
- 3. Ammonia.
- 4. Bleach.

**14.** A female client who has a urinary diversion tells the nurse, "This urinary pouch is embarrassing. Everyone will know that I'm not normal. I don't see how I can go out in public anymore." The **most** appropriate nursing diagnosis for this client is:

- 1. *Anxiety* related to the presence of a urinary diversion.
- 2. *Deficient knowledge* about how to care for the urinary diversion.
- 3. *Low self-esteem* related to feelings of worthlessness.
- 4. *Disturbed body image* related to creation of a urinary diversion.

**15.** The nurse teaches the client with a urinary diversion to attach the appliance to a standard urine collection bag at night. The **most** important reason for doing this is to prevent:

- 1. Urine reflux into the stoma.
- 2. Appliance separation.
- 3. Urine leakage.
- 4. The need to restrict fluids.

**16.** The nurse teaches the client with an ileal conduit measures to prevent a urinary tract infection. Which of the following measures would be **most** effective?

- 1. Avoid people with respiratory tract infections.
- 2. Maintain a daily fluid intake of 2,000 to 3,000 mL.
- 3. Use sterile technique to change the appliance.
- 4. Irrigate the stoma daily.

**17.** The nurse evaluates the effectiveness of the client's postoperative plan of care. Which of the following would be an expected outcome for a client with an ileal conduit?

- 1. The client verbalizes the understanding that his physical activity must be curtailed.
- 2. The client states that he will place an aspirin in the drainage pouch to help control odor.
- 3. The client demonstrates how to catheterize the stoma.
- 4. The client states that he will empty the drainage pouch frequently throughout the day.

**18.** A nurse is planning care for a client who underwent a percutaneous needle biopsy of the kidney. What should the nurse plan to do immediately after the biopsy? Select all that apply.

- 1. Assess the biopsy site.
- 2. Take vital signs every hour.
- 3. Assess urine for hematuria.
- 4. Place the client in a prone position.
- 5. Assess the client for chest pain.

### The Client with Renal Calculi

**19.** A client has renal colic due to renal lithiasis. What is the nurse's **first** priority in managing care for this client?

- 1. Do not allow the client to ingest fluids.
- 2. Encourage the client to drink at least 500 mL of water each hour.
- 3. Request the central supply department to send supplies for straining urine.
- 4. Administer an opioid analgesic as prescribed.

**20.** A client is admitted to the hospital with a diagnosis of renal calculi. The client is experiencing severe flank pain and nausea; the temperature is 100.6° F (38.1° C). Which of the following would be a **priority** outcome for this client?

- 1. Prevention of urinary tract complications.
- 2. Alleviation of nausea.
- 3. Alleviation of pain.
- 4. Maintenance of fluid and electrolyte balance.

**21.** The client is scheduled to have a kidney, ureter, and bladder (KUB) radiograph. To prepare the client for this procedure, the nurse should explain to the client that:

- 1. Fluid and food will be withheld the morning of the examination.
- 2. A tranquilizer will be given before the examination.
- 3. An enema will be given before the examination.
- 4. No special preparation is required for the examination.

**22.** In addition to nausea and severe flank pain, a female client with renal calculi has pain in the groin and bladder. The nurse should assess the client further for signs of:

- 1. Nephritis.
- 2. Referred pain.
- 3. Urine retention.
- 4. Additional stone formation.

**23.** Which of the following nursing interventions is likely to provide the **most** relief from the pain associated with renal colic?

- 1. Applying moist heat to the flank area.
- 2. Administering meperidine (Demerol).
- 3. Encouraging high fluid intake.
- 4. Maintaining complete bed rest.

**24.** A client who has been diagnosed with renal calculi reports that the pain is intermittent and less colicky. Which of the following nursing actions is **most** important at this time?

- 1. Report hematuria to the physician.
- 2. Strain the urine carefully.
- 3. Administer meperidine (Demerol) every 3 hours.
- 4. Apply warm compresses to the flank area.

**25.** The client is scheduled for an intravenous pyelogram (IVP) to determine the location of the renal calculi. Which of the following measures would be **most** important for the nurse to include in pretest preparation?

- 1. Ensuring adequate fluid intake on the day of the test.
- 2. Preparing the client for the possibility of bladder spasms during the test.
- 3. Checking the client's history for allergy to iodine.
- 4. Determining when the client last had a bowel movement.

**26.** After an intravenous pyelogram (IVP), the nurse should anticipate incorporating which of the following measures into the client's plan of care?

- 1. Maintaining bed rest.
- 2. Encouraging adequate fluid intake.
- 3. Assessing for hematuria.
- 4. Administering a laxative.

**27.** A client has a ureteral catheter in place after renal surgery. A priority nursing action for care of the ureteral catheter would be to:

- 1. Irrigate the catheter with 30 mL of normal saline every 8 hours.
- 2. Ensure that the catheter is draining freely.
- 3. Clamp the catheter every 2 hours for 30 minutes.
- 4. Ensure that the catheter drains at least 30 mL/hour.

**28.** Which of the following interventions would be the **most** appropriate for preventing the development of a paralytic ileus in a client who has undergone renal surgery?

- 1. Encourage the client to ambulate every 2 to 4 hours.
- 2. Offer 3 to 4 oz of a carbonated beverage periodically.
- 3. Encourage use of a stool softener.
- 4. Continue I.V. fluid therapy.

**29.** The nurse is conducting a postoperative assessment of a client on the first day after renal surgery. Which of the following findings would be **most** important for the nurse to report to the physician?

- 1. Temperature, 99.8° F (37.7° C).
- 2. Urine output, 20 mL/hour.
- 3. Absence of bowel sounds.
- 4. A 2" × 2" area of serosanguineous drainage on the flank dressing.

**30.** A client with a history of renal calculi formation is being discharged after surgery to remove the calculus. What instructions should the nurse include in the client's discharge teaching plan?

- 1. Increase daily fluid intake to at least 2 to 3 L.
- 2. Strain urine at home regularly.
- 3. Eliminate dairy products from the diet.
- 4. Follow measures to alkalinize the urine.

**31.** Because a client's renal stone was found to be composed of uric acid, a low-purine, alkaline-ash diet was ordered. Incorporation of which of the following food items into the home diet would indicate that the client understands the necessary diet modifications?

- 1. Milk, apples, tomatoes, and corn.
- 2. Eggs, spinach, dried peas, and gravy.
- 3. Salmon, chicken, caviar, and asparagus.
- 4. Grapes, corn, cereals, and liver.

**32.** Allopurinol (Zyloprim), 200 mg/day, is prescribed for the client with renal calculi to take at home. The nurse should teach the client about which of the following adverse effects of this medication?

- 1. Retinopathy.
- 2. Maculopapular rash.
- 3. Nasal congestion.
- 4. Dizziness.

**33.** A client has been prescribed allopurinol (Zyloprim) for renal calculi that are caused by high uric acid levels. Which of the following indicate the client is experiencing adverse effect(s) of this drug? Select all that apply.

- 1. Nausea.
- 2. Rash.
- 3. Constipation.
- 4. Flushed skin.
- 5. Bone marrow depression.

**34.** The nurse is reviewing laboratory reports for a client who is taking allopurinol (Zyloprim). Which of the following indicate that the drug has had a therapeutic effect?

- 1. Decreased urine alkaline phosphatase level.
- 2. Increased urine calcium excretion.
- 3. Increased serum calcium level.
- 4. Decreased serum uric acid level.

## The Client with Acute Renal Failure

**35.** A client is to receive peritoneal dialysis. To prepare for the procedure, the nurse should?

- 1. Assess the dialysis access for a bruit and thrill.
- 2. Insert an indwelling urinary catheter and drain all urine from the bladder.
- 3. Ask the client to turn toward the left side.
- 4. Warm the solution in the warmer.

**36.** A client has been admitted with acute renal failure. What should the nurse do? Select all that apply.

- 1. Elevate the head of the bed 30 to 45 degrees.
- 2. Take vital signs.
- 3. Establish an I.V. access site.
- 4. Call the admitting physician for orders.
- 5. Contact the hemodialysis unit.

**37.** Which of the following is the **most** common initial manifestation of acute renal failure?

- 1. Dysuria.
- 2. Anuria.
- 3. Hematuria.
- 4. Oliguria.

**38.** A client developed shock after a severe myocardial infarction and has now developed acute renal failure. The client's family asks the nurse why the client has developed acute renal failure. The nurse should base the response on the knowledge that there was:

- 1. A decrease in the blood flow through the kidneys.
- 2. An obstruction of urine flow from the kidneys.
- 3. A blood clot formed in the kidneys.
- 4. Structural damage to the kidney resulting in acute tubular necrosis.

**39.** The client's blood urea nitrogen (BUN) concentration is elevated in acute renal failure. What is the **likely** cause of this finding?

- 1. Fluid retention.
- 2. Hemolysis of red blood cells.
- 3. Below-normal metabolic rate.
- 4. Reduced renal blood flow.

**40.** The client's serum potassium level is elevated in acute renal failure, and the nurse administers sodium polystyrene sulfonate (Kayexalate). This drug acts to:

- 1. Increase potassium excretion from the colon.
- 2. Release hydrogen ions for sodium ions.
- 3. Increase calcium absorption in the colon.
- 4. Exchange sodium for potassium ions in the colon.



**41.** A client with acute renal failure has an increase in the serum potassium level. The nurse should monitor the client for:

- 1. Cardiac arrest.
- 2. Pulmonary edema.
- 3. Circulatory collapse.
- 4. Hemorrhage.

**42.** A high-carbohydrate, low-protein diet is prescribed for the client with acute renal failure. The intended outcome of this diet is to:

- 1. Act as a diuretic.
- 2. Reduce demands on the liver.
- 3. Help maintain urine acidity.
- 4. Prevent the development of ketosis.

**43.** The client with acute renal failure asks the nurse for a snack. Because the client's potassium level is elevated, which of the following snacks is **most** appropriate?

- 1. A gelatin dessert.
- 2. Yogurt.
- 3. An orange.
- 4. Peanuts.

**44.** In the oliguric phase of acute renal failure, the nurse should assess the client for:

- 1. Pulmonary edema.
- 2. Metabolic alkalosis.
- 3. Hypotension.
- 4. Hypokalemia.

**45.** The client in acute renal failure has an external cannula inserted in the forearm for hemodialysis. Which of the following nursing measures is appropriate for the care of this client?

- 1. Use the unaffected arm for blood pressure measurements.
- 2. Draw blood from the cannula for routine laboratory work.
- 3. Percuss the cannula for bruits each shift.
- 4. Inject heparin into the cannula each shift.

**46.** The nurse initiates the client's first hemodialysis treatment. The client develops a headache, confusion, and nausea. The nurse should assess the client further for:

- 1. Disequilibrium syndrome.
- 2. Myocardial infarction.
- 3. Air embolism.
- 4. Peritonitis.

**47.** During dialysis, the client has disequilibrium syndrome. The nurse should **first**?

- 1. Administer oxygen per nasal cannula.
- 2. Slow the rate of dialysis.
- 3. Reassure the client that the symptoms are normal.
- 4. Place the client in Trendelenburg's position.

**48.** The client receives heparin while receiving hemodialysis. The nurse explains the rationale supporting anticoagulation by making which of the following statements?

- 1. "Regional anticoagulation is achieved by putting heparin in the dialysis machine and protamine sulfate, which reverses the anticoagulation, in the client."
- 2. "You will receive warfarin sodium (Coumadin) to maintain anticoagulation between treatments."
- 3. "Heparin does not enter the body, so there is no risk of bleeding."
- 4. "Clotting time is seriously prolonged for several hours after each treatment."

**49.** Which of the following abnormal blood values would not be improved by dialysis treatment?

- 1. Elevated serum creatinine level.
- 2. Hyperkalemia.
- 3. Decreased hemoglobin concentration.
- 4. Hyponatremia.

**50.** The nurse teaches the client how to recognize signs and symptoms of infection in the shunt by telling the client to assess the shunt each day for:

- 1. Absence of a bruit.
- 2. Sluggish capillary refill time.
- 3. Coolness of the involved extremity.
- 4. Swelling at the shunt site.

**51.** The client with acute renal failure is recovering and asks the nurse, "Will my kidneys ever function normally again?" The nurse's response is based on knowledge that the client's renal status will **most** likely:

- 1. Continue to improve over a period of weeks.
- 2. Result in the need for permanent hemodialysis.
- 3. Improve only if the client receives a renal transplant.
- 4. Result in end-stage renal failure.

## The Client with Urinary Tract Infection

**52.** The nurse is teaching an 80-year-old client with a urinary tract infection about the importance of increasing fluids in the diet. Which of the following puts this client at a risk for not obtaining sufficient fluids?

- 1. Diminished liver function.
- 2. Increased production of antidiuretic hormone.
- 3. Decreased production of aldosterone.
- 4. Decreased ability to detect thirst.

**53.** A client with a urinary tract infection is to take nitrofurantoin (Macrochantin) four times each day. The client asks the nurse, “What should I do if I forget a dose?” What should the nurse tell the client?

- 1. “You can wait and take the next dose when it is due.”
- 2. “Double the amount prescribed with your next dose.”
- 3. “Take the prescribed dose as soon as you remember it, and if it is very close to the time for the next dose, delay that next dose.”
- 4. “Take a lot of water with a double amount of your prescribed dose.”

**54.** A nurse is assessing a client with a urinary tract infection who takes an antihypertensive drug. The nurse reviews the client’s urinalysis results (see chart). The nurse should:

- 1. Encourage the client to increase fluid intake.
- 2. Withhold the next dose of antihypertensive medication.
- 3. Restrict the client’s sodium intake.
- 4. Encourage the client to eat at least half of a banana per day.

#### Laboratory Results

Test	Result
pH	6.8
Red blood cells	3 per high power field
Color	Yellow
Specific gravity	1.030

**55.** A client has nephropathy. The physician orders that a 24-hour urine collection be done for creatinine clearance. Which of the following actions is necessary to ensure proper collection of the specimen?

- 1. Collect the urine in a preservative-free container and keep it on ice.
- 2. Inform the client to discard the last voided specimen at the conclusion of urine collection.
- 3. Ask the client what his weight is before beginning the collection of urine.
- 4. Request an order for insertion of an indwelling urinary catheter.

**56.** A client who weighs 207 lb is to receive 1.5 mg/kg of gentamicin sulfate (Garamycin) I.V. three times each day. How many milligrams of medication should the nurse administer for each dose? Round to the nearest whole number.

\_\_\_\_\_ mg.

**57.** A 24-year-old female client comes to an ambulatory care clinic in moderate distress with a probable diagnosis of acute cystitis. When obtaining the client’s history, the nurse should ask the client if she has had:

- 1. Fever and chills.
- 2. Frequency and burning on urination.
- 3. Flank pain and nausea.
- 4. Hematuria.

**58.** The client asks the nurse, “How did I get this urinary tract infection?” The nurse should explain that in **most** instances, cystitis is caused by:

- 1. Congenital strictures in the urethra.
- 2. An infection elsewhere in the body.
- 3. Urinary stasis in the urinary bladder.
- 4. An ascending infection from the urethra.

**59.** The client, who is a newlywed, is afraid to discuss her diagnosis of cystitis with her husband. Which would be the nurse’s **best** approach?

- 1. Arrange a meeting with the client, her husband, the physician, and the nurse.
- 2. Insist that the client talk with her husband because good communication is necessary for a successful marriage.
- 3. Talk first with the husband alone and then with both of them together to share the husband’s reactions.
- 4. Spend time with the client addressing her concerns and then stay with her while she talks with her husband.

**60.** The nurse teaches a female client who has cystitis methods to relieve her discomfort until the antibiotic takes effect. Which of the following responses by the client would indicate that she understands the nurse’s instructions?

- 1. “I will place ice packs on my perineum.”
- 2. “I will take hot tub baths.”
- 3. “I will drink a cup of warm tea every hour.”
- 4. “I will void every 5 to 6 hours.”

**61.** The client with cystitis is given a prescription for phenazopyridine hydrochloride (Pyridium). The nurse should teach the client that this drug is used to treat urinary tract infections by:

- 1. Releasing formaldehyde and providing bacteriostatic action.
- 2. Potentiating the action of the antibiotic.
- 3. Providing an analgesic effect on the bladder mucosa.
- 4. Preventing the crystallization that can occur with sulfa drugs.

**62.** When teaching the client with a urinary tract infection about taking phenazopyridine hydrochloride (Pyridium), the nurse should tell the client to expect:

- 1. Bright orange-red urine.
- 2. Incontinence.
- 3. Constipation.
- 4. Slight drowsiness.

**63.** A client has been prescribed nitrofurantoin (Macrochantin) for treatment of a lower urinary tract infection. Which of the following instructions should the nurse include when teaching the client how to take this medication? Select all that apply.

- 1. "Take the medication on an empty stomach."
- 2. "Your urine may become brown in color."
- 3. "Increase your fluid intake."
- 4. "Take the medication until your symptoms subside."
- 5. "Take the medication with an antacid to decrease gastrointestinal distress."

**64.** Nitrofurantoin (Macrochantin), 75 mg four times per day, has been prescribed for a client with a lower urinary tract infection. The medication comes in an oral suspension of 25 mg/5 mL. How many milliliters should the nurse administer for each dose?

\_\_\_\_\_ mL.

**65.** Which of the following statements by the client would indicate that she is at high risk for a recurrence of cystitis?

- 1. "I can usually go 8 to 10 hours without needing to empty my bladder."
- 2. "I take a tub bath every evening."
- 3. "I wipe from front to back after voiding."
- 4. "I drink a lot of water during the day."

**66.** To prevent recurrence of cystitis, the nurse should plan to encourage the female client to include which of the following measures in her daily routine?

- 1. Wearing cotton underpants.
- 2. Increasing citrus juice intake.
- 3. Douching regularly with 0.25% acetic acid.
- 4. Using vaginal sprays.

**67.** The nurse explains to the client the importance of drinking large quantities of fluid to prevent cystitis. The nurse should tell the client to drink:

- 1. Twice as much fluid as usual.
- 2. At least 1 quart more than usual.
- 3. A lot of water, juice, and other fluids throughout the day.
- 4. At least 3,000 mL of fluids daily.

## The Client with Pyelonephritis

**68.** A client is diagnosed with acute pyelonephritis. Which of the following instructions should the nurse provide to the client about managing the disease?

- 1. "Urinate frequently because the bacteria that cause acute pyelonephritis reach the kidneys by means of an infection that progresses upward from lower in the urinary tract."
- 2. "Taking frequent bubble baths will decrease the likelihood of further episodes of pyelonephritis."
- 3. "You should take antibiotics for the rest of your life to prevent urinary tract infections."
- 4. "By decreasing your fluid intake, you will decrease the need for frequent urination and the irritating effect of urine in your ureter."

**69.** Which of the following symptoms would **most** likely indicate that the client has pyelonephritis?

- 1. Ascites.
- 2. Costovertebral angle (CVA) tenderness.
- 3. Polyuria.
- 4. Nausea and vomiting.

**70.** Which of the following factors would put the client at increased risk for pyelonephritis?

- 1. History of hypertension.
- 2. Intake of large quantities of cranberry juice.
- 3. Fluid intake of 2,000 mL/day.
- 4. History of diabetes mellitus.

**71.** To assess the client's renal status, the nurse should monitor which of the following laboratory tests? Select all that apply.

- 1. Serum sodium
- 2. Potassium levels.
- 3. Arterial blood gases
- 4. Hemoglobin.
- 5. Serum blood urea nitrogen
- 6. Creatinine levels.
- 7. Urinalysis.

**72.** The client with pyelonephritis asks the nurse, "How will I know whether the antibiotics are effectively treating my infection?" The nurse's **most** appropriate response would be which of the following?

- 1. "After you take the antibiotics for 2 weeks, you'll not have any infection."
- 2. "Your health care provider can tell by the color and odor of your urine."
- 3. "Your health care provider will take a urine culture."
- 4. "When your symptoms disappear, you'll know that your infection is gone."

**73.** The client with acute pyelonephritis wants to know the possibility of developing chronic pyelonephritis. The nurse's response is based on knowledge that which of the following disorders **most** commonly leads to chronic pyelonephritis?

- 1. Acute pyelonephritis.
- 2. Recurrent urinary tract infections.
- 3. Acute renal failure.
- 4. Glomerulonephritis.

### The Client with Chronic Renal Failure

**74.** The nurse assesses the client who has chronic renal failure and notes the following: crackles in the lung bases, elevated blood pressure, and weight gain of 2 lb in 1 day. Based on these data, which of the following nursing diagnoses is appropriate?

- 1. *Excess fluid volume* related to the kidney's inability to maintain fluid balance.
- 2. *Ineffective breathing pattern* related to fluid in the lungs.
- 3. *Ineffective tissue perfusion* related to interrupted arterial blood flow.
- 4. *Ineffective therapeutic regimen management* related to lack of knowledge about therapy.

**75.** What is the **primary** disadvantage of using peritoneal dialysis for long-term management of chronic renal failure?

- 1. The danger of hemorrhage is high.
- 2. It cannot correct severe imbalances.
- 3. It is a time-consuming method of treatment.
- 4. The risk of contracting hepatitis is high.

**76.** A client with chronic renal failure who receives hemodialysis three times a week is experiencing severe nausea. What should the nurse advise the client to do to manage the nausea? Select all that apply.

- 1. Drink fluids before eating solid foods.
- 2. Have limited amounts of fluids only when thirsty.
- 3. Limit activity.
- 4. Keep all dialysis appointments.
- 5. Eat smaller, more frequent meals.

**77.** The dialysis solution is warmed before use in peritoneal dialysis **primarily** to:

- 1. Encourage the removal of serum urea.
- 2. Force potassium back into the cells.
- 3. Add extra warmth to the body.
- 4. Promote abdominal muscle relaxation.

**78.** Which of the following assessments would be **most** appropriate for the nurse to make while the dialysis solution is dwelling within the client's abdomen?

- 1. Assess for urticaria.
- 2. Observe respiratory status.
- 3. Check capillary refill time.
- 4. Monitor electrolyte status.

**79.** During the client's dialysis, the nurse observes that the solution draining from the abdomen is consistently blood-tinged. The client has a permanent peritoneal catheter in place. Which interpretation of this observation would be correct?

- 1. Bleeding is expected with a permanent peritoneal catheter.
- 2. Bleeding indicates abdominal blood vessel damage.
- 3. Bleeding can indicate kidney damage.
- 4. Bleeding is caused by too-rapid infusion of the dialysate.

**80.** During dialysis, the nurse observes that the flow of dialysate stops before all the solution has drained out. The nurse should:

- 1. Have the client sit in a chair.
- 2. Turn the client from side to side.
- 3. Reposition the peritoneal catheter.
- 4. Have the client walk.

**81.** Which of the following nursing interventions should be included in the client's plan of care during dialysis therapy?

- 1. Limit the client's visitors.
- 2. Monitor the client's blood pressure.
- 3. Pad the side rails of the bed.
- 4. Keep the client on nothing-by-mouth (NPO) status.

**82.** The client performs his own peritoneal dialysis. What should the nurse teach the client about preventing peritonitis? Select all that apply.

- 1. Broad-spectrum antibiotics may be administered to prevent infection.
- 2. Antibiotics may be added to the dialysate to treat peritonitis.
- 3. Clean technique is permissible for prevention of peritonitis.
- 4. Peritonitis is characterized by cloudy dialysate drainage and abdominal discomfort.
- 5. Peritonitis is the most common and serious complication of peritoneal dialysis.

**83.** After completion of peritoneal dialysis, the nurse should expect the client to exhibit which of the following characteristics?

- 1. Hematuria.
- 2. Weight loss.
- 3. Hypertension.
- 4. Increased urine output.

**84.** Aluminum hydroxide gel (Amphojel) is prescribed for the client with chronic renal failure to take at home. What is the expected outcome of giving this drug?

- 1. Relieving the pain of gastric hyperacidity.
- 2. Preventing Curling's stress ulcers.
- 3. Binding phosphate in the intestine.
- 4. Reversing metabolic acidosis.

**85.** The nurse teaches the client with chronic renal failure when to take aluminum hydroxide gel (Amphojel). Which of the following statements would indicate that the client understands the teaching?

- 1. "I'll take it every 4 hours around the clock."
- 2. "I'll take it between meals and at bedtime."
- 3. "I'll take it when I have a sour stomach."
- 4. "I'll take it with meals and bedtime snacks."

**86.** The client with chronic renal failure tells the nurse he takes magnesium hydroxide (milk of magnesia) at home for constipation. The nurse suggests that the client switch to psyllium hydrophilic mucilloid (Metamucil) because:

- 1. Milk of magnesia can cause magnesium intoxication.
- 2. Milk of magnesia is too harsh on the bowel.
- 3. Metamucil is more palatable.
- 4. Milk of magnesia is high in sodium.

**87.** The nurse is determining which teaching approaches for the client with chronic renal failure and uremia would be most appropriate. The nurse should:

- 1. Provide all needed teaching in one extended session.
- 2. Validate the client's understanding of the material frequently.
- 3. Conduct a one-on-one session with the client.
- 4. Use videotapes to reinforce the material as needed.

**88.** The nurse is instructing the client with chronic renal failure to maintain adequate nutritional intake. Which of the following diets would be **most** appropriate?

- 1. High-carbohydrate, high-protein.
- 2. High-calcium, high-potassium, high-protein.
- 3. Low-protein, low-sodium, low-potassium.
- 4. Low-protein, high-potassium.

**89.** The nurse is discussing concerns about sexual activity with a client with chronic renal failure. Which one of the following strategies would be **most** useful?

- 1. Help the client to accept that sexual activity will be decreased.
- 2. Suggest using alternative forms of sexual expression and intimacy.
- 3. Tell the client to plan rest periods after sexual activity.
- 4. Suggest that the client avoid sexual activity to prevent embarrassment.

**90.** A client with chronic renal failure has asked to be evaluated for a home continuous ambulatory peritoneal dialysis (CAPD) program. The nurse should explain that the major advantage of this approach is that it:

- 1. Is relatively low in cost.
- 2. Allows the client to be more independent.
- 3. Is faster and more efficient than standard peritoneal dialysis.
- 4. Has fewer potential complications than standard peritoneal dialysis.

**91.** The client asks about diet changes when using continuous ambulatory peritoneal dialysis (CAPD). Which of the following would be the nurse's **best** response?

- 1. "Diet restrictions are more rigid with CAPD because standard peritoneal dialysis is a more effective technique."
- 2. "Diet restrictions are the same for both CAPD and standard peritoneal dialysis."
- 3. "Diet restrictions with CAPD are fewer than with standard peritoneal dialysis because dialysis is constant."
- 4. "Diet restrictions with CAPD are fewer than with standard peritoneal dialysis because CAPD works more quickly."

**92.** A client is receiving continuous ambulatory peritoneal dialysis (CAPD). The nurse should assess the client for which of the following signs of peritoneal infection?

- 1. Cloudy dialysate fluid.
- 2. Swelling in the legs.
- 3. Poor drainage of the dialysate fluid.
- 4. Redness at the catheter insertion site.

## The Client with Urinary Incontinence

**93.** What should the nurse teach the client to do to prevent stress incontinence? Select all that apply.

- 1. Use techniques that strengthen the sphincter and structural supports of the bladder, such as Kegel exercises.
- 2. Avoid dietary irritants (e.g., caffeine, alcoholic beverages).
- 3. Not to laugh when in social gatherings.
- 4. Carry an extra incontinence pad when away from home.
- 5. Obtain a fluid intake of 500 mL/day.

**94.** A client has stress incontinence. Which of the following data from the client's history contributes to the client's incontinence?

- 1. The client's intake of 2 to 3 L of fluid per day.
- 2. The client's history of three full-term pregnancies.
- 3. The client's age of 45 years.
- 4. The client's history of competitive swimming.

**95.** The **primary** goal of nursing care for a client with stress incontinence is to:

- 1. Help the client adjust to the frequent episodes of incontinence.
- 2. Eliminate all episodes of incontinence.
- 3. Prevent the development of urinary tract infections.
- 4. Decrease the number of incontinence episodes.

**96.** The nurse is developing a teaching plan for a client with stress incontinence. Which of the following instructions should be included?

- 1. Avoid activities that are stressful and upsetting.
- 2. Avoid caffeine and alcohol.
- 3. Do not wear a girdle.
- 4. Limit physical exertion.

**97.** A client has urge incontinence. When obtaining the health history, the nurse should ask if the client has:

- 1. Inability to empty the bladder.
- 2. Loss of urine when coughing.
- 3. Involuntary urination with minimal warning.
- 4. Frequent dribbling of urine.

**98.** Which of the following interventions would be **most** appropriate for a client who has urge incontinence?

- 1. Have the client urinate on a timed schedule.
- 2. Provide a bedside commode.
- 3. Administer prophylactic antibiotics.
- 4. Teach the client intermittent self-catheterization technique.

### Managing Care Quality and Safety

**99.** A client is scheduled for an intravenous pyelogram (IVP). The evening before the procedure, the nurse learns that the client has a sensitivity to shellfish. The nurse should:

- 1. Administer a cathartic to the client to empty the colon.
- 2. Administer an antiflatulent to the client to relieve gas.
- 3. Keep the client on nothing-by-mouth (NPO) status.
- 4. Cancel the IVP and notify the physician.

**100.** The nurse finds a container with the client's urine specimen sitting on a counter in the bathroom. The client states that the specimen has been sitting in the bathroom for at least 2 hours. The nurse should:

- 1. Discard the urine and obtain a new specimen.
- 2. Send the urine to the laboratory as quickly as possible.
- 3. Add fresh urine to the collected specimen and send the specimen to the laboratory.
- 4. Refrigerate the specimen until it can be transported to the laboratory.

**101.** A client with early acute renal failure has anemia, tachycardia, hypotension, and shortness of breath. The physician has ordered 2 units of packed red blood cells (RBCs). Prior to initiating the blood transfusion the nurse should determine if? Select all that apply.

- 1. there is an I.V. access with the appropriate tubing and normal saline as the priming solution
- 2. there is a signed informed consent for transfusion therapy
- 3. blood typing and cross-matching is documented in the medical record?
- 4. the vital signs have been taken and documented in accordance with facility policy and procedure?
- 5. there is the second unit of blood in the medication room?
- 6. the client has an identification bracelet and red blood band?

**102.** The nurse is instructing the unlicensed nursing personnel (UAP) about the correct technique for obtaining a clean-catch urine culture from a female client. Which of the following statements indicates that the assistant has understood the instructions?

- 1. "I will have the client completely empty her bladder into the specimen cup."
- 2. "I will need to catheterize the client to get the urine specimen."
- 3. "I will ask the client to clean her labia, void into the toilet, and then into the specimen cup."
- 4. "I will obtain the specimen in the afternoon after the client has had plenty of fluids."

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Cancer of the Bladder

**1. 1, 4.** An adequate fluid intake aids in the prevention of urinary calculi and infection. Odor-producing foods can produce offensive odors that may impact the client's lifestyle and relationships. Lack of activity leads to urinary stasis, which promotes urinary calculi development and infection.


Acidic urine helps prevent urinary tract infections. Tight clothing over the stoma obstructs blood circulation and urine flow.

 CN: Reduction of risk potential;  
CL: Synthesize

**2. 1, 2, 3.** Dermatitis with alkaline encrustations may occur when alkaline urine comes in contact with exposed skin. Yeast infections (or fungal infections) are another common peristomal skin problem. If the stoma is irritated from rubbing, there will be bleeding. The nurse and client should avoid irritating the stoma. Adhesive solvent is used on a gauze pad to remove old adhesive and would not contact the stoma directly. Only a minimal amount of skin cement is applied to the faceplate and skin to secure the appliance over the stoma, so obstruction of the stoma by the cement would not be possible.

 CN: Physiological adaptation;  
CL: Evaluate


**3. 3.** Painless hematuria is the most common clinical finding in bladder cancer. Other symptoms include urinary frequency, dysuria, and urinary urgency, but these are not as common as hematuria. Suprapubic pain and urine retention do not occur in bladder cancer.

 CN: Physiological adaptation;  
CL: Analyze

**4. 2.** Chills could indicate the onset of acute infection that can progress to septic shock. Dizziness would not be an anticipated symptom after a cystoscopy. Pink-tinged urine and bladder spasms are common after cystoscopy.

 CN: Reduction of risk potential;  
CL: Analyze

**5. 4.** Lower abdominal pain after a cystoscopy is frequently caused by bladder spasms. Warm water can help relax muscles. Ice is not effective in relieving spasms. Massage and ambulation may increase bladder irritability.

 CN: Basic care and comfort;  
CL: Synthesize

**6. 3.** An ileal conduit is a permanent urinary diversion in which a portion of the ileum is surgically resected and one end of the segment is closed. The ureters are surgically attached to this segment of the ileum, and the open end of the ileum is brought to the skin surface on the abdomen to form the stoma. The client must wear a pouch to collect the urine that continually flows through the conduit. The bladder is removed during the surgical procedure and the ileal conduit is not reversible. Diversion of urine to the sigmoid colon is called a *ureteroileosigmoidostomy*. An opening in

the bladder that allows urine to drain externally is called a *cystostomy*.

 CN: Reduction of risk potential;  
CL: Apply


**7. 2.** After pelvic surgery, there is an increased chance of thrombophlebitis owing to the pelvic manipulation that can interfere with circulation and promote venous stasis. Peritonitis is a potential complication of any abdominal surgery, not just pelvic surgery. Ascites is most frequently an indication of liver disease. Inguinal hernia may be caused by an increase in intra-abdominal pressure or a congenital weakness of the abdominal wall; ventral hernia occurs at the site of a previous abdominal incision.

 CN: Reduction of risk potential;  
CL: Analyze


**8. 4.** Mucus is secreted by the intestinal segment used to create the conduit and is a normal occurrence. The client should be encouraged to maintain a large fluid intake to help flush the mucus out of the conduit. Because mucus in the urine is expected, it is not necessary to change the appliance bag or to notify the physician. The mucus is not an indication of an infection, so a urine culture is not necessary.

 CN: Reduction of risk potential;  
CL: Synthesize

**9. 4.** If the appliance becomes too full, it is likely to pull away from the skin completely or to leak urine onto the skin; thus if the seal is intact, the client is emptying the appliance regularly. The skin around the seal should not be red or irritated, which could indicate a leak. There will likely be an odor from the urine. Deep yellow urine indicates that the client should be increasing fluid intake.

 CN: Physiological adaptation;  
CL: Evaluate

**10. 1.** Inserting a gauze wick into the stoma helps prevent urine leakage when changing the appliance. The stoma should not be sealed or suctioned. Oral fluids do not need to be avoided.

 CN: Physiological adaptation;  
CL: Synthesize

**11. 2.** A reusable appliance should be routinely cleaned with soap and water.


 CN: Physiological adaptation; CL: Apply

**12. 3, 4.** The client with an ileal conduit must learn self-care activities related to care of the stoma and ostomy appliances. The client should be taught to increase fluid intake to about 3,000 mL/day and should not limit intake. Adequate fluid intake helps to flush mucus from the ileal conduit. The ostomy


appliance should be changed approximately every 3 to 7 days and whenever a leak develops. A skin barrier is essential to protecting the skin from the irritation of the urine. An aspirin should not be used as a method of odor control because it can be an irritant to the stoma and lead to ulceration. The ostomy pouch should be emptied when it is one-third to one-half full to prevent the weight of the urine from pulling the appliance away from the skin.

 CN: Reduction of risk potential;  
CL: Evaluate

**13. 2.** A distilled vinegar solution acts as a good deodorizing agent after an appliance has been cleaned well with soap and water. If the client prefers, a commercial deodorizer may be used. Salt solution does not deodorize. Ammonia and bleaching agents may damage the appliance.

 CN: Basic care and comfort; CL: Apply


**14. 4.** It is normal for clients to express fears and concerns about the body changes associated with a urinary diversion. Allowing the client time to verbalize concerns in a supportive environment and suggesting that she discuss these concerns with people who have successfully adjusted to ostomy surgery can help her begin coping with these changes in a positive manner. Although the client may be anxious about this situation and self-esteem may be diminished, the underlying problem is a disturbance in body image. There are no data to support a diagnosis of *Deficient knowledge*.

 CN: Psychosocial adaptation;  
CL: Analyze


**15. 1.** The most important reason for attaching the appliance to a standard urine collection bag at night is to prevent urine reflux into the stoma and ureters, which can result in infection. Use of a standard collection bag also keeps the appliance from separating from the skin and helps prevent urine leakage from an overly full bag, but the primary purpose is to prevent reflux of urine. A client with a urinary diversion should drink 2,000 to 3,000 mL of fluid each day; it would be inappropriate to suggest decreasing fluid intake.

 CN: Physiological adaptation; CL: Apply

**16. 2.** Maintaining a fluid intake of 2,000 to 3,000 mL/day is likely to be most effective in preventing urinary tract infection. A high fluid intake results in high urine output, which prevents urinary stasis and bacterial growth. Avoiding people with respiratory tract infections will not prevent urinary tract infections. Clean, not sterile, technique is used to change the appliance. An ileal conduit stoma is not irrigated.

 CN: Physiological adaptation;  
CL: Synthesize

**17. 4.** It is important that the client empty the drainage pouch throughout the day to decrease the risk of leakage. The client does not normally need to curtail physical activity. Aspirin should never be placed in a pouch because aspirin can irritate or ulcerate the stoma. The client does not catheterize an ileal conduit stoma.

 CN: Physiological adaptation;  
CL: Evaluate

**18. 1, 3, 4.** The nurse should assess the biopsy site for bleeding and hematoma formation. The client should remain prone for 8 to 24 hours after the biopsy. A pressure dressing will aid in blood coagulation. Vital signs assessment should be taken every 5 to 15 minutes for the first hour and then less often if the client is stable. The urine does not need to be collected and kept on ice. The nurse should collect serial urine specimens to assess for hematuria. A renal biopsy does not put the client at increased risk for chest pain.


 CN: Reduction of risk potential;  
CL: Synthesize

### The Client with Renal Calculi

**19. 4.** If infection or blockage caused by calculi is present, a client can experience sudden severe pain in the flank area, known as *renal colic*. Pain from a kidney stone is considered an emergency situation and requires analgesic intervention. Withholding fluids will make urine more concentrated and stones more difficult to pass naturally. Forcing large quantities of fluid may cause hydronephrosis if urine is prevented from flowing past calculi. Straining urine for small stones is important, but does not take priority over pain management.

 CN: Management of care; CL: Synthesize

**20. 3.** The priority nursing goal for this client is to alleviate the pain, which can be excruciating. Prevention of urinary tract complications and alleviation of nausea are appropriate throughout the client's hospitalization, but relief of the severe pain is a priority. The client is at little risk for fluid and electrolyte imbalance.


 CN: Physiological adaptation;  
CL: Synthesize

**21. 4.** A KUB radiographic examination ordinarily requires no preparation. It is usually done while the client lies supine and does not involve the use of radiopaque substances.

 CN: Reduction of risk potential;  
CL: Apply




**22. 2.** The pain associated with renal colic due to calculi is commonly referred to the groin and bladder in female clients and to the testicles in male clients. Nausea, vomiting, abdominal cramping, and diarrhea may also be present. Nephritis or urine retention is an unlikely cause of the referred pain. The type of pain described in this situation is unlikely to be caused by additional stone formation.

 CN: Physiological adaptation;  
CL: Analyze

**23. 2.** During episodes of renal colic, the pain is excruciating. It is necessary to administer opioid analgesics to control the pain. Application of heat, encouraging high fluid intake, and limitation of activity are important interventions, but they will not relieve the renal colic pain.

 CN: Reduction of risk potential;  
CL: Synthesize

**24. 2.** Intermittent pain that is less colicky indicates that the calculi may be moving along the urinary tract. Fluids should be encouraged to promote movement, and the urine should be strained to detect passage of the stone. Hematuria is to be expected from the irritation of the stone. Analgesics should be administered when the client needs them, not routinely. Moist heat to the flank area is helpful when renal colic occurs, but it is less necessary as pain is lessened.

 CN: Physiological adaptation;  
CL: Synthesize

**25. 3.** A client scheduled for an IVP should be assessed for allergies to iodine and shellfish. Clients with such allergies may be allergic to the IVP dye and be at risk for an anaphylactic reaction. Adequate fluid intake is important after the examination. Bladder spasms are not common during an IVP. Bowel preparation is important before an IVP to allow visualization of the ureters and bladder, but checking for allergies is most important.

 CN: Reduction of risk potential;  
CL: Synthesize

**26. 2.** After an IVP, the nurse should encourage fluids to decrease the risk of renal complications caused by the contrast agent. There is no need to place the client on bed rest or administer a laxative. An IVP would not cause hematuria.


 CN: Reduction of risk potential;  
CL: Synthesize

**27. 2.** The ureteral catheter should drain freely without bleeding at the site. The catheter is rarely irrigated, and any irrigation would be done by the physician. The catheter is never clamped. The client's total urine output (ureteral catheter plus


voiding or indwelling urinary catheter output) should be 30 mL/hour.

 CN: Reduction of risk potential;  
CL: Synthesize


**28. 1.** Ambulation stimulates peristalsis. A client with paralytic ileus is kept on nothing-by-mouth status until peristalsis returns. Carbonated beverages will increase gas and distention but will not stimulate peristalsis. A stool softener will not stimulate peristalsis. I.V. fluid infusion is a routine postoperative order that does not have any effect on preventing paralytic ileus.

 CN: Physiological adaptation;  
CL: Synthesize


**29. 2.** The decrease in urine output may reflect inadequate renal perfusion and should be reported immediately. Urine output of 30 mL/hour or greater is considered acceptable. A slight elevation in temperature is expected after surgery. Peristalsis returns gradually, usually the second or third day after surgery. Bowel sounds will be absent until then. A small amount of serosanguineous drainage is to be expected.

 CN: Physiological adaptation;  
CL: Analyze

**30. 1.** A high daily fluid intake is essential for all clients who are at risk for calculi formation because it prevents urinary stasis and concentration, which can cause crystallization. Depending on the composition of the stone, the client also may be instructed to institute specific dietary measures aimed at preventing stone formation. Clients may need to limit purine, calcium, or oxalate. Urine may need to be either alkaline or acid. There is no need to strain urine regularly.


 CN: Basic care and comfort;  
CL: Synthesize

**31. 1.** Because a high-purine diet contributes to the formation of uric acid, a low-purine diet is advocated. An alkaline-ash diet is also advocated because uric acid crystals are more likely to develop in acid urine. Foods that may be eaten as desired in a low-purine diet include milk, all fruits, tomatoes, cereals, and corn. Foods allowed on an alkaline-ash diet include milk, fruits (except cranberries, plums, and prunes), and vegetables (especially legumes and green vegetables). Gravy, chicken, and liver are high in purine.

 CN: Basic care and comfort;  
CL: Evaluate

**32. 2.** Allopurinol (Zyloprim) is used to treat renal calculi composed of uric acid. Adverse effects of allopurinol include drowsiness, maculopapular rash, anemia, abdominal pain, nausea, vomiting,


and bone marrow depression. Clients should be instructed to report rashes and unusual bleeding or bruising. Retinopathy, nasal congestion, and dizziness are not adverse effects of allopurinol.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**33. 1, 2, 5.** Common adverse effects of allopurinol (Zyloprim) include gastrointestinal distress, such as anorexia, nausea, vomiting, and diarrhea. A rash is another potential adverse effect. A potentially life-threatening adverse effect is bone marrow depression. Constipation and flushed skin are not associated with this drug.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**34. 4.** By inhibiting uric acid synthesis, allopurinol (Zyloprim) decreases its excretion. The drug's effectiveness is assessed by evaluating for a decreased serum uric acid concentration. Allopurinol does not alter the level of alkaline phosphatase, nor does it affect urine calcium excretion or the serum calcium level.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

### The Client with Acute Renal Failure


**35. 4.** Solution for peritoneal dialysis should be warmed to body temperature in a warmer or with a heating pad; do not use the microwave. Cold dialysate increases discomfort. Assessment for a bruit and thrill is necessary with hemodialysis when the client has a fistula, graft, or shunt. An indwelling urinary catheter is not required for this procedure. The nurse should position the client in a supine or low Fowler's position.

 CN: Reduction of risk potential; CL: Synthesize

**36. 1, 2, 3, 4.** Elevation of the head of the bed will promote ease of breathing. Respiratory manifestations of acute renal failure include shortness of breath, orthopnea, crackles, and the potential for pulmonary edema. Therefore, priority is placed on facilitation of respiration. The nurse should assess the vital signs because the pulse and respirations will be elevated. Establishing a site for I.V. therapy will become important because fluids will be administered I.V. in addition to orally. The physician will need to be contacted for further orders; there is no need to contact the hemodialysis unit.

 CN: Physiological adaptation; CL: Synthesize


**37. 4.** Oliguria is the most common initial symptom of acute renal failure. Anuria is rarely the initial symptom. Dysuria and hematuria are not associated with acute renal failure.

 CN: Physiological adaptation; CL: Analyze


**38. 1.** There are three categories of acute renal failure: prerenal, intrarenal, and postrenal. Causes of prerenal failure occur outside the kidney and include poor perfusion and decreased circulating volume resulting from such factors as trauma, septic shock, impaired cardiac function, and dehydration. In this case of severe myocardial infarction, there was a decrease in perfusion of the kidneys caused by impaired cardiac function. An obstruction within the urinary tract, such as from kidney stones, tumors, or benign prostatic hypertrophy, is called *postrenal failure*. Structural damage to the kidney resulting from acute tubular necrosis is called *intrarenal failure*. It is caused by such conditions as hypersensitivity (allergic disorders), renal vessel obstruction, and nephrotoxic agents.

 CN: Physiological adaptation; CL: Apply


**39. 4.** Urea, an end product of protein metabolism, is excreted by the kidneys. Impairment in renal function caused by reduced renal blood flow results in an increase in the plasma urea level. Fluid retention, hemolysis of red blood cells, and lowered metabolic rate do not cause an elevated BUN value.

 CN: Reduction of risk potential; CL: Analyze

**40. 4.** Polystyrene sulfonate, a cation-exchange resin, causes the body to excrete potassium through the gastrointestinal tract. In the intestines, particularly the colon, the sodium of the resin is partially replaced by potassium. The potassium is then eliminated when the resin is eliminated with feces. Although the result is to increase potassium excretion, the specific method of action is the exchange of sodium ions for potassium ions. Polystyrene sulfonate does not release hydrogen ions or increase calcium absorption.

 CN: Pharmacological and parenteral therapies; CL: Apply

**41. 1.** Hyperkalemia places the client at risk for serious cardiac arrhythmias and cardiac arrest. Therefore, the nurse should carefully monitor the client for cardiac arrhythmias and be prepared to treat cardiac arrest when caring for a client with hyperkalemia. Increased potassium levels do not result in pulmonary edema, circulatory collapse, or hemorrhage.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**42. 4.** High-carbohydrate foods meet the body's caloric needs during acute renal failure. Protein is limited because its breakdown may result in accumulation of toxic waste products. The main goal of nutritional therapy in acute renal failure is to decrease protein catabolism. Protein catabolism causes increased levels of urea, phosphate, and potassium. Carbohydrates provide energy and decrease the need for protein breakdown. They do not have a diuretic effect. Some specific carbohydrates influence urine pH, but this is not the reason for encouraging a high-carbohydrate, low-protein diet. There is no need to reduce demands on the liver through dietary manipulation in acute renal failure.

 CN: Basic care and comfort; CL: Apply

**43. 1.** Gelatin desserts contain little or no potassium and can be served to a client on a potassium-restricted diet. Foods high in potassium include bran and whole grains; most dried, raw, and frozen fruits and vegetables; most milk and milk products; chocolate, nuts, raisins, coconut, and strong brewed coffee.

 CN: Basic care and comfort; CL: Apply

**44. 1.** Pulmonary edema can develop during the oliguric phase of acute renal failure because of decreased urine output and fluid retention. Metabolic acidosis develops because the kidneys cannot excrete hydrogen ions, and bicarbonate is used to buffer the hydrogen. Hypertension may develop as a result of fluid retention. Hyperkalemia develops as the kidneys lose the ability to excrete potassium.

 CN: Physiological adaptation;  
CL: Analyze

**45. 1.** The unaffected arm should be used for blood pressure measurement. The external cannula must be handled carefully and protected from damage and disruption. In addition, a tourniquet or clamps should be kept at the bedside because dislodgment of the cannula would cause arterial hemorrhage. The arm with the cannula is not used for blood pressure measurement, I.V. therapy, or venipuncture. Patency is assessed by auscultating for bruits every shift. Heparin is not injected into the cannula to maintain patency. Because it is part of the general circulation, the cannula cannot be heparinized.

 CN: Reduction of risk potential;  
CL: Synthesize

**46. 1.** Common symptoms of disequilibrium syndrome include headache, nausea and vomiting, confusion, and even seizures. Disequilibrium syndrome typically occurs near the end or after the completion of hemodialysis treatment. It is the result of rapid


changes in solute composition and osmolality of the extracellular fluid. These symptoms are not related to cardiac function, air embolism, or peritonitis.

 CN: Reduction of risk potential;  
CL: Analyze

**47. 2.** If disequilibrium syndrome occurs during dialysis, the most appropriate intervention is to slow the rate of dialysis. The syndrome is believed to result from too-rapid removal of urea and excess electrolytes from the blood; this causes transient cerebral edema, which produces the symptoms. Administration of oxygen and position changes do not affect the symptoms. It would not be appropriate to reassure the client that the symptoms are normal.

 CN: Reduction of risk potential;  
CL: Synthesize

**48. 1.** Regional anticoagulation can be achieved by infusing heparin in the dialyzer and protamine sulfate, its antagonist, in the client. Warfarin sodium (Coumadin) is not used in dialysis treatment. There is some risk of bleeding; however, clotting time is monitored carefully. The client's clotting time will not be seriously affected, although some rebound effect may occur.

 CN: Pharmacological and parenteral therapies; CL: Apply

**49. 3.** Dialysis has no effect on anemia. Because some red blood cells are injured during the procedure, dialysis aggravates a low hemoglobin concentration. Dialysis will clear metabolic waste products from the body and correct electrolyte imbalances.

 CN: Reduction of risk potential;  
CL: Apply

**50. 4.** Signs and symptoms of an external access shunt infection include redness, tenderness, swelling, and drainage from around the shunt site. The absence of a bruit indicates closing of the shunt. Sluggish capillary refill time and coolness of the extremity indicate decreased blood flow to the extremity.


 CN: Reduction of risk potential;  
CL: Analyze

**51. 1.** The kidneys have a remarkable ability to recover from serious insult. Recovery may take 3 to 12 months. The client should be taught how to recognize the signs and symptoms of decreasing renal function and to notify the physician if such problems occur. In a client who is recovering from acute renal failure, there is no need for renal transplantation or permanent hemodialysis. Chronic renal failure develops before end-stage renal failure.


 CN: Physiological adaptation; CL: Apply

## The Client with Urinary Tract Infection

**52. 4.** The sensation of thirst diminishes in those greater than 60 years of age; hence, fluid intake is decreased and dissolved particles in the extracellular fluid compartment become more concentrated. There is no change in liver function in older adults, nor is there a reduction of ADH and aldosterone as a normal part of aging.

 CN: Physiological adaptation;  
CL: Apply

**53. 3.** Antibiotics have the maximum effect when a blood level of the medication is maintained. However, because nitrofurantoin (Macrochantin) is readily absorbed from the gastrointestinal tract and is primarily excreted in urine, toxicity may develop by doubling the dose. The client should not skip a dose if she realizes that she has missed one. Additional fluids, especially water, should be encouraged, but not forced to promote elimination of the antibiotic from the body. Adequate fluid intake aids in the prevention of urinary tract infections, in addition to an acidic urine.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**54. 1.** The client's urine specific gravity is elevated. Specific gravity is a reflection of the concentrating ability of the kidneys. This level indicates that the urine is concentrated. By increasing fluid intake, the urine will become more dilute. Antihypertensives do not make urine more concentrated unless there is a diuretic component within them. The nurse should not hold a dose of antihypertensive medication. Sodium tends to pull water with it; by restricting sodium, less water, not more, will be present. Bananas do not aid in the dilution of urine.

 CN: Reduction of risk potential;  
CL: Synthesize

**55. 1.** All urine for creatinine clearance determination must be saved in a container with no preservatives and refrigerated or kept on ice. The first urine voided at the beginning of the collection is discarded, not the last. A self-report of weight may not be accurate. It is not necessary to have an indwelling urinary catheter inserted for urine collection.

 CN: Reduction of risk potential;  
CL: Apply

## 56. 141 mg

$$1 \text{ kg} = 2.2 \text{ lb}$$

$$1 \text{ kg} : 2.2 \text{ lb} = X \text{ kg} : 207 \text{ lb}$$

$$2.2 \text{ lb} \times X \text{ kg} = 1 \text{ kg} \times 207 \text{ lb}$$


$$X \text{ kg} = \frac{1 \text{ kg} \times 207 \text{ lb}}{2.2 \text{ lb}} = \frac{94.1}{1}$$

$$X = 94.1 \text{ kg}$$

$$1.5 \text{ mg} \times 94.1 = 141.15 = 141 \text{ mg.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**57. 2.** The classic symptoms of cystitis are severe burning on urination, urgency, and frequent urination. Systemic symptoms, such as fever and nausea and vomiting, are more likely to accompany pyelonephritis than cystitis. Hematuria may occur, but it is not as common as frequency and burning.

 CN: Physiological adaptation;  
CL: Analyze

**58. 4.** Although various conditions may result in cystitis, the most common cause is an ascending infection from the urethra. Strictures and urine retention can lead to infections, but these are not the most common cause. Systemic infections are rarely causes of cystitis.

 CN: Physiological adaptation; CL: Apply


**59. 4.** As newlyweds, the client and her husband need to develop a strong communication base. The nurse can facilitate communication by preparing and supporting the client. Given the situation, an interdisciplinary conference is inappropriate and would not promote intimacy for the client and her husband. Insisting that the client talk with her husband is not addressing her fears. Being present allows the nurse to facilitate the discussion of a difficult topic. Having the nurse speak first with the husband alone shifts responsibility away from the couple.

 CN: Psychosocial adaptation;  
CL: Synthesize


**60. 2.** Hot tub baths promote relaxation and help relieve urgency, discomfort, and spasm. Applying heat to the perineum is more helpful than cold because heat reduces inflammation. Although liberal fluid intake should be encouraged, caffeinated beverages, such as tea, coffee, and cola, can be irritating to the bladder and should be avoided. Voiding at least every 2 to 3 hours should be encouraged because it reduces urinary stasis.

 CN: Basic care and comfort; CL: Evaluate


**61. 3.** Phenazopyridine hydrochloride (Pyridium) is a urinary analgesic that works directly on the bladder mucosa to relieve the distressing symptoms of dysuria. Phenazopyridine does not have a bacteriostatic effect. It does not potentiate antibiotics or prevent crystallization.

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 1.** The client should be told that phenazopyridine hydrochloride (Pyridium) turns the urine a bright orange-red, which may stain underwear. It can be frightening for a client to see orange-red urine without having been forewarned. Other common adverse effects associated with phenazopyridine include headaches, gastrointestinal disturbances, and rash. Phenazopyridine does not cause incontinence, constipation, or drowsiness.

 CN: Pharmacological and parenteral therapies; CL: Apply

**63. 2, 3.** Clients who are taking nitrofurantoin (Macrochantin) should be instructed to take the medication with meals and to increase their fluid intake to minimize gastrointestinal distress. The urine may become brown in color. Although this change is harmless, clients need to be prepared for this color change. The client should be instructed to take the full prescription and not to stop taking the drug because symptoms have subsided. The medication should not be taken with antacids as this may interfere with the drug's absorption.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**64. 15 mL**

The following formula is used to calculate the correct dosage:

$$25 \text{ mg}/5 \text{ mL} = 75 \text{ mg}/X \text{ mL}$$

$$X = 15 \text{ mL}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**65. 1.** Stasis of urine in the bladder is one of the chief causes of bladder infection, and a client who voids infrequently is at greater risk for reinfection. A tub bath does not promote urinary tract infections as long as the client avoids harsh soaps and bubble baths. Scrupulous hygiene and liberal fluid intake (unless contraindicated) are excellent preventive measures, but the client also should be taught to void every 2 to 3 hours during the day.

 CN: Reduction of risk potential; CL: Analyze

**66. 1.** A woman can adopt several health-promotion measures to prevent the recurrence of

cystitis, including avoiding too-tight pants, noncotton underpants, and irritating substances, such as bubble baths and vaginal soaps and sprays. Increasing citrus juice intake can be a bladder irritant. Regular douching is not recommended; it can alter the pH of the vagina, increasing the risk of infection.

 CN: Health promotion and maintenance; CL: Synthesize

**67. 4.** Instructions should be as specific as possible, and the nurse should avoid general statements such as “a lot.” A specific goal is most useful. A mix of fluids will increase the likelihood of client compliance. It may not be sufficient to tell the client to drink twice as much as or 1 quart more than she usually drinks if her intake was inadequate to begin with.


 CN: Basic care and comfort; CL: Apply

### The Client with Pyelonephritis


**68. 1.** Pyelonephritis usually begins with colonization and infection of the lower urinary tract via the ascending urethral route, and the client should have an adequate intake of fluids to promote the flushing action of urination. Bubble baths and limiting fluid intake increase the risk of developing a urinary tract infection. Antibiotics should be used on a short-term basis because the risk of antibiotic resistance may lead to breakthrough infections with increasingly virulent pathogens.

 CN: Health promotion and maintenance; CL: Synthesize

**69. 2.** Common symptoms of pyelonephritis include CVA tenderness, burning on urination, urinary urgency or frequency, chills, fever, and fatigue. Ascites, polyuria, and nausea and vomiting are not indicative of pyelonephritis.


 CN: Physiological adaptation; CL: Analyze

**70. 4.** A client with a history of diabetes mellitus, urinary tract infections, or renal calculi is at increased risk for pyelonephritis. Others at high risk include pregnant women and people with structural alterations of the urinary tract. A history of hypertension may put the client at risk for kidney damage, but not kidney infection. Intake of large quantities of cranberry juice and a fluid intake of 2,000 mL/day are not risk factors for pyelonephritis.


 CN: Reduction of risk potential; CL: Analyze

**71. 5, 6.** Serum BUN and creatinine are the tests most commonly used to assess renal function, with creatinine being the most reliable indicator.

Nonrenal factors may affect BUN levels as well as serum sodium and potassium levels. Arterial blood gases and hemoglobin are not used to assess renal status. Urinalysis is a general screening test.

 CN: Physiological adaptation;  
CL: Analyze

**72. 3.** Antibiotics are usually prescribed for a 2- to 4-week period. A urine culture is needed to evaluate the effectiveness of antibiotic therapy. Urine must be examined microscopically to adequately determine the presence of bacteria; looking at the color of the urine or checking the odor is not sufficient. Symptoms usually disappear 48 to 72 hours after antibiotic therapy is started, but antibiotics may need to continue for up to 4 weeks.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**73. 2.** Chronic pyelonephritis is most commonly the result of recurrent urinary tract infections. Chronic pyelonephritis can lead to chronic renal failure. Single cases of acute pyelonephritis rarely cause chronic pyelonephritis. Acute renal failure is not a cause of chronic pyelonephritis. Glomerulonephritis is an immunologic disorder, not an infectious disorder.

 CN: Physiological adaptation; CL: Apply

### The Client with Chronic Renal Failure

**74. 1.** Crackles in the lungs, weight gain, and elevated blood pressure are indicators of excess fluid volume, a common complication in chronic renal failure. The client's fluid status should be monitored carefully for imbalances on an ongoing basis. Although the client has ineffective breathing, the primary cause is related to the renal failure. There are no data to suggest ineffective tissue perfusion or lack of knowledge.

 CN: Physiological adaptation;  
CL: Analyze

**75. 3.** A disadvantage of peritoneal dialysis in long-term management of chronic renal failure is that it requires large blocks of time. The risk of hemorrhage or hepatitis is not high with peritoneal dialysis. Peritoneal dialysis is effective in maintaining a client's fluid and electrolyte balance.

 CN: Reduction of risk potential;  
CL: Apply

**76. 2, 4, 5.** To manage nausea, the nurse can advise the client to drink limited amounts of fluid only when thirsty, eat food before drinking fluids to alleviate dry mouth, encourage strict follow-up for

blood work, dialysis, and health care provider visits. Smaller, more frequent meals may help to reduce nausea and facilitate medication taking. The client should be as active as possible to avoid immobilization because it increases bone demineralization. The client should also maintain the dialysis schedule because the dialysis will remove wastes that can contribute to nausea.

 CN: Physiological adaptation;  
CL: Synthesize

**77. 1.** The main reason for warming the peritoneal dialysis solution is that the warm solution helps dilate peritoneal vessels, which increases urea clearance. Warmed dialyzing solution also contributes to client comfort by preventing chilly sensations, but this is a secondary reason for warming the solution. The warmed solution does not force potassium into the cells or promote abdominal muscle relaxation.

 CN: Reduction of risk potential;  
CL: Apply

**78. 2.** During dwell time, the dialysis solution is allowed to remain in the peritoneal cavity for the time ordered by the physician (usually 20 to 45 minutes). During this time, the nurse should monitor the client's respiratory status because the pressure of the dialysis solution on the diaphragm can create respiratory distress. The dialysis solution would not cause urticaria or affect circulation to the fingers. The client's laboratory values are obtained before beginning treatment and are monitored every 4 to 8 hours during the treatment, not just during the dwell time.

 CN: Reduction of risk potential;  
CL: Analyze

**79. 2.** Because the client has a permanent catheter in place, blood-tinged drainage should not occur. Persistent blood-tinged drainage could indicate damage to the abdominal vessels, and the physician should be notified. The bleeding is originating in the peritoneal cavity, not the kidneys. Too-rapid infusion of the dialysate can cause pain, not blood-tinged drainage.

 CN: Reduction of risk potential;  
CL: Analyze


**80. 2.** Fluid return with peritoneal dialysis is accomplished by gravity flow. Actions that enhance gravity flow include turning the client from side to side, raising the head of the bed, and gently massaging the abdomen. The client is usually confined to a recumbent position during the dialysis. The nurse should not attempt to reposition the catheter.

 CN: Reduction of risk potential;  
CL: Synthesize

**81. 2.** Because hypotension is a complication associated with peritoneal dialysis, the nurse records intake and output, monitors vital signs, and observes the client's behavior. The nurse also encourages visiting and other diversional activities. A client on peritoneal dialysis does not need to be placed in a bed with padded side rails or kept on NPO status.

 CN: Reduction of risk potential;  
CL: Synthesize


**82. 1, 2, 4, 5.** Broad-spectrum antibiotics may be administered to prevent infection when a peritoneal catheter is inserted for peritoneal dialysis. If peritonitis is present, antibiotics may be added to the dialysate. Aseptic technique is imperative. Peritonitis, the most common and serious complication of peritoneal dialysis, is characterized by cloudy dialysate drainage, diffuse abdominal pain, and rebound tenderness.

 CN: Safety and infection control;  
CL: Synthesize


**83. 2.** Weight loss is expected because of the removal of fluid. The client's weight before and after dialysis is one measure of the effectiveness of treatment. Blood pressure usually decreases because of the removal of fluid. Hematuria would not occur after completion of peritoneal dialysis. Dialysis only minimally affects the damaged kidneys' ability to manufacture urine.

 CN: Reduction of risk potential;  
CL: Evaluate


**84. 3.** A client in renal failure develops hyperphosphatemia that causes a corresponding excretion of the body's calcium stores, leading to renal osteodystrophy. To decrease this loss, aluminum hydroxide gel is prescribed to bind phosphates in the intestine and facilitate their excretion. Gastric hyperacidity is not necessarily a problem associated with chronic renal failure. Antacids will not prevent Curling's stress ulcers and do not affect metabolic acidosis.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**85. 4.** Aluminum hydroxide gel (Amphojel) is administered to bind the phosphates in ingested foods and must be given with or immediately after meals and snacks. There is no need for the client to take it on a 24-hour schedule. It is not administered to treat hyperacidity in clients with chronic renal failure and therefore is not prescribed between meals.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**86. 1.** Magnesium is normally excreted by the kidneys. When the kidneys fail, magnesium can accumulate and cause severe neurologic problems. Milk of magnesia is harsher than Metamucil, but magnesium toxicity is a more serious problem. A client may find both milk of magnesia and Metamucil unpalatable. Milk of magnesia is not high in sodium.

 CN: Pharmacological and parenteral therapies; CL: Apply


**87. 2.** Uremia can cause decreased alertness, so the nurse needs to validate the client's comprehension frequently. Because the client's ability to concentrate is limited, short lessons are most effective. If family members are present at the sessions, they can reinforce the material. Written materials that the client can review are superior to videotapes because clients may not be able to maintain alertness during the viewing of the videotape.

 CN: Physiological adaptation;  
CL: Synthesize

**88. 3.** Dietary management for clients with chronic renal failure is usually designed to restrict protein, sodium, and potassium intake. Protein intake is reduced because the kidney can no longer excrete the byproducts of protein metabolism. The degree of dietary restriction depends on the degree of renal impairment. The client should also receive a high-carbohydrate diet along with appropriate vitamin and mineral supplements. Calcium requirements remain 1,000 to 2,000 mg/day.

 CN: Basic care and comfort;  
CL: Synthesize


**89. 2.** Altered sexual functioning commonly occurs in chronic renal failure and can stress marriages and relationships. Altered sexual functioning can be caused by decreased hormone levels, anemia, peripheral neuropathy, or medication. The client should not decrease or avoid sexual activity but instead should modify it. The client should rest before sexual activity.

 CN: Psychosocial adaptation;  
CL: Synthesize

**90. 2.** The major benefit of CAPD is that it frees the client from daily dependence on dialysis centers, health care personnel, and machines for life-sustaining treatment. This independence is a valuable outcome for some people. CAPD is costly and must be done daily. Adverse effects and complications are similar to those of standard peritoneal dialysis. Peritoneal dialysis usually takes less time but cannot be done at home.

 CN: Reduction of risk potential;  
CL: Apply

**91. 3.** Dietary restrictions with CAPD are fewer than those with standard peritoneal dialysis because dialysis is constant, not intermittent. The constant slow diffusion of CAPD helps prevent accumulation of toxins and allows for a more liberal diet. CAPD does not work more quickly, but more consistently. Both types of peritoneal dialysis are effective.

 CN: Basic care and comfort;  
CL: Synthesize

**92. 1.** Cloudy drainage indicates bacterial activity in the peritoneum. Other signs and symptoms of infection are fever, hyperactive bowel sounds, and abdominal pain. Swollen legs may indicate heart failure. Poor drainage of dialysate fluid is probably the result of a kinked catheter. Redness at the insertion site indicates local infection, not peritonitis. However, a local infection that is left untreated can progress to the peritoneum.

 CN: Reduction of risk potential;  
CL: Analyze

### The Client with Urinary Incontinence

**93. 1, 2.** Laughing may be a part of one's socialization, so it should not be discouraged. In non-restricted clients, a fluid intake of at least 2 to 3 L/day is encouraged; clients with stress incontinence may reduce their fluid intake to avoid incontinence at the risk of developing dehydration and urinary tract infections. Establishing a voiding schedule would be more effective in the prevention of stress incontinence rather than carrying incontinence pads. Dietary irritants and natural diuretics, such as caffeine and alcoholic beverages, may increase stress incontinence. Kegel exercises strengthen the sphincter and structural supports of the bladder.


 CN: Health promotion and maintenance;  
CL: Synthesize

**94. 2.** The history of three pregnancies is most likely the cause of the client's current episodes of stress incontinence. The client's fluid intake, age, or history of swimming would not create an increase in intra-abdominal pressure.

 CN: Reduction of risk potential;  
CL: Analyze

**95. 4.** The primary goal of nursing care is to decrease the number of incontinence episodes and the amount of urine expressed in an episode. Behavioral interventions (e.g., diet and exercise) and medications are the nonsurgical management methods used to treat stress incontinence. Without surgical intervention, it may not be possible to eliminate all episodes of incontinence. Helping the client adjust to the incontinence is not treating the

problem. Clients with stress incontinence are not prone to the development of urinary tract infection.

 CN: Physiological adaptation;  
CL: Synthesize


**96. 2.** Clients with stress incontinence are encouraged to avoid substances, such as caffeine and alcohol, that are bladder irritants. Emotional stressors do not cause stress incontinence. It is most commonly caused by relaxed pelvic musculature. Wearing girdles is not contraindicated. Although clients may want to limit physical exertion to avoid incontinence episodes, they should be encouraged to seek treatment instead of limiting their activities.

 CN: Reduction of risk potential;  
CL: Create

**97. 3.** A characteristic of urge incontinence is involuntary urination with little or no warning. The inability to empty the bladder is urine retention. Loss of urine when coughing occurs with stress incontinence. Frequent dribbling of urine is common in male clients after some types of prostate surgery or may occur in women after the development of a vesicovaginal or urethrovaginal fistula.

 CN: Physiological adaptation;  
CL: Analyze

**98. 1.** Instructing the client to void at regularly scheduled intervals can help decrease the frequency of incontinence episodes. Providing a bedside commode does not decrease the number of incontinence episodes and does not help the client who leads an active lifestyle. Infections are not a common cause of urge incontinence, so antibiotics are not an appropriate treatment. Intermittent self-catheterization is appropriate for overflow or reflux incontinence, but not urge incontinence, because it does not treat the underlying cause.

 CN: Physiological adaptation;  
CL: Synthesize

### Managing Care Quality and Safety

**99. 4.** Sensitivity to shellfish or iodine may cause an anaphylactic reaction to the contrast material, which contains iodine. Administering a cathartic or antiflatulent will not prevent an anaphylactic reaction to the contrast material. Keeping a client on NPO status for 8 hours before the procedure is part of the usual preparation for such a procedure to prevent aspiration of food or fluids if the client vomits when lying on the X-ray table.

 CN: Reduction of risk potential;  
CL: Synthesize



**100. 1.** The appropriate action would be to discard the specimen and obtain a new one. Urine that is allowed to stand at room temperature will become alkaline, with multiplying bacteria. The specimen should be examined within 1 hour after urination.


 CN: Reduction of risk potential;  
CL: Synthesize

**101. 1, 2, 3, 4, 6.** Before ordering and administering packed RBCs, the nurse should assess the I.V. site to make sure it has an 18G to 20G Angiocath. The nurse should also ensure that normal saline solution is used to prime the tubing to prevent RBCs from adhering to the tubing. The client must indicate informed consent for the procedure by signing the consent form. The client's blood must be typed to determine ABO blood typing and Rh factor and ensure that the client receives compatible blood. Cross-matching is done to detect the presence of recipient antibodies to the donor's minor antigens. Vital signs provide a baseline reference for continuous monitoring throughout the transfusion.

An identification bracelet and red blood band are essential for client identification per facility policy. Two nurses must double check the client's identification with the client listed on the unit of RBCs. The transfusion should be started within 30 minutes of the time that the RBC unit is checked out of the blood bank. Thus, no blood should be kept in the medication room before transfusion.

 CN: Safety and infection control;  
CL: Synthesize

**102. 3.** The correct technique for a clean-catch urine culture specimen is to have the female client clean the labia from front to back, void into the toilet, and then void into the cup. The client does not need to fully empty her bladder into the cup. It is not necessary to catheterize the client to obtain the specimen. The first voided specimen of the day has the highest bacterial counts.

 CN: Basic care and comfort;  
CL: Evaluate

**TEST  
10**

# The Client with Reproductive Health Problems

- The Client with a Vaginal Infection
- The Client with Uterine Fibroids
- The Client with Breast Disease
- The Client with Benign Prostatic Hypertrophy
- The Client with a Sexually Transmitted Disease
- The Client with Cancer of the Cervix
- The Client with Cancer of the Ovaries
- The Client Having Gynecological Surgery
- The Client with Testicular Disease
- The Client with Cancer of the Prostate
- The Client with Erectile Dysfunction
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with a Vaginal Infection

**1.** A nurse is reviewing a client's chart and notes the Papanicolaou smear laboratory report indicates visualization of clue cells and a vaginal pH of 3.8. What should the nurse teach this client? Select all that apply.

- 1. Seek care if the vaginal discharge has a fishy odor.
- 2. Seek care if experiencing thick, white, adherent vaginal discharge.
- 3. All vaginal infections are sexually transmitted infections.
- 4. Do not douche unless instructed by a health care provider.
- 5. Usually vaginal infections can be treated with over-the-counter preparations.

**2.** A nurse is discussing daily activities with a client. Which of the following activities puts the client at risk for altering the normal pH of her vagina?

- 1. Consuming over 4 cups of coffee per day.
- 2. Having sexual intercourse during the menstrual cycle.
- 3. Douching unless instructed to do so by the health care provider.
- 4. Using tampons during the menstrual cycle.

**3.** A client is prescribed oral metronidazole (Flagyl) for treatment of bacterial vaginosis. What should the nurse instruct the client to avoid during treatment and for 24 hours thereafter?

- 1. Douching.
- 2. Sexual intercourse.
- 3. Hot tub baths.
- 4. Alcohol consumption.

**4.** Which of the following females is at **greatest** risk for bacterial vaginosis?

- 1. A 75-year-old.
- 2. A 52-year-old experiencing menopause.
- 3. A 28-year-old.
- 4. A 12-year-old experiencing menarche.

**5.** A nurse is assessing a client with vaginal discharge. Which of the following diseases are commonly associated with vaginal discharge? Select all that apply.

- 1. Candidiasis.
- 2. Bacterial vaginosis.
- 3. Gonorrhea.
- 4. Trichomoniasis.
- 5. Syphilis.

**6.** A female client with which condition would be at increased risk for vulvovaginal candidiasis? Select all that apply.

- 1. Uncontrolled diabetes.
- 2. Immunosuppression due to cancer.
- 3. Human immunodeficiency virus (HIV) infection.
- 4. Hypertension.
- 5. Asthma.

**7.** A client taking oral contraceptives is placed on a 10-day course of antibiotics for an infection. Which of the following instructions should the nurse include in the teaching plan?

- 1. “Use a barrier method of birth control for the rest of your cycle.”
- 2. “You should stop taking the oral contraceptives while taking the antibiotic.”
- 3. “Call your health care provider for increased hunger or fluid retention.”
- 4. “Take the antibiotics 2 hours after the oral contraceptive.”

**8.** A client is asking for information about using an intrauterine device (IUD). Which of the following questions asked by the nurse would provide pertinent information on whether or not a client is a candidate for an IUD?

- 1. “Do you smoke?”
- 2. “Do you have hypertension?”
- 3. “How often do you have sex?”
- 4. “Are you in a monogamous relationship?”

**9.** A nurse is caring for a 22-year-old female client with type 1 diabetes mellitus and toxic shock syndrome (TSS). Which of the following physician orders should the nurse perform **first**?

- 1. Administer 5% dextrose in half-normal saline solution at 150 mL/hour I.V.
- 2. Administer 50 mg of meperidine (Demerol) I.M. every 4 hours as needed for pain.
- 3. Teach the client to use pads at night instead of tampons during her menstrual period.
- 4. Administer 400 mg of ciprofloxacin (Cipro) I.V. every 12 hours infused over 1 hour.

### The Client with Uterine Fibroids

**10.** A 39-year-old female client has been experiencing intermittent vaginal bleeding for several months. Her physician tells her that she has uterine fibroids and recommends an abdominal hysterectomy. The nurse is completing the routine admission assessment when the client expresses fear about the surgery. Which of the following statements offers the **best** guide for the nurse’s response? The nurse should:

- 1. Reassure the client of her physician’s competence.
- 2. Give the client opportunities to express her fears.
- 3. Teach the client that fear impedes recovery.
- 4. Change the subject of conversation to pleasantries when the client appears fearful.

**11.** A female with uterine fibroids presents with dysmenorrhea and menorrhagia. The health care provider orders a complete blood count and blood chemistry. Which results should the nurse report to the health care provider? Select all that apply.

- 1. Hemoglobin, 9.0 g/dL.
- 2. Hematocrit, 27.1%.
- 3. White blood cell count, 10,000 cells/mm<sup>3</sup>.
- 4. Potassium, 4.0 mEq/L.
- 5. Normocytic red blood cells.

**12.** The client will be admitted tomorrow for an abdominal hysterectomy. Which of the following information will be **most** important for the nurse to give to the client prior to admission?

- 1. What to wear to the hospital.
- 2. What she can eat and drink before admission.
- 3. The type of pain medication that will be prescribed postoperatively.
- 4. The amount of activity she can have after surgery.

**13.** The nurse is witnessing the client’s signature on the informed surgical consent for an abdominal hysterectomy. It is important to ascertain that the client understands that with this surgical procedure she will have:

- 1. Decreased libido.
- 2. Infertility.
- 3. Depression.
- 4. Weight gain.

**14.** Which is the correct order, from first to last, for proper placement of a urinary catheter?

1. Lubricate the catheter adequately with a water-soluble lubricant.

2. Ensure free flow of urine.

3. Insert the catheter far enough into the bladder to prevent trauma to the urethral tissue.

4. Prepare a sterile field.

**15.** Which of the following physical sensations will the client who has had an abdominal hysterectomy **most** likely experience if she hyperventilates while performing deep-breathing exercises?

- 1. Dyspnea.
- 2. Dizziness.
- 3. Blurred vision.
- 4. Mental confusion.

**16.** Which nursing measure would **most** likely relieve postoperative gas pains after abdominal hysterectomy?

- 1. Offering the client a hot beverage.
- 2. Providing extra warmth.
- 3. Applying a snugly fitting abdominal binder.
- 4. Helping the client walk.

**17.** On the second postoperative day after an abdominal hysterectomy, the client develops a temperature of 100.4° F (38° C). The nurse's **first** action should be to:

- 1. Increase the number of wound changes to minimize infection.
- 2. Obtain a culture and sensitivity study of the urine to determine the source of infection.
- 3. Ensure that the client takes at least 10 deep breaths every hour.
- 4. Change the site of the client's I.V. fluid catheter to reduce the risk of infection.

**18.** A client is being admitted from the emergency department with a nursing home-acquired pneumonia. The unit has four empty beds in semi-private rooms. The room that would be **most** suitable for this client is the one with a:

- 1. 60-year-old client admitted for investigation of transient ischemic attacks.
- 2. 45-year-old client with an abdominal hysterectomy.
- 3. 24-year-old client with non-Hodgkin's lymphoma.
- 4. 55-year-old client with alcoholic cirrhosis.

**19.** The nurse is changing the dressing of a client after an abdominal hysterectomy. Which of the following nursing measures would be **most** appropriate if the dressing adheres to the client's incisional area?

- 1. Pull off the dressing quickly and then apply slight pressure over the area.
- 2. Lift an easily moved portion of the dressing and then remove it slowly.
- 3. Moisten the dressing with sterile normal saline solution and then remove it.
- 4. Remove part of the dressing and then remove the remainder gradually over a period of several minutes.

**20.** The client with an abdominal hysterectomy is being prepared for discharge in the morning. The client has a mentally retarded adult son whom she cares for at home. The nurse should discuss with the physician the need for referral to which of the following departments?

- 1. Home health care.
- 2. Social work.
- 3. Pastoral care.
- 4. Volunteer services.

**21.** When preparing discharge instructions for a client after an abdominal hysterectomy, the nurse should **first**:

- 1. Have the client watch an educational video.
- 2. Assess the client's available social supports.
- 3. Call the social worker to evaluate the client.
- 4. Read the discharge instructions to the client.

**22.** Which should the nurse include when teaching a 55-year-old woman in the beginning of menopause? Select all that apply.

- 1. The average age of onset for menopause is 50 to 52 years.
- 2. Follicle-stimulating hormone (FSH) and luteinizing hormone (LH) levels elevate.
- 3. Depression is very common as a result of menopause.
- 4. Hot flashes, especially at night, can occur in about 80% of women.
- 5. When periods become irregular, contraception is unnecessary.

### The Client with Breast Disease

**23.** A postmenopausal woman is worried about pain in the upper outer quadrant of her left breast. The nurse's **first** course of action is to:

- 1. Do a breast examination and report the results to the physician.
- 2. Explain that pain is caused by hormonal fluctuations.
- 3. Reassure the client that pain is not a symptom of breast cancer.
- 4. Teach the client the correct procedure for breast self-examination (BSE).

**24.** The nurse teaches a female client that the **best** time in the menstrual cycle to examine the breasts is during the:

- 1. Week that ovulation occurs.
- 2. Week that menstruation occurs.
- 3. First week after menstruation.
- 4. Week before menstruation occurs.

**25.** A female with bilateral breast implants asks if she still needs to do breast examinations because she does not know what to feel for. Which of the following is the nurse's **best** response?

- 1. "Have your partner assess your breasts on a regular basis."
- 2. "I will show you the correct technique as I do the breast examination."
- 3. "A breast examination is very difficult when you have had implant surgery."
- 4. "You need to have a mammogram instead."

**26.** The client states that she has noticed that her bra fits more snugly at certain times of the month. She asks the nurse if this is a sign of breast disease. The nurse should base the reply to this client on the knowledge that:

- 1. Benign cysts tend to cause the breasts to vary in size.
- 2. It is normal for the breasts to increase in size before menstruation begins.
- 3. A change in breast size warrants further investigation.
- 4. Differences in breast size are related to normal growth and development.

**27.** A 76-year-old client tells the nurse that she has lived long and does not need mammograms. Which is the nurse's **best** response?

- 1. "Having a mammogram when you are older is less painful."
- 2. "The incidence of breast cancer increases with age."
- 3. "We need to consider your family history of breast cancer first."
- 4. "It will be sufficient if you perform breast examinations monthly."

**28.** After the surgeon's meeting with a client to obtain the client's informed consent for a modified radical mastectomy, the client asks the nurse many questions about breast reconstruction that the nurse finds difficult to answer. The nurse should:

- 1. Inform the surgeon that the client has questions about reconstruction before she signs the consent.
- 2. Inform the client that she should concentrate on recovering from the mastectomy first.
- 3. Inform the client that she can have a consultation with the plastic surgeon in a few weeks.
- 4. Inform the client she can ask the surgeon these questions later when the surgeon makes rounds.

**29.** During the admission workup for a modified radical mastectomy, the client is extremely anxious and asks many questions. Which of the following approaches would offer the **best** guide for the nurse to answer questions raised by this apprehensive preoperative client?

- 1. Tell the client as much as she wants to know and is able to understand.
- 2. Delay discussing the client's questions with her until she is convalescing.
- 3. Delay discussing the client's questions with her until her apprehension subsides.
- 4. Explain to the client that she should discuss her questions first with the physician.

**30.** A client asks the nurse, "Where is cancer usually found in the breast?" When responding to the client, the nurse uses a diagram of a left breast and indicates that most malignant tumors occur in which quadrant of the breast?

- 1. Upper outer quadrant.
- 2. Upper inner quadrant.
- 3. Lower outer quadrant.
- 4. Lower inner quadrant.

**31.** Atropine sulfate is included in the preoperative orders for a client undergoing a modified radical mastectomy. The expected outcome is to:

- 1. promote general muscular relaxation.
- 2. decrease pulse and respiratory rates.
- 3. decrease nausea.
- 4. inhibit oral and respiratory secretions.

**32.** During the postoperative period after a modified radical mastectomy, the client confides in the nurse that she thinks she got breast cancer because she had an abortion and she did not tell her husband. The **best** response by the nurse is which of the following?

- 1. "Cancer is not a punishment; it is a disease."
- 2. "You might feel better if you confided in your husband."
- 3. "Tell me more about your feelings on this."
- 4. "I can have the social worker talk to you if you would like."

**33.** Postoperatively after a modified radical mastectomy, a client has an incisional drainage tube attached to Hemovac suction. The nurse determines the suction is effective when:

- 1. The intrathoracic pressure is decreased and the client breathes easier.
- 2. There is an increased collateral lymphatic flow toward the operative area.
- 3. Accumulated serum and blood in the operative area are removed.
- 4. No adhesions are formed between the skin and chest wall in the operative area.

**34.** Which of the following positions would be **best** for a client's right arm when she returns to her room after a right modified radical mastectomy with multiple lymph node excisions?

- 1. Across her chest wall.
- 2. At her side at the same level as her body.
- 3. In the position that affords her the greatest comfort without placing pressure on the incision.
- 4. On pillows, with her hand higher than her elbow and her elbow higher than her shoulder.

**35.** The client with breast cancer is prescribed tamoxifen (Nolvadex) 20 mg daily. The client states she does not like taking medicine and asks the nurse if the tamoxifen is really worth taking. The nurse's **best** response is which of the following?

- 1. "This drug is part of your chemotherapy program."
- 2. "This drug has been found to decrease metastatic breast cancer."
- 3. "This drug will act as an estrogen in your breast tissue."
- 4. "This drug will prevent hot flashes since you cannot take hormone replacement."

**36.** A client undergoing chemotherapy after a modified radical mastectomy asks the nurse questions about a breast prosthesis and wigs. After answering the questions directly, the nurse should also:

- 1. Provide a list of resources, including the local breast cancer support group.
- 2. Offer a referral to the social worker.
- 3. Call the home health care agency.
- 4. Contact the plastic surgeon.

**37.** A client is to have radiation therapy after a modified radical mastectomy. The nurse should teach the client to care for the skin at the site of therapy by:

- 1. Washing the area with water.
- 2. Exposing the area to dry heat.
- 3. Applying an ointment to the area.
- 4. Using talcum powder on the area.

**38.** The nurse should teach a client that a normal local tissue response to radiation is:

- 1. Atrophy of the skin.
- 2. Scattered pustule formation.
- 3. Redness of the surface tissue.
- 4. Sloughing of two layers of skin.

**39.** The nurse refers a client who had a mastectomy to "Reach to Recovery." The **primary** purpose of the American Cancer Society's Reach to Recovery program is to:

- 1. Foster rehabilitation in women who have had mastectomies.
- 2. Raise funds to support early breast cancer detection programs.
- 3. Provide free dressings for women who have had radical mastectomies.
- 4. Collect statistics for research from women who have had mastectomies.

## The Client with Benign Prostatic Hypertrophy

**40.** A 72-year-old male is in the emergency department because he has been unable to void for the past 12 hours. The **best** method for the nurse to use when assessing for bladder distention in a male client is to check for:

- 1. A rounded swelling above the pubis.
- 2. Dullness in the lower left quadrant.
- 3. Rebound tenderness below the symphysis.
- 4. Urine discharge from the urethral meatus.

**41.** During a client's urinary bladder catheterization, the nurse ensures that the bladder is emptied gradually. The **best** rationale for the nurse's action is that completely emptying an overdistended bladder at one time tends to cause:

- 1. Renal failure.
- 2. Abdominal cramping.
- 3. Possible shock.
- 4. Atrophy of bladder musculature.

**42.** The **primary** reason for lubricating the urinary catheter generously before inserting it into a male client is that this technique helps reduce:

- 1. Spasms at the orifice of the bladder.
- 2. Friction along the urethra when the catheter is being inserted.
- 3. The number of organisms gaining entrance to the bladder.
- 4. The formation of encrustations that may occur at the end of the catheter.

**43.** The **primary** reason for taping an indwelling catheter laterally to the thigh of a male client is to:

- 1. Eliminate pressure at the penoscrotal angle.
- 2. Prevent the catheter from kinking in the urethra.
- 3. Prevent accidental catheter removal.
- 4. Allow the client to turn without kinking the catheter.

**44.** Many older men with prostatic hypertrophy do not seek medical attention until urinary obstruction is almost complete. One reason for this delay in seeking attention is that these men may:

- 1. Feel too self-conscious to seek help when reproductive organs are involved.
- 2. Expect that it is normal to have to live with some urinary problems as they grow older.
- 3. Fear that sexual indiscretions in earlier life may be the cause of their problem.
- 4. Have little discomfort in relation to the amount of pathology because responses to pain stimuli fade with age.

**45.** When caring for a client with a history of benign prostatic hypertrophy (BPH), the nurse should do which of the following? Select all that apply.

- 1. Provide privacy and time for the client to void.
- 2. Monitor intake and output.
- 3. Catheterize the client for post void residual urine.
- 4. Ask the client if he has urinary retention.
- 5. Test the urine for hematuria.

**46.** The nurse should specifically assess a client with prostatic hypertrophy for which of the following?

- 1. Voiding at less frequent intervals.
- 2. Difficulty starting the flow of urine.
- 3. Painful urination.
- 4. Increased force of the urine stream.

**47.** The nurse is reviewing the medication history of a client with benign prostatic hypertrophy (BPH). Which medication will likely aggravate BPH?

- 1. Metformin (Glucophage).
- 2. Buspirone (BuSpar).
- 3. Inhaled ipratropium (Atrovent).
- 4. Ophthalmic timolol (Timoptic).

**48.** A client is scheduled to undergo transurethral resection of the prostate. The procedure is to be done under spinal anesthesia. Postoperatively, the nurse should assess the client for:

- 1. Seizures.
- 2. Cardiac arrest.
- 3. Renal shutdown.
- 4. Respiratory paralysis.

**49.** A client with benign prostatic hypertrophy (BPH) is being treated with terazosin (Hytrin) 2 mg at bedtime. The nurse should monitor the client's:

- 1. Urine nitrites.
- 2. White blood cell count.
- 3. Blood pressure.
- 4. Pulse.

**50.** A client underwent transurethral resection of the prostate (TURP), and a large three-way indwelling urinary catheter was inserted in the bladder with continuous bladder irrigation. In which of the following circumstances should the nurse increase the flow rate of the continuous bladder irrigation?

- 1. When drainage is continuous but slow.
- 2. When drainage appears cloudy and dark yellow.
- 3. When drainage becomes bright red.
- 4. When there is no drainage of urine and irrigating solution.

**51.** A client is to receive belladonna and opium suppositories, as needed, postoperatively after transurethral resection of the prostate (TURP). The nurse should give the client these drugs when he demonstrates signs of:

- 1. A urinary tract infection.
- 2. Urine retention.
- 3. Frequent urination.
- 4. Pain from bladder spasms.

**52.** A nursing assistant tells the nurse, "I think the client is confused. He keeps telling me he has to void, but that isn't possible because he has a catheter in place that is draining well." Which of the following responses would be **most** appropriate for the nurse to make?

- 1. "His catheter is probably plugged. I'll irrigate it in a few minutes."
- 2. "That's a common complaint after prostate surgery. The client only imagines the urge to void."
- 3. "The urge to void is usually created by the large catheter, and he may be having some bladder spasms."
- 4. "I think he may be somewhat confused."

**53.** A physician has ordered amoxicillin 100 P.O. BID (Ampicillin). The nurse should teach the client to: Select all that apply.

- 1. Drink 2,500 mL of fluids daily.
- 2. Void frequently, at least every 2 to 3 hours.
- 3. Take time to empty the bladder completely.
- 4. Take the last dose of the antibiotic for the day at bedtime.
- 5. Take the antibiotic with food.

**54.** In discussing home care with a client after transurethral resection of the prostate (TURP), the nurse should teach the male client that dribbling of urine:

- 1. Can be a chronic problem.
- 2. Can persist for several months.
- 3. Is an abnormal sign that requires intervention.
- 4. Is a sign of healing within the prostate.

**55.** A priority nursing diagnosis for the client who is being discharged to home 3 days after transurethral resection of the prostate (TURP) is:

- 1. *Deficient fluid volume.*
- 2. *Imbalanced nutrition: Less than body requirements.*
- 3. *Impaired tissue integrity.*
- 4. *Ineffective airway clearance.*

- 56.** A client with benign prostatic hypertrophy (BPH) has an elevated prostate-specific antigen (PSA) level. The nurse should?
- 1. Instruct the client to have a colonoscopy before coming to conclusions about the PSA results.
  - 2. Instruct the client that a urologist will monitor the PSA level biannually when elevated.
  - 3. Determine if the prostatic palpation was done before or after the blood sample was drawn.
  - 4. Ask the client if he emptied his bladder before the blood sample was obtained.

### The Client with a Sexually Transmitted Disease

**57.** What is **most** important for the nurse to teach a client newly diagnosed with genital herpes?

- 1. Use condoms at all times during sexual intercourse.
- 2. A urologist should be seen only when lesions occur.
- 3. Oral sex is permissible without a barrier.
- 4. Determine if your partner has received a vaccine against herpes.

**58.** A nurse is planning care for a 25-year-old female client who has just been diagnosed with human immunodeficiency virus (HIV) infection. The client asks the nurse, “How could this have happened?” The nurse responds to the question based on the most frequent mode of HIV transmission, which is:

- 1. Hugging an HIV-positive sexual partner without using barrier precautions.
- 2. Inhaling cocaine.
- 3. Sharing food utensils with an HIV-positive person without proper cleaning of the utensils.
- 4. Having sexual intercourse with an HIV-positive person without using a condom.

**59.** A client with human immunodeficiency virus (HIV) infection is taking zidovudine (AZT). The expected outcome of AZT is to:

- 1. Destroy the virus.
- 2. Enhance the body’s antibody production.
- 3. Slow replication of the virus.
- 4. Neutralize toxins produced by the virus.

**60.** Women who have human papillomavirus (HPV) are at risk for development of:

- 1. Sterility.
- 2. Cervical cancer.
- 3. Uterine fibroid tumors.
- 4. Irregular menses.

**61.** The **primary** reason that a herpes simplex virus (HSV) infection is a serious concern to a client with human immunodeficiency virus (HIV) infection is that it:

- 1. Is an acquired immunodeficiency virus (AIDS)–defining illness.
- 2. Is curable only after 1 year of antiviral therapy.
- 3. Leads to cervical cancer.
- 4. Causes severe electrolyte imbalances.

**62.** In educating a client about human immunodeficiency virus (HIV), the nurse should take into account the fact that the **most** effective method known to control the spread of HIV infection is:

- 1. Premarital serologic screening.
- 2. Prophylactic treatment of exposed people.
- 3. Laboratory screening of pregnant women.
- 4. Ongoing sex education about preventive behaviors.

**63.** A male client with human immunodeficiency virus (HIV) infection becomes depressed and tells the nurse: “I have nothing worth living for now.” Which of the following statements would be the **best** response by the nurse?

- 1. “You are a young person and have a great deal to live for.”
- 2. “You should not be too depressed; we are close to finding a cure for AIDS.”
- 3. “You are right; it is very depressing to have HIV.”
- 4. “Tell me more about how you are feeling about being HIV-positive.”

**64.** The typical chancre of syphilis appears as:

- 1. A grouping of small, tender pimples.
- 2. An elevated wart.
- 3. A painless, moist ulcer.
- 4. An itching, crusted area.

**65.** The nurse is interviewing a client with newly diagnosed syphilis. In order to prevent the spread of the disease, the nurse should focus the interview by:

- 1. Motivating the client to undergo treatment.
- 2. Obtaining a list of the client’s sexual contacts.
- 3. Increasing the client’s knowledge of the disease.
- 4. Reassuring the client that records are confidential.

**66.** Benzathine penicillin G, 2.4 million units I.M., is prescribed as treatment for an adult client with primary syphilis. The nurse should administer the injection in the:

- 1. Deltoid.
- 2. Upper outer quadrant of the buttock.
- 3. Quadriceps lateralis of the thigh.
- 4. Midlateral aspect of the thigh.



**67.** A priority nursing diagnosis for a client with primary syphilis is:

- 1. *Deficient knowledge* related to lack of information about the mode of transmission.
- 2. *Pain* related to cutaneous skin lesions on palms and soles.
- 3. *Ineffective tissue perfusion* related to a bleeding chancre.
- 4. *Disturbed body image* related to alopecia.

**68.** An 18-year-old female college student is seen at the university health center. She undergoes a pelvic examination and is diagnosed with gonorrhea. Which of the following responses by the nurse would be **best** when the client says that she is nervous about the upcoming pelvic examination?

- 1. "Can you tell me more about how you're feeling?"
- 2. "You're not alone. Most women feel uncomfortable about this examination."
- 3. "Do not worry about Dr. Smith. He's a specialist in female problems."
- 4. "We'll do everything we can to avoid embarrassing you."

**69.** When educating a female client with gonorrhea, the nurse should emphasize that for women gonorrhea:

- 1. Is often marked by symptoms of dysuria or vaginal bleeding.
- 2. Does not lead to serious complications.
- 3. Can be treated but not cured.
- 4. May not cause symptoms until serious complications occur.

**70.** Which of the following groups has experienced the **greatest** rise in the incidence of sexually transmitted diseases (STDs) over the past two decades?

- 1. Teenagers.
- 2. Divorced people.
- 3. Young married couples.
- 4. Older adults.

**71.** A 16-year-old sexually active male client comes to the clinic with a complaint of burning on urination and a milky discharge from the urethral meatus. Documentation on the client's chart should include which of the following information? Select all that apply.

- 1. History of unprotected sex (sex without a condom).
- 2. Length of time since symptoms presented.
- 3. History of fever or chills.
- 4. Presence of any enlarged lymph nodes on examination.
- 5. Names and phone numbers of all sexual contacts.
- 6. Allergies to any medications.

**72.** A 19-year-old male client is diagnosed with a chlamydial infection. Azithromycin (Zithromax) 1 g is ordered. The supply of azithromycin is in 250-mg tablets. How many tablets should the nurse administer?

\_\_\_\_\_ tablets.

**73.** A female client with gonorrhea informs the nurse that she has had sexual intercourse with her boyfriend and asks the nurse, "Would he have any symptoms?" The nurse responds that in men the symptoms of gonorrhea include:

- 1. Impotence.
- 2. Scrotal swelling.
- 3. Urine retention.
- 4. Dysuria.

**74.** The nurse assesses the mouth and oral cavity of a client with human immunodeficiency virus (HIV) infection because the **most** common opportunistic infection initially presents as:

- 1. Herpes simplex virus (HSV) lesions on the lips.
- 2. Oral candidiasis.
- 3. Cytomegalovirus (CMV) infection.
- 4. Aphthae on the gingiva.

**75.** The nurse is administering Didanosine (Videx) to a client with HIV. Before administering this medication, the nurse should check which lab test results? Select all that apply.

- 1. Elevated serum creatinine.
- 2. Elevated blood urea nitrogen (BUN).
- 3. Elevated aspartate aminotransferase (AST).
- 4. Elevated alanine aminotransferase (ALT).
- 5. Elevated serum amylase.

**76.** The nurse is caring for a client from Southeast Asia who has HIV/AIDS. The client does not speak or comprehend the English language. What should the nurse do to provide culturally appropriate care?

- 1. Contact the hospital's chaplain.
- 2. Do an Internet search for the Joint United Nations Programme on HIV/AIDS.
- 3. Utilize language-appropriate interpreters.
- 4. Ask a family member to obtain informed consent.

### The Client with Cancer of the Cervix

**77.** The nurse is preparing a 45-year-old female for a vaginal examination. The nurse should place the client in which position?

- 1. Sims position.
- 2. Lithotomy position.
- 3. Genupectoral position.
- 4. Dorsal recumbent position.

**78.** A client asks the nurse to explain the meaning of her abnormal Papanicolaou (Pap) smear result of atypical squamous cells. Which of the following concepts should the nurse include in the response?

- 1. An atypical Pap smear means that abnormal viral cells were found in the smear.
- 2. An atypical Pap smear means that cancer cells were found in the smear.
- 3. A positive Pap smear alone is not very important diagnostically because there are many false-positive results.
- 4. Abnormal cells in a Pap smear may be caused by various conditions that help identify a problem early.

**79.** Which of the following is a risk factor for cervical cancer?

- 1. Sexual experiences with one partner.
- 2. Sedentary lifestyle.
- 3. Obesity.
- 4. Adolescent pregnancy.

**80.** A woman tells the nurse that “there’s been a lot of cancer in my family.” The nurse should instruct the client to report which possible sign of cervical cancer?

- 1. Pain.
- 2. Leg edema.
- 3. Urinary and rectal symptoms.
- 4. Light bleeding or watery vaginal discharge.

**81.** A 30-year-old female client asks the nurse about douching. What information should the nurse include in the teaching plan?

- 1. Douching during menstruation is safe.
- 2. Daily douching will decrease vaginal odor.
- 3. Perfumed douches are recommended to decrease odors.
- 4. Douching removes natural mucus and changes the balance of normal vaginal flora.

**82.** A 28-year-old female without health insurance is receiving treatment for cervical cancer. She is a single parent of two young children and is referred to the social worker. The client states to the nurse, “I feel overwhelmed and beyond help. What can the social worker do to help me?” Which responses by the nurse about the role of the social worker are **most** appropriate? Select all that apply.

- 1. “The social worker is a part of a multidisciplinary team that provides care for clients with cancer.”
- 2. “The social worker can explain federal, state, and not-for-profit resources and programs to you.”
- 3. “Based on your income and family situation, the social worker will help you in applying for various assistance programs.”
- 4. “Your entire family will be included in the treatment plan. Your needs and those of your children will be assessed and determined so that referrals can be made to appropriate resources.”
- 5. “As the client, you will not have choices about the programs and resources you utilize.”

**83.** The husband of a client with cervical cancer says to the nurse, “The doctor told my wife that her cancer is curable. Is he just trying to make us feel better?” Which would be the nurse’s **most** accurate response?

- 1. “When cervical cancer is detected early and treated aggressively, the cure rate is almost 100%.”
- 2. “The 5-year survival rate is about 75%, which makes the odds pretty good.”
- 3. “Saying a cancer is curable means that 50% of all women with the cancer survive at least 5 years.”
- 4. “Cancers of the female reproductive tract tend to be slow-growing and respond well to treatment.”

**84.** A client with suspected cervical cancer is undergoing a colposcopy with conization. The nurse gives instructions to the client about her menstrual periods, emphasizing that:

- 1. Her periods will return to normal after 6 months.
- 2. Her next two or three periods may be heavier and more prolonged than usual.
- 3. Her next two or three periods will be lighter than normal.
- 4. She may skip her next two periods.

**85.** A client with cervical cancer is undergoing internal radium implant therapy. A lead-lined container and a pair of long forceps are kept in the client's hospital room for:

- 1. Disposal of emesis or other bodily secretions.
- 2. Handling of the dislodged radiation source.
- 3. Disposal of the client's eating utensils.
- 4. Storage of the radiation dose.

**86.** The mother of a client who has a radium implant asks why so many nurses are involved in her daughter's care. She states, "The doctor said I can be in the room for up to 2 hours each day, but the nurses say they're restricted to 30 minutes." The nurse explains that this variation is based on the fact that nurses:

- 1. Touch the client, which increases their exposure to radiation.
- 2. Work with many clients and could carry infection to a client receiving radiation therapy, if exposure is prolonged.
- 3. Work with radiation on an ongoing basis, while visitors have infrequent exposure to radiation.
- 4. Are at greater risk from the radiation because they are younger than the mother.

**87.** A priority nursing diagnosis for a client with cervical cancer who has an internal radium implant is:

- 1. *Pain* related to cervical tumor.
- 2. *Anxiety* related to self-care deficit from imposed immobility during radiation.
- 3. *Ineffective health maintenance* related to surgery.
- 4. *Insomnia* related to interruptions by health care personnel.

**88.** A client with human papillomavirus (HPV) infection is being treated by a colposcopy. The client asks the nurse if this procedure is really necessary. The nurse explains that the procedure to treat the warts is important because HPV can lead to:

- 1. Infertility.
- 2. Cervical cancer.
- 3. Pelvic inflammatory disease.
- 4. Rectal cancer.

**89.** Which of the following would be standard nursing care for a client with cervical cancer who has an internal radium implant in place?

- 1. Offer the bedpan every 2 hours.
- 2. Provide perineal care twice daily.
- 3. Check the position of the applicator hourly.
- 4. Offer a low-residue diet.

**90.** The nurse should carefully observe a client with internal radium implants for typical adverse effects associated with radiation therapy to the cervix. These effects include:

- 1. Severe vaginal itching.
- 2. Confusion.
- 3. High fever in the afternoon or evening.
- 4. Nausea and a foul vaginal discharge.

## The Client With Cancer of the Ovaries

**91.** When teaching a client about ovarian cancer, the nurse should include which of the following?

Select all that apply.

- 1. Details about the prognosis.
- 2. Staging and grading of cancer.
- 3. Need for routine colonoscopy beginning at age 30.
- 4. Procedures for diagnosis if there is a pelvic mass.
- 5. Symptoms occur early in the disease process.

**92.** Interdisciplinary management of ovarian cancer includes which of the following? Select all that apply.

- 1. Combination chemotherapy to cure the cancer.
- 2. Bilateral salpingo-oophorectomy to remove diseased organs.
- 3. Radiation therapy to eliminate all cancer cells.
- 4. Referral to social services for supportive care.
- 5. Nutrition therapy for parenteral lipids.

**93.** A client with ovarian cancer asks the nurse, "What is the cause of this cancer?" The **most** accurate response by the nurse is?

- 1. Use of oral contraceptives increases the risk of ovarian cancer.
- 2. Women who have had at least two live births are protected from ovarian cancer.
- 3. There is less chance of developing ovarian cancer when one lives in an industrialized country.
- 4. The risk of developing ovarian cancer is related to environmental, endocrine, and genetic factors.

**94.** The nurse is providing a community presentation about ovarian cancer. Which topic should receive **priority** attention in the lesson plan?

- 1. Ovarian cancer signs and symptoms are often vague until late in development.
- 2. Ovarian cancer should be considered in any woman older than 30 years of age.
- 3. A rigid board-like abdomen is the most common sign.
- 4. Methods for early detection have made a dramatic reduction in the mortality rate due to ovarian cancer.

## The Client Having Gynecological Surgery

**95.** When preparing a client for discharge 2 days after an abdominal hysterectomy, the nurse should instruct the client to avoid which activities until recovery is complete?

- 1. Swimming in a pool treated with chlorine for 6 weeks after surgery.
- 2. Walking at a leisurely pace for 30 minutes at least once a day.
- 3. Driving until the client can push the brake pedal without pain.
- 4. Lifting greater than 2 lb until the abdominal incision has healed.

**96.** A client returned to the recovery room after a dilatation and curettage has the postoperative medication orders shown in the chart. What should the nurse do **next**?

- 1. Ask the client to rate the intensity of her pain on a scale of 1 to 10 and administer the analgesia according to the intensity of the pain.
- 2. Administer the Demerol first because the client had surgery today.
- 3. Administer the Tylenol #3 first, and if it does not relieve the pain in 2 hours, administer the Demerol.
- 4. Administer the Motrin first and if it does not relieve the pain, administer the Demerol.

### Prescriptions

Rx Meperidine (Demerol) 50 mg I.M. every 4 hours for severe pain  
 Acetaminophen (Tylenol #3) P.O. every 4 hours for pain  
 Ibuprofen (Motrin) 800 mg P.O. every 4 hours for pain.

**97.** On the second day following an abdominal hysterectomy, a client reports she has had three brown, loose stools in moderate amount. The morning medications include an order for 100 mg of docusate sodium (Colace) daily. What should the nurse do **next**?

- 1. Administer the Colace according to the physician's order.
- 2. Ask the client if she is having gas pains or hunger.
- 3. Withhold the medication and document withholding the medication on the medical record.
- 4. Administer the Colace and instruct the client to avoid high-fiber foods.

## The Client with Testicular Disease

**98.** A 28-year-old male is diagnosed with acute epididymitis. The nurse should assess the client for:

- 1. Burning and pain on urination.
- 2. Severe tenderness and swelling in the scrotum.
- 3. Foul-smelling ejaculate.
- 4. Foul-smelling urine.

**99.** A 20-year-old client is being treated for epididymitis. Teaching for this client should include the fact that epididymitis is commonly a result of a:

- 1. Virus.
- 2. Parasite.
- 3. Sexually transmitted infection.
- 4. Protozoon.

**100.** When teaching a client to perform testicular self-examination, the nurse explains that the examination should be performed:

- 1. After intercourse.
- 2. At the end of the day.
- 3. After a warm bath or shower.
- 4. After exercise.

**101.** The nurse is assessing a client's testes. Which of the following findings indicate the testes are normal?

- 1. Soft.
- 2. Egg-shaped.
- 3. Spongy.
- 4. Lumpy.

**102.** A client has a testicular nodule that is highly suspicious for testicular cancer. A laboratory test that supports this diagnosis is:

- 1. Decreased alpha fetoprotein (AFP).
- 2. Decreased beta-human chorionic gonadotropin (hCG).
- 3. Increased testosterone.
- 4. Increased AFP.

**103.** Although the cause of testicular cancer is unknown, it is associated with a history of:

- 1. Undescended testes.
- 2. Sexual relations at an early age.
- 3. Seminal vesiculitis.
- 4. Epididymitis.

**104.** Risk factors associated with testicular malignancies include:

- 1. African-American race.
- 2. Residing in a rural area.
- 3. Lower socioeconomic status.
- 4. Age older than 40 years.

**105.** A client with a testicular malignancy undergoes a radical orchiectomy. In the immediate postoperative period the nurse should particularly assess the client for:

- 1. Bladder spasms.
- 2. Urine output.
- 3. Pain.
- 4. Nausea.

**106.** A right orchiectomy is performed on a client with a testicular malignancy. The client expresses concerns regarding his sexuality. The nurse should base the response on the knowledge that the client:

- 1. Is not a candidate for sperm banking.
- 2. Should retain normal sexual drive and function.
- 3. Will be impotent.
- 4. Will have a change in secondary sexual characteristics.

**107.** A client diagnosed with seminomatous testicular cancer expresses fear and questions the nurse about his prognosis. The nurse should base the response on the knowledge that:

- 1. Testicular cancer is almost always fatal.
- 2. Testicular cancer has a cure rate of 90% when diagnosed early.
- 3. Surgery is the treatment of choice for testicular cancer.
- 4. Testicular cancer has a 50% cure rate when diagnosed early.

### The Client with Cancer of the Prostate

**108.** The nurse is developing a program about prostate cancer for a health fair. The nurse should provide information about which of the following topics?

- 1. The Prostate-Specific Antigen (PSA) test is reliable for detecting the presence of prostate cancer.
- 2. For all men, age 50 and older, the American Cancer Society recommends an annual rectal examination.
- 3. Avoid lifting more than 20 lb aids in prevention of prostate cancer.
- 4. Regular sexual activity promotes health of the prostate gland to prevent cancer.

**109.** The nurse is caring for a client who will have a bilateral orchiectomy. The client asks what is involved with this procedure. The nurse's **most** appropriate response would be? "The surgery:

- 1. Removes the entire prostate gland, prostatic capsule, and seminal vesicles."
- 2. Tends to cause urinary incontinence and impotence."
- 3. Freezes prostate tissue, killing cells."
- 4. Results in reduction of the major circulating androgen, testosterone."

**110.** The nurse is teaching a client newly diagnosed with prostate cancer. Which of the following points should be included in the instruction? Select all that apply.

- 1. Prostate cancer is usually multifocal and slow-growing.
- 2. Most prostate cancers are adenocarcinoma.
- 3. The incidence of prostate cancer is higher in African American men, and the onset is earlier.
- 4. A prostate specific antigen (PSA) lab test greater than 4 ng/mg will need to be monitored.
- 5. Cancer cells are detectable in the urine.

**111.** When a client is receiving hormone replacement for prostate cancer, the nurse should do which of the following? Select all that apply.

- 1. Inform the client that increased libido is expected with hormone therapy.
- 2. Reassure the client and his significant other that erectile dysfunction will not occur as a consequence of hormone therapy.
- 3. Provide the client the opportunity to communicate concerns and needs.
- 4. Utilize communication strategies that enable the client to gain some feeling of control.
- 5. Suggest that an appointment be made to see a psychiatrist.

**112.** A client asks the nurse why the prostate specific antigen (PSA) level is determined before the digital rectal examination. The nurse's **best** response is which of the following?

- 1. "It is easier for the client."
- 2. "A prostate examination can possibly decrease the PSA."
- 3. "A prostate examination can possibly increase the PSA."
- 4. "If the PSA is normal, the client will not have to undergo the rectal examination."

**113.** The nurse is performing a digital rectal examination. Which of the following finding is a **key** sign for prostate cancer?

- 1. A hard prostate, localized or diffuse.
- 2. Abdominal pain.
- 3. A boggy, tender prostate.
- 4. A nonindurated prostate.

**114.** A client is undergoing a total prostatectomy for prostate cancer. The client asks questions about his sexual function. The **best** response by the nurse is which of the following?

- 1. "Loss of the prostate gland means that you will be impotent."
- 2. "Loss of the prostate gland means that you will be infertile and there will be no ejaculation. You can still experience the sensations of orgasm."
- 3. "Loss of the prostate gland means that you will have no loss of sexual function and drive."
- 4. "Loss of the prostate gland means that your erectile capability will return immediately after surgery."

**115.** A 65-year-old client has been told by the physician that his prostate cancer was graded at stage IIB. The client inquires if this means he is going to die soon. The **best** response by the nurse is which of the following?

- 1. "Prostate cancer at this stage is very slow growing."
- 2. "Prostate cancer at this stage is very fast growing."
- 3. "Prostate cancer at this stage has spread to the bone."
- 4. "Prostate cancer at this stage is difficult to predict."

**116.** A client with prostate cancer is treated with hormone therapy consisting of diethylstilbestrol (DES; Stilphostrol), 2 mg daily. The nurse should instruct the client to expect to have:

- 1. Tenderness of the scrotum.
- 2. Tenderness of the breasts.
- 3. Loss of pubic hair.
- 4. Decreased blood pressure.

### The Client with Erectile Dysfunction

**117.** The client is taking sildenafil (Viagra) P.O. for erectile dysfunction. The nurse should instruct the client about which of the following?

- 1. Sildenafil (Viagra) may be taken more than one time per day.
- 2. The health care provider should be notified promptly if the client experiences sudden or diminished vision.
- 3. Sildenafil (Viagra) offers protection against some sexually transmitted diseases (STDs).
- 4. Sildenafil (Viagra) does not require sexual stimulation to work.

**118.** A male client complains of impotence. The nurse examines the client's medication regimen and is aware that a contributing factor to impotence could be:

- 1. Aspirin.
- 2. Antihypertensives.
- 3. Nonsteroidal anti-inflammatory drugs.
- 4. Anticoagulants.

**119.** A 65-year-old male client with erectile dysfunction (ED) asks the nurse, "Is all this just in my head? Am I crazy?" The **best** response by the nurse is based on the knowledge that:

- 1. ED is believed to be psychogenic in most cases.
- 2. More than 50% of the cases are attributed to organic causes.
- 3. Evaluation of nocturnal erections does not help differentiate psychogenic or organic causes.
- 4. ED is an uncommon problem among men older than age 65.

**120.** The nurse should teach the client with erectile dysfunction (ED) to alter his lifestyle to:

- 1. Avoid alcohol.
- 2. Follow a low-salt diet.
- 3. Decrease smoking.
- 4. Increase attempts at sexual intercourse.

### Managing Care Quality and Safety

**121.** The nurse is assigning tasks to the unlicensed assistive personnel (UAP) for a client with an abdominal hysterectomy on the first postoperative day. Which of the following can **not** be delegated to the UAP?

- 1. Taking vital signs.
- 2. Recording intake and output.
- 3. Giving perineal care.
- 4. Assessing the incision site.

**122.** The nurse-manager on a gynecologic surgical unit is addressing reports from clients that they have to wait too long on the night shift for their pain medication. Which course of action should the nurse-manager take **first**?

- 1. Change the staffing schedule on nights to include a medication nurse.
- 2. Consult the nursing supervisor.
- 3. Consult the nurses on the evening shift about their evaluation of the night nurses regarding these complaints.
- 4. Complete a quality improvement study with the night nurses to document the waiting times for pain medication and other data, including staffing and client acuity.

**123.** A nurse is reviewing the physician's admitting orders on a 52-year-old client scheduled for a dilatation and curettage. The nurse is unable to decipher the handwriting and determines the medication order reads either metoprolol succinate (Toprol) or topiramate (Topamax). What should the nurse do next?

- 1. Ask the client if she has hypertension.
- 2. Ask the client if she has migraines.
- 3. Call the physician to clarify the order.
- 4. Ask the pharmacist to interpret the order.

**124.** The unlicensed assistive personnel (UAP) reports to the nurse that the client with an abdominal hysterectomy who returned from the recovery room 1 hour earlier has saturated the blue pad with bright red blood. The nurse should:

- 1. Call the surgeon to report the bleeding.
- 2. Ask the UAP to obtain vital signs while the nurse calls the surgeon.
- 3. Ask the UAP to increase the flow of I.V. fluids to prevent shock.
- 4. Assess the client again in 15 minutes before the nurse takes any further action.

**125.** A nurse on the gynecologic surgery unit observes a respiratory therapist (RT) take a medication cup with pills that was sitting in the medication room. What course of action should the nurse take?

- 1. Report the situation to the supervisor of respiratory therapy.
- 2. Tell the RT that you saw her take the pills from the medication room.
- 3. Report the situation to the nursing supervisor.
- 4. Tell the nurse who was administering medications not to leave pills out.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with a Vaginal Infection

**1. 1, 2, 4.** Bacterial vaginosis is a clinical syndrome resulting from the replacement of the normal vaginal *Lactobacillus* species with overgrowth of anaerobic bacteria that cause a cluster of symptoms. Presence of a thick, white, adherent vaginal

discharge with a fishy odor is evidence for bacterial vaginosis, and the client should seek treatment. The client should not douche unless under medical orders because douching can cause bacteria to ascend into the uterus. Bacterial vaginosis is not sexually transmitted, and it does not require treatment of the partner. Vaginal infections commonly require an examination and diagnostic assessment.

🔑 CN: Reduction of risk potential;  
CL: Synthesize

**2. 3.** Douching may disrupt the normal flora of the vaginal lactobacilli and change the pH, which could result in overgrowth of other bacteria. Coffee, intercourse during menses, and tampons are not related to changes in vaginal pH or the incidence of bacterial vaginosis.

🔑 CN: Health promotion and maintenance;  
CL: Apply

**3. 4.** Metronidazole (Flagyl) interacts with alcohol and can cause a serious disulfiram (Antabuse)-type reaction, with severe, prolonged vomiting. The client should not douche unless following a medical order, but douching does not interact with Flagyl. Sexual intercourse and hot tub baths are not known to affect the incidence or treatment of bacterial vaginosis.

🔑 CN: Pharmacological and parenteral therapies;  
CL: Synthesize

**4. 3.** Bacterial vaginosis is the most common vaginal infection in reproductive-age women, and up to 50% of women may be asymptomatic. Bacterial vaginosis is not associated with menarche, menopause, or aging. Bacterial vaginosis is not usually transmitted sexually, and treatment of the male sex partner has not been beneficial in preventing recurrence of bacterial vaginosis.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**5. 1, 2, 4.** According to the Centers for Disease Control and Prevention, the three most common diseases associated with vaginal discharge are candidiasis, bacterial vaginosis, and trichomoniasis. Candidiasis causes a white discharge that results in redness and itching. Bacterial vaginosis causes a thick, white, adherent discharge. Trichomoniasis causes a diffuse, yellow-green discharge and is a sexually transmitted infection. Gonorrhea and syphilis usually do not change vaginal discharge.

🔑 CN: Reduction of risk potential;  
CL: Apply

**6. 1, 2, 3.** Candidiasis is classified by the Centers for Disease Control and Prevention as complicated or uncomplicated. Women with underlying medical conditions, such as uncontrolled diabetes


and HIV infection or cancer-causing immunosuppression, correlate with an increasing severity of candidiasis. Hypertension and asthma are not related to immunosuppression or complicated candidiasis.

 CN: Health promotion and maintenance;  
CL: Analyze

**7. 1.** Antibiotics may decrease the effectiveness of oral contraceptives. The client should be instructed to continue the contraceptives and use a barrier method as a back-up method of birth control until the next menstrual cycle. The client should not stop taking her oral contraceptives and there is no indication for or benefit to taking the antibiotic 2 hours after the contraceptive. There is no incidence of the adverse effects of increased hunger and fluid retention with the interaction of antibiotic therapy and oral contraceptives.

 CN: Pharmacological and parenteral therapies; CL: Create

**8. 4.** Due to the increased risk of pelvic inflammatory disease, candidates for the IUD should be in a monogamous relationship. Smoking and hypertension are not contraindications for an IUD. The frequency of sexual relations will not affect IUD use.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**9. 1.** Fluid losses can occur from vomiting, diarrhea, and fever and can lead to hypovolemic shock. The first nursing action is to treat the hypovolemic shock that accompanies toxic shock, so the I.V. fluids must be administered immediately. The fluid replacement is critical to avoid circulatory collapse. Pain medication and teaching can be implemented later. Antibiotics will be given because TSS is caused by a staphylococcal infection; however, fluid replacement is initiated first to treat life-threatening hypovolemic shock.

 CN: Reduction of risk potential;  
CL: Synthesize

### The Client with Uterine Fibroids


**10. 2.** The best approach for a client who is fearful about having surgery is to allow the client opportunities to express her fears. Open-ended questions should elicit the client's individual and specific fears. This then gives the nurse the opportunity to provide clarification, information, and support and possibly to offer other resources. The other actions are not supportive and deny the client the opportunity to express her feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**11. 1, 2.** A woman with uterine fibroids and dysmenorrhea is at risk for iron deficiency anemia. The hemoglobin and hematocrit indicate the likelihood that the fibroids causing heavy menstrual blood loss have resulted in anemia. A hemoglobin of less than 12 g/dL in women is considered low. The white blood cell count and potassium levels are within normal parameters, and normocytic red blood cells are normal.

 CN: Management of care; CL: Synthesize

**12. 2.** It is a priority that the client knows she will not be able to eat or drink for 8 hours before admission. A client who consumes food and fluid before receiving a general anesthetic is at risk for aspiration, which can lead to aspiration pneumonia, respiratory arrest, and even death. The clothing she should wear to the hospital and the type of medication she will receive are important, but not the priority. Information on exercise and resumption of normal activities can be included in the discharge teaching.

 CN: Basic care and comfort;  
CL: Synthesize

**13. 2.** The client needs to understand that with removal of the uterus she will no longer be able to bear children or have menstrual periods. The surgical procedure should not change her libido or sexual functioning. Research does not support the idea that hysterectomy contributes to depression or weight gain. Research demonstrates that women who have managed health problems for some time before the hysterectomy may actually have a more positive effect, with less worry about their health condition, contraception, or pregnancy.

 CN: Management of care; CL: Apply

#### 14.

4. Prepare a sterile field.

1. Lubricate the catheter adequately with a water-soluble lubricant.

3. Insert the catheter far enough into the bladder to prevent trauma to the urethral tissue.

2. Ensure free flow of urine.

After gathering appropriate supplies, the nurse should prepare a sterile field. After lubricating the catheter adequately with a water-soluble lubricant to minimize trauma to the urethra, the nurse should insert the catheter far enough into the bladder so the retention balloon does not traumatize urethral tissues. Ensuring a free flow of urine prevents infection; improper drainage occurs when tubing is kinked or twisted.


 CN: Safety and infection control; CL: Apply



**15. 2.** Hyperventilation occurs when the client breathes so rapidly and deeply that she exhales excessive amounts of carbon dioxide. A characteristic symptom of hyperventilation is dizziness. To avoid hyperventilation, the nurse should assist the client in the practice of slow, deep breathing in a regular breathing pattern. Dyspnea, blurred vision, and mental confusion are not associated with hyperventilation.

 CN: Physiological adaptation; CL: Apply

**16. 4.** The discomfort associated with gas pains is likely to be relieved when the client ambulates. The gas will be more easily expelled with exercise. The anesthesia, analgesics, and immobility have altered normal peristalsis. Peristalsis will be stimulated by exercise. Offering a hot beverage, providing extra warmth, and applying an abdominal binder are not recommended and could aggravate the discomfort of postoperative gas pains.

 CN: Physiological adaptation;  
CL: Synthesize

**17. 3.** Elevated temperature on the second postoperative day is suggestive of a respiratory tract infection. Respiratory infections most often occur during the first 48 hours after surgery. The client's vital signs should be monitored closely, and abnormalities should be reported to the surgeon. Signs of infection, if present in the wound or urinary tract, are likely to occur later in the postoperative period. There is no indication that the I.V. catheter is the source of infection.

 CN: Physiological adaptation;  
CL: Synthesize

**18. 1.** The client with a possible transient ischemic attack is the only client who has not had surgery and is not immunocompromised. The client with a recent surgery and incision should not be exposed to a client with infection. Clients with cancer or alcoholic cirrhosis are very susceptible to infection, and it would not be safe to expose them to a client with a respiratory infection.

 CN: Management of care; CL: Synthesize

**19. 3.** When a dressing sticks to a wound, it is best to moisten the dressing with sterile normal saline solution and then remove it carefully. Trying to remove a dry dressing is likely to irritate the skin and wound. This may contribute to tension or tearing along the suture line.


 CN: Management of care; CL: Apply

**20. 2.** The social worker will be able to coordinate respite care for the son and other community resources for this family. Home health care would provide care for the client herself, but respite care for the son is the priority need for this family.

Pastoral care provides spiritual care. The volunteer department would not be responsible for coordination of care at the client's home.

 CN: Management of care; CL: Apply

**21. 2.** Assessment is the first step in planning client education. Assessing social support resources is a key aspect of discharge planning that begins when the client is admitted to the hospital. It is imperative to know what assistance and support the client has at home. Assessment includes obtaining data about any family or home responsibilities the client is concerned with during the recovery period. It is within the scope of nursing practice to provide discharge instructions. A social worker is not needed at this time. The nurse should assess the client's needs before determining whether using a video or reading instructions to the client is appropriate.


 CN: Health promotion and maintenance;  
CL: Create

**22. 1, 2, 4.** The average age of menopause is 50 to 52 years, although some variation exists. With menopause, FSH and LH levels increase dramatically. Hot flashes occur in about 80% of women; they can range from mild to very debilitating with disruption of sleep patterns. Depression is not usual during menopause; if symptoms of depression do occur, the nurse should refer the woman to her health care provider. Contraception should be used until menses has ceased for a full year.

 CN: Physiological adaptation; CL: Create

## The Client with Breast Disease

**23. 1.** This complaint warrants the nurse's performing an examination and reporting the results to the physician. Hormone fluctuations do cause breast discomfort, but an examination must be done at this time to assess the breast. Although pain is not common with breast cancer, it can be a symptom. Teaching the client to perform BSE is important, but it is not the priority action in this case.

 CN: Physiological adaptation;  
CL: Synthesize


**24. 3.** It is generally recommended that the breasts be examined during the first week after menstruation. During this time, the breasts are least likely to be tender or swollen because estrogen is at its lowest level. Therefore, the examination will be more comfortable for the client. The examination may also be more accurate because the client is more likely to notice an actual change in her breast that is not simply related to hormonal changes.

 CN: Health promotion and maintenance;  
CL: Apply

**25. 2.** The client needs to become more confident and knowledgeable about the normal feel of the implants and her breast tissue. The best technique is for the nurse to demonstrate breast self-examination (BSE) to the client as the nurse conducts the clinical breast examination. Implant surgery does not exclude the need for monthly BSE. A mammogram is not a substitute for monthly BSE.

 CN: Health promotion and maintenance;  
CL: Synthesize

**26. 2.** The breasts may vary in size before menstruation because of breast engorgement caused by hormonal changes. A woman may then note that her bra fits more tightly than usual. Benign cysts do not cause variation in breast size. A change in breast size that does not follow hormonal changes could warrant further assessment. The breasts normally are about the same size, although some women have one breast slightly larger than the other.

 CN: Health promotion and maintenance;  
CL: Apply

**27. 2.** Advancing age in postmenopausal women has been identified as a risk factor for breast cancer. A 76-year-old client needs monthly breast self-examination and a yearly clinical breast examination and mammogram to comply with the screening schedule. While mammograms are less painful as breast tissue becomes softer, the nurse should advise the woman to have the mammogram. Family history is important, but only about 5% of breast cancers are genetic.


 CN: Health promotion and maintenance;  
CL: Synthesize

**28. 1.** If a client has questions the nurse cannot answer, it is best to delay the signing of the consent until the questions are clarified for the client. The surgeon should be notified, and the appropriate information or collaboration should be provided for the client before she signs the surgical consent. Telling her she should concentrate on recovery first ignores the client's questions and concerns. Frequently the plastic surgeon needs to be consulted at the beginning of the treatment because various surgical decisions depend on the future plans for breast reconstruction.

 CN: Management of care;  
CL: Synthesize

**29. 1.** An important nursing responsibility is preoperative teaching, and the most frequently recommended guide for teaching is to tell the client as much as she wants to know and is able to understand. Delaying discussion of issues about which


the client has concerns is likely to aggravate the situation and cause the client to feel distrust. As a general guide, the client would not ask the question if she were not ready to discuss her situation. The nurse is available to answer the client's questions and concerns and should not delay discussing these with the client.

 CN: Psychosocial adaptation;  
CL: Synthesize


**30. 1.** About half of malignant breast tumors occur in the upper outer quadrant of the breast. For no known reason, cancer appears in the left breast more often than in the right breast. The upper outer quadrants of the breast, and especially the axillary area, should be covered thoroughly in the clinical breast examination and breast self-examination.

 CN: Physiological adaptation;  
CL: Apply

**31. 4.** Atropine sulfate, a cholinergic blocking agent, is given preoperatively to reduce secretions in the mouth and respiratory tract, which assists in maintaining the integrity of the respiratory system during general anesthesia. Atropine is not used to promote muscle relaxation, decrease nausea and vomiting, or decrease pulse and respiratory rates. It causes the pulse to increase.

 CN: Pharmacological and parenteral therapies;  
CL: Evaluate


**32. 3.** The nurse should respond with an open-ended statement that elicits further exploration of the client's feelings. Women with cancer may feel guilt or shame. Previous life decisions, sexuality, and religious beliefs may influence a client's adjustment to a diagnosis of cancer. The nurse should not contradict the client's feelings of punishment or offer advice such as confiding in the husband. A social worker referral may be beneficial in the future, but is not the first response needed to elicit exploration of the client's feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**33. 3.** A drainage tube is placed in the wound after a modified radical mastectomy to help remove accumulated blood and fluid in the area. Removal of the drainage fluids assists in wound healing and is intended to decrease the incidence of hematoma, abscess formation, and infection. Drainage tubes placed in a wound do not decrease intrathoracic pressure, increase collateral lymphatic flow, or prevent adhesion formation.

 CN: Reduction of risk potential;  
CL: Evaluate


**34. 4.** Lymph nodes can be removed from the axillary area when a modified radical mastectomy is done, and each of the nodes is biopsied. To facilitate drainage from the arm on the affected side, the client's arm should be elevated on pillows with her hand higher than her elbow and her elbow higher than her shoulder. A sentinel node biopsy procedure is associated with a decreased risk of lymphedema because fewer nodes are excised.

 CN: Physiological adaptation;  
CL: Synthesize

**35. 2.** Tamoxifen is an antiestrogen drug that has been found to be effective against metastatic breast cancer and to improve the survival rate. The drug causes hot flashes as an adverse effect.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**36. 1.** Giving the client a list of community resources that could provide support and guidance assists the client to maintain her self-image and independence. The support group will include other women who have undergone similar therapies and can offer suggestions for breast products and wigs. Because the client is asking about specific resources, she does not need a referral to a social worker, home health agency, or plastic surgeon.

 CN: Management of care; CL: Synthesize

**37. 1.** A client receiving radiation therapy should avoid lotions, ointments, and anything that may cause irritation to the skin, such as exposure to sunlight, heat, or talcum powder. The area may safely be washed with water if it is done gently and if care is taken not to injure the skin.

 CN: Reduction of risk potential;  
CL: Synthesize

**38. 3.** The most common reaction of the skin to radiation therapy is redness of the surface tissues. Dryness, tanning, and capillary dilation are also common. Atrophy of the skin, pustules, and sloughing of two layers would not be expected and should be reported to the radiologist.

 CN: Reduction of risk potential;  
CL: Apply

**39. 1.** The American Cancer Society's Reach to Recovery is a rehabilitation program for women who have had breast surgery. It is designed to meet their physical, psychological, and emotional needs. The Reach to Recovery program is implemented by women who have had breast cancer themselves. Many women benefit from this peer information and support.

 CN: Psychosocial adaptation; CL: Apply

## The Client with Benign Prostatic Hypertrophy

**40. 1.** The best way to assess for a distended bladder in either a male or female client is to check for a rounded swelling above the pubis. This swelling represents the distended bladder rising above the pubis into the abdominal cavity. Dullness does not indicate a distended bladder. The client might experience tenderness or pressure above the symphysis. No urine discharge is expected; the urine flow is blocked by the enlarged prostate.

 CN: Reduction of risk potential;  
CL: Analyze


**41. 3.** Rapid emptying of an overdistended bladder may cause hypotension and shock due to the sudden change of pressure within the abdominal viscera. Previously, removing no more than 1,000 mL at one time was the standard of practice, but this is no longer thought to be necessary as long as the overdistended bladder is emptied slowly.

 CN: Reduction of risk potential;  
CL: Apply

**42. 2.** Liberal lubrication of the catheter before catheterization of a male reduces friction along the urethra and irritation and trauma to urethral tissues. Because the male urethra is tortuous, a liberal amount of lubrication is advised to ease catheter passage. The female urethra is not tortuous, and, although the catheter should be lubricated before insertion, less lubricant is necessary. Lubrication of the catheter will not decrease spasms. The nurse should use sterile technique to prevent introducing organisms. Crusts will not form immediately. Irrigating the catheter as needed will prevent clot and crust formation.

 CN: Reduction of risk potential;  
CL: Apply

**43. 1.** The primary reason for taping an indwelling catheter to a male client so that the penis is held in a lateral position is to prevent pressure at the penoscrotal angle. Prolonged pressure at the penoscrotal angle can cause a ureterocutaneous fistula.

 CN: Reduction of risk potential;  
CL: Apply

**44. 2.** Research shows that older men tend to believe it is normal to live with some urinary problems. As a result, these men often overlook symptoms and simply attribute them to aging. As part of preventive care for men older than age 40, the yearly physical examination should include palpation of the prostate via rectal examination. Prostate-specific antigen screening also is done annually to determine elevations or increasing trends in


elevations. The nurse should teach male clients the value of early detection and adequate follow-up for the prostate.

 CN: Reduction of risk potential;  
CL: Apply


**45. 1, 2, 4, 5.** Because of the history of benign prostatic hypertrophy (BPH), the nurse should provide privacy and time for the client to void. The nurse should also monitor intake and output, assess the client for urinary retention, and test the urine for hematuria. It is not necessary to catheterize the client.

 CN: Physiological adaptation;  
CL: Synthesize


**46. 2.** Signs and symptoms of prostatic hypertrophy include difficulty starting the flow of urine, urinary frequency and hesitancy, decreased force of the urine stream, interruptions in the urine stream when voiding, and nocturia. The prostate gland surrounds the urethra, and these symptoms are all attributed to obstruction of the urethra resulting from prostatic hypertrophy. Nocturia from incomplete emptying of the bladder is common. Straining and urine retention are usually the symptoms that prompt the client to seek care. Painful urination is generally not a symptom of prostatic hypertrophy.

 CN: Physiological adaptation;  
CL: Analyze

**47. 3.** Ipratropium is a bronchodilator, and its anticholinergic effects can aggravate urine retention. Metformin and buspirone do not affect the urinary system; timolol does not have a systemic effect.

 CN: Pharmacological and parenteral therapies; CL: Apply


**48. 4.** If paralysis of vasomotor nerves in the upper spinal cord occurs when spinal anesthesia is used, the client is likely to develop respiratory paralysis. Artificial ventilation is required until the effects of the anesthesia subside. Seizures, cardiac arrest, and renal shutdown are not likely results of spinal anesthesia.

 CN: Physiological adaptation;  
CL: Analyze


**49. 3.** Terazosin is an antihypertensive drug that is also used in the treatment of BPH. Blood pressure must be monitored to ensure that the client does not develop hypotension, syncope, or orthostatic hypotension. The client should be instructed to change positions slowly. Urine nitrates, white blood cell count, and pulse rate are not affected by terazosin.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**50. 3.** The decision by the surgeon to insert a catheter after TURP or prostatectomy depends on the amount of bleeding that is expected after the procedure. During continuous bladder irrigation after a TURP or prostatectomy, the rate at which the solution enters the bladder should be increased when the drainage becomes brighter red. The color indicates the presence of blood. Increasing the flow of irrigating solution helps flush the catheter well so that clots do not plug it. There would be no reason to increase the flow rate when the return is continuous or when the return appears cloudy and dark yellow. Increasing the flow would be contraindicated when there is no return of urine and irrigating solution.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**51. 4.** Belladonna and opium suppositories are prescribed and administered to reduce bladder spasms that cause pain after TURP. Bladder spasms frequently accompany urologic procedures. Antispasmodics offer relief by eliminating or reducing spasms. Antimicrobial drugs are used to treat an infection. Belladonna and opium do not relieve urine retention or urinary frequency.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**52. 3.** The indwelling urinary catheter creates the urge to void and can also cause bladder spasms. The nurse should ensure adequate bladder emptying by monitoring urine output and characteristics. Urine output should be at least 50 mL/hour. A plugged catheter, imagining the urge to void, and confusion are less likely reasons for the client's complaint.


 CN: Reduction of risk potential;  
CL: Synthesize

**53. 1, 2, 3, 4.** Ampicillin may be given with or without food, but the nurse should instruct the client to obtain an adequate fluid intake (2,500 mL) to promote urinary output and to flush out bacteria from the urinary tract. The nurse should also encourage the client to void frequently (every 2 to 3 hours) and empty the bladder completely. Taking the antibiotic at bedtime, after emptying the bladder, helps to ensure an adequate concentration of the drug during the overnight period.


 CN: Physiological adaptation;  
CL: Synthesize

**54. 2.** Dribbling of urine can occur for several months after TURP. The client should be informed that this is expected and is not an abnormal sign. The nurse should teach the client perineal exercises to strengthen sphincter tone. The client may need to use pads for temporary incontinence. The client

should be reassured that continence will return in a few months and will not be a chronic problem. Dribbling is not a sign of healing, but is related to the trauma of surgery.

 CN: Basic care and comfort;  
CL: Synthesize

**55. 1.** *Deficient fluid volume* is a priority diagnosis because the client needs to drink a large amount of fluids to keep the urine clear. The urine should be almost without color. About 2 weeks after TURP, when desiccated tissue is sloughed out, a secondary hemorrhage could occur. The client should be instructed to call the surgeon or go to the emergency department if at any time the urine turns bright red. The client is not specifically at risk for nutritional problems after TURP. The client is not specifically at risk for impaired tissue integrity because there is no external incision, and the client is not specifically at risk for airway problems because the procedure is done under spinal anesthesia.


 CN: Basic care and comfort; CL: Analyze

**56. 3.** Rectal and prostate examinations can increase serum PSA levels; therefore, instruct the client that a manual rectal examination is usually part of the test regimen to determine prostate changes. The prostatic palpation should be done after the blood sample is drawn. The PSA level must be monitored more often than biannually when it is elevated. Having a colonoscopy is not related to the findings of the PSA test. It is not necessary to void prior to having PSA blood levels tested.

 CN: Health promotion and maintenance;  
CL: Synthesize


### The Client with a Sexually Transmitted Disease

**57. 1.** The client should be taught to abstain from sexual intercourse while lesions are present. Condoms should be used at all times as the virus can be shed without lesions present. Multiple partners would promote the spread of genital herpes. There is not a vaccine available to prevent genital herpes. Although periodic examinations should be advised, a urologist does not necessarily need to be seen when lesions occur.


 CN: Physiological adaptation;  
CL: Synthesize

**58. 4.** HIV infection is transmitted through blood and body fluids, particularly vaginal and seminal fluids. A blood transfusion is one way the disease can be contracted. Other modes of transmission are sexual intercourse with an infected partner and sharing I.V. needles with an infected person. Women

now have the highest rate of newly diagnosed HIV infection. Many of these women have contracted HIV from unprotected sex with male partners. HIV cannot be transmitted by hugging, inhaling cocaine, or sharing utensils.

 CN: Safety and infection control;  
CL: Apply

**59. 3.** Zidovudine (AZT) interferes with replication of HIV and thereby slows progression of HIV infection to acquired immunodeficiency syndrome (AIDS). There is no known cure for HIV infection. Today, clients are not treated with monotherapy but are usually on triple therapy due to a much-improved clinical response. Decreased viral loads with the drug combinations have improved the longevity and quality of life in clients with HIV/AIDS. AZT does not destroy the virus, enhance the body's antibody production, or neutralize toxins produced by the virus.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**60. 2.** Women who have HPV are much more likely to develop cervical cancer than women who have never had the disease. Cervical cancer is now considered a sexually transmitted disease. Regular examinations, including Papanicolaou tests, are recommended to detect and treat cervical cancer at an early stage. HPV does not cause sterility, uterine fibroid tumors, or irregular menses.

 CN: Health promotion and maintenance;  
CL: Analyze

**61. 1.** HSV infection is one of a group of disorders that, when diagnosed in the presence of HIV infection, are considered to be diagnostic for AIDS. Other AIDS-defining illnesses include Kaposi's sarcoma; cytomegalovirus of the liver, spleen, or lymph nodes; and *Pneumocystis carinii* pneumonia. HSV infection is not curable and does not cause severe electrolyte imbalances. Human papillomavirus can lead to cervical cancer.


 CN: Physiological adaptation; CL: Apply

**62. 4.** Education to prevent behaviors that cause HIV transmission is the primary method of controlling HIV infection. Behaviors that place people at risk for HIV infection include unprotected sexual intercourse and sharing of needles for I.V. drug injection. Educating clients about using condoms during sexual relations is a priority in controlling HIV transmission.


 CN: Safety and infection control;  
CL: Apply

**63. 4.** The nurse should respond with a statement that allows the client to express his thoughts and feelings. After sharing feelings about their


diagnosis, clients will need information, support, and community resources. Statements of encouragement or agreement do not provide an opportunity for the client to express himself.

 CN: Psychosocial adaptation;  
CL: Synthesize


**64. 3.** The chancre of syphilis is characteristically a painless, moist ulcer. The serous discharge is very infectious. Because the chancre is usually painless and disappears, the client may not be aware of it or may not seek care. The chancre does not appear as pimples or warts, and does not itch, thus making diagnosis difficult.

 CN: Physiological adaptation;  
CL: Analyze


**65. 2.** An important aspect of controlling the spread of sexually transmitted diseases (STDs) is obtaining a list of the sexual contacts of an infected client. These contacts, in turn, should be encouraged to obtain immediate care. Many people with STDs are reluctant to reveal their sexual contacts, which makes controlling STDs difficult. Increasing clients' knowledge of the disease and reassuring clients that their records are confidential can motivate them to seek treatment, which does help to control the spread of the disease, but it is not as critical as information about the client's sexual contacts.

 CN: Physiological adaptation;  
CL: Synthesize

**66. 2.** Because of the large dose, the upper outer quadrant of the buttocks is the recommended site. The Centers for Disease Control and Prevention recommends benzathine penicillin G 2.4 million units I.M. in a single dose for adults with primary or secondary syphilis who are not allergic to penicillin. The deltoid and the quadriceps lateralis of the thigh are not large enough for the recommended dose. In infants and small children, the midlateral aspect of the thigh may be preferred.


 CN: Pharmacological and parenteral therapies; CL: Apply

**67. 1.** A client with primary syphilis is at risk for transmitting the disease to sexual partners if he or she is not knowledgeable about how the disease is spread. Cutaneous lesions on the palms and soles and alopecia are signs of secondary syphilis. Chancres do not bleed sufficiently to alter tissue perfusion. Chancres often disappear even without treatment.


 CN: Physiological adaptation;  
CL: Analyze

**68. 1.** Asking the client to describe her nervousness gives her the opportunity to express her concerns. It also allows the nurse to understand her

better and gives the nurse a base to respond to the client's stated fears, questions, or need for further information. Responses that make assumptions about the source of the concern or offer reinforcement are not supportive and block successful communication.

 CN: Psychosocial adaptation;  
CL: Synthesize


**69. 4.** Many women do not seek treatment because they are unaware that they have gonorrhea. They may be symptom-free or have only very mild symptoms until the disease progresses to pelvic inflammatory disease. Dysuria and vaginal bleeding are not present in gonorrhea. Gonorrhea can lead to very serious complications. It can be cured with the proper treatment.

 CN: Physiological adaptation;  
CL: Synthesize

**70. 1.** Statistics reveal that the incidence of STDs is rising more rapidly among teenagers than among any other age-group. Many reasons have been given for this trend, including a change in societal mores and increasing sexual activity among teenagers. During this developmental stage, teenagers may engage in high-risk sexual behaviors because they often are living in the present and feel that it won't happen to them.

 CN: Health promotion and maintenance;  
CL: Apply

**71. 1, 2, 3, 4, 6.** The client is suspected of having a sexually transmitted infection. Therefore, the client's sexual history, assessment, and examination must be documented, including symptoms (such as fever, chills, and enlarged glands) and their onset and duration. Allergies are critical to document for every client, but are especially noteworthy in this case because antibiotics will be ordered. If a sexually transmitted infection is confirmed, sexual contacts need to be treated. To protect privacy, the names and phone numbers should never be placed in the chart. The public health department will also assist in obtaining information and treating known sexual contacts.

 CN: Safety and infection control;  
CL: Analyze


#### **72. 4 tablets**

First, convert 1 g to milligrams:


$$1 \text{ g} = 1,000 \text{ mg.}$$

Next, divide the desired dose by the dose on hand:

$$1,000 \text{ mg}/250 \text{ mg} = 4 \text{ tablets.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**73. 4.** Dysuria and a mucopurulent urethral discharge characterize gonorrhea in men. Gonococcal symptoms are so painful and bothersome for men that they usually seek treatment with the onset of symptoms. Impotence, scrotal swelling, and urine retention are not associated with gonorrhea.

 CN: Physiological adaptation;  
CL: Apply

**74. 2.** The most common opportunistic infection in HIV infection initially presents as oral candidiasis, or thrush. The client with HIV should always have an oral assessment. HSV and CMV are opportunistic infections that present later in acquired immunodeficiency syndrome. Aphthous stomatitis, or recurrent canker sores, is not an opportunistic infection, although the sores are thought to occur more often when the client is under stress.

 CN: Health promotion and maintenance;  
CL: Apply

**75. 3, 4, 5.** The nurse should withhold the medication and notify the physician immediately if the client develops manifestations of pancreatitis or hepatic failure including nausea and vomiting, severe abdominal pain, elevated bilirubin, or elevated serum enzymes (e.g., amylase, AST, ALT). If both BUN and creatinine are elevated, the client may have kidney disease.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**76. 3.** Interpreters are essential in enabling the nurses' communications to be understood accurately. The chaplain may not know the client's language. The Joint United Nations Programme on HIV/AIDS has the number of reported cases of AIDS. It is not necessary for the family member to obtain informed consent.

 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Cancer of the Cervix

**77. 2.** Although other positions may be used, the preferred position for a vaginal examination is the lithotomy position. This position offers the best visualization. If the client is elderly and frail, staff members may need to support the client's flexed legs while the examiner conducts the examination and obtains the Papanicolaou smear. Positioning the client in the other positions will make visualization more difficult and may not be as comfortable for the client.

 CN: Health promotion and maintenance;  
CL: Apply


**78. 4.** The Pap smear identifies atypical cervical cells that may be present for various reasons. Cancer is the most common possible cause, but not the only one. The Pap smear does not show abnormal viral cells unless specific gene typing is done for human papillomavirus. An adequate smear provides accurate diagnostic data; the false-positive rate is only about 5%.

 CN: Health promotion and maintenance;  
CL: Apply

**79. 4.** Young age at first pregnancy is a risk factor for cervical cancer. Other risk factors include a family history of the disease, sexual experience with multiple partners, and a history of sexually transmitted disease (e.g., syphilis, human papillomavirus infection, gonorrhea). Cigarette smoking, promiscuous male partner, human immunodeficiency virus infection or other immunosuppression, and low socioeconomic status are other risk factors. Sexual relations with one partner, sedentary lifestyle, and obesity are not risk factors for cervical cancer.

 CN: Health promotion and maintenance;  
CL: Apply

**80. 4.** In its early stages, cancer of the cervix is usually asymptomatic, which underscores the importance of regular Pap smears. A light bleeding or serosanguineous discharge may be apparent as the first noticeable symptom. Pain, leg edema, urinary and rectal symptoms, and weight loss are late signs of cervical cancer.

 CN: Physiological adaptation;  
CL: Apply

**81. 4.** The vagina naturally cleans itself, and douching is not recommended unless it is prescribed by a health care provider for a medical condition. Daily douching could destroy normal flora. Perfumed douches could trigger allergenic responses. Douching should be avoided during menses.

 CN: Reduction of risk potential;  
CL: Synthesize

**82. 1, 2, 3, 4.** The social worker is part of the comprehensive, holistic health care team. Because the client does not have insurance and is a single parent, appropriate government and charity programs and potential resources need to be explained to the client. The needs of the client and the family members are included in the treatment plan. The client will have choices about whether or not she elects to participate in any of the assistance programs.

 CN: Management of care; CL: Apply

**83. 1.** When cervical cancer is detected early and treated aggressively, the cure rate approaches 100%. The incidence of cervical cancer has increased among African Americans, Native Americans, and Latinas, and these women often have a poorer prognosis because the cancer is not identified early. Papanicolaou smears and colposcopy have the potential to decrease mortality from invasive carcinoma when these screening and treatment programs are utilized by women.

 CN: Physiological adaptation;  
CL: Synthesize

**84. 2.** The client should be informed that her next two or three periods could be heavy and prolonged. The client is instructed to report any excessive bleeding. The nurse should reinforce the necessity for the follow-up check and the review of the biopsy results with the client. The client's periods will not be normal for 2 to 3 months.

 CN: Reduction of risk potential;  
CL: Synthesize


**85. 2.** Dislodged radioactive materials should not be touched with bare or gloved hands. Forceps are used to place the material in the lead-lined container, which shields the radiation. Exposure to radiation can occur only by direct exposure to the encased radioactive substance; it cannot result from contact with emesis or urine or from touching the client. Disposal of eating utensils cannot lead to radiation exposure. Radioactive dose materials are kept only in the radiation department.

 CN: Safety and infection control;  
CL: Apply

**86. 3.** The three factors related to radiation safety are time, distance, and shielding. Nurses on radiation oncology units work with radiation frequently and so must limit their contact. Nurses are physically closer to clients than are visitors, who are often asked to sit 6 feet away from the client. Touching the client does not increase the amount of radiation exposure. Aseptic technique and isolation prevent the spread of infection. Age is a risk factor for people in their reproductive years.

 CN: Safety and infection control; CL: Apply


**87. 2.** A client can experience anxiety because she is immobilized on strict bed rest and cannot care for herself while the implant is in place. During an intracavity implant, the woman is kept flat in bed to prevent dislodgment of the radioactive substance. The implant may be left in place for 24 to 72 hours. Usually, the tumor is removed before implant insertion. *Ineffective health maintenance* and *Insomnia* are not priority nursing diagnoses.

 CN: Psychosocial adaptation;  
CL: Analyze


**88. 2.** HPV infection, or genital warts, can lead to dysplastic changes of the cervix, referred to as cervical intraepithelial neoplasia. The development of cervical cancer remains the largest threat of all condyloma-associated neoplasias. Infertility, pelvic inflammatory disease, and rectal cancer are not complications of genital warts.

 CN: Health promotion and maintenance;  
CL: Apply

**89. 4.** Bowel movements can be difficult with the radium applicator in place. The purpose of the low-residue diet is to decrease bowel movements. The bowel is cleaned before therapy, and the woman is maintained on a low-residue diet during treatment to prevent bowel distention and defecation. To prevent dislodgment of the applicator, the client is maintained on strict bed rest and allowed only to turn from side to side. Perineal care is omitted during radium implant therapy, although any vaginal discharge should be reported to the physician. It is rare for the applicator to extrude, so this does not need to be checked every hour.

 CN: Basic care and comfort;  
CL: Synthesize

**90. 4.** Nausea, vomiting, and a foul vaginal discharge are common adverse effects of internal radiation therapy for cervical cancer. A foul-smelling discharge may develop from the destruction and sloughing of cells. Vaginal discharge may persist for some time. General signs and symptoms of radiation syndrome include nausea, vomiting, anorexia, and malaise. Vaginal itching, confusion, and high fever are not typical adverse effects of radiation therapy for cervical cancer.

 CN: Safety and infection control;  
CL: Apply

## The Client With Cancer of the Ovaries

**91. 2, 4.** Client teaching emphasizes the importance of regular gynecologic examinations. If a pelvic mass is found, completely explain the procedures for diagnosis. Explain pre-surgical and post-surgical instructions, and explain the terminology particular to staging and grading of cancer, when appropriate. Refer all questions about the prognosis to the physician. Routine colonoscopies are typically begun at age 50 unless family history warrants otherwise. Ovarian tumors are commonly occult until symptoms of advanced disease are present.


 CN: Health promotion and maintenance;  
CL: Create



**92. 2, 4.** Ovarian cancer is a malignant tumor of the ovary. Ovarian cancer is the fourth most common gynecologic cancer, but the most lethal. It is usually found in advanced stages because it is asymptomatic in early stages. Interdisciplinary management may involve chemotherapy, radiation therapy, surgery and supportive services. Chemotherapy may be used to achieve remission of the disease; it is not, however, curative. Surgery is the treatment of choice, usually involving total hysterectomy with bilateral salpingo-oophorectomy and removal of the omentum. Radiation therapy may be performed for palliative purposes only. The nurse should provide referral to home health services, financial assistance, psychological counseling, clergy, and other social services, as appropriate. Nutrition therapy for par-enteral lipids is not part of management of ovarian cancer.

 CN: Health promotion and maintenance;  
CL: Create

**93. 4.** A definitive cause of carcinoma of the ovary is unknown and the disease is multi-factorial. The risk of developing ovarian cancer is related to environmental, endocrine, and genetic factors. The highest incidence is in industrialized Western countries. Endocrine risk factors for ovarian cancer include women who are nulliparous. Use of oral contraceptives does not increase the risk for developing ovarian cancer, but may actually be protective.

 CN: Health promotion and maintenance;  
CL: Apply

**94. 1.** Ovarian cancer is rarely diagnosed early. Methods for mass screening and early detection have not been successful. Signs and symptoms are often vague until late in development. Ovarian cancer should be considered in any woman older than 40 years of age who has complaints of vague abdominal and/or pelvic discomfort or enlargement, a sense of bloating, or flatulence. Enlargement of the abdomen due to the accumulation of fluid is the most common sign.

 CN: Health promotion and maintenance;  
CL: Synthesize

### The Client Having Gynecological Surgery

**95. 3.** The client should be prepared for what to expect after surgery. The client should not drive until she can use the brake pedal without abdominal pain. The nurse should teach the client to avoid activities that may increase pelvic congestion, such as dancing or brisk walking, for several months, whereas activities, such as swimming and leisurely


walking, may be both physically and mentally helpful. Heavy lifting should be avoided for two months, but the client can lift up to 10 lb as long as there is not tension on the abdomen or abdominal pain.

 CN: Physiological adaptation;  
CL: Synthesize

**96. 1.** The nurse must first assess the intensity of the client's pain before selecting the correct analgesia. A high score would necessitate administering the meperidine (Demerol). If the intensity rating is low, an oral analgesic would be appropriate. If acetaminophen (Tylenol #3) is given without assessing the intensity of the client's pain, the nurse must then wait 4 hours before administering another analgesic.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**97. 3.** The nurse should withhold administering docusate sodium (Colace), a stool softener, and document the rationale on the medical record. The nurse must assess the need for a medication even though it is ordered. Documentation of why the medication was withheld should be written in the medical record. The nurse is responsible for assessing contraindications and adverse effects of medications, and administering the medication when the client already has loose stools is unsafe. The assessment should also include auscultation of bowel sounds and inquiry about gas pains, but the stool softener should still be withheld.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

### The Client with Testicular Disease

**98. 2.** Epididymitis causes acute tenderness and pronounced swelling of the scrotum. Gradual onset of unilateral scrotal pain, urethral discharge, and fever are other key signs. Epididymitis is occasionally, but not routinely, associated with urinary tract infection. Burning and pain on urination and foul-smelling ejaculate or urine are not classic symptoms of epididymitis.


 CN: Physiological adaptation;  
CL: Analyze

**99. 3.** Among men younger than age 35, epididymitis is most frequently caused by a sexually transmitted infection. Causative organisms are usually chlamydia or *Neisseria gonorrhoeae*. The other major form of epididymitis is bacterial, caused by the *Escherichia coli* or *Pseudomonas* organisms. The nurse should always include safe sex teaching for a client with epididymitis. The client should also be

advised against anogenital intercourse because this is a mode of transmission of gram-negative rods to the epididymis.

 CN: Reduction of risk potential;  
CL: Apply


**100. 3.** After a warm bath or shower, the testes hang lower and are both relaxed and in the ideal position for manual evaluation and palpation.

 CN: Health promotion and maintenance;  
CL: Apply


**101. 2.** Normal testes feel smooth, egg-shaped, and firm to the touch, without lumps. The surface should feel smooth and rubbery. The testes should not be soft or spongy to the touch. Testicular malignancies are usually nontender, nonpainful hard lumps. Lumps, swelling, nodules, or signs of inflammation should be reported to the physician.

 CN: Health promotion and maintenance;  
CL: Analyze


**102. 4.** AFP and hCG are considered markers that indicate the presence of testicular disease. Elevated AFP and hCG and decreased testosterone are markers for testicular disease. Measurements of AFP, hCG, and testosterone are also obtained throughout the course of therapy to help measure the effectiveness of treatment.

 CN: Physiological adaptation;  
CL: Apply

**103. 1.** Cryptorchidism (undescended testes) carries a greatly increased risk for testicular cancer. Undescended testes occurs in about 3% of male infants, with an increased incidence in premature infants. Other possible causes of malignancy include chemical carcinogens, trauma, orchitis, and environmental factors. Testicular cancer is not associated with early sexual relations in men, even though cervical cancer is associated with early sexual relations in women. Testicular cancer is not associated with seminal vesiculitis or epididymitis.

 CN: Health promotion and maintenance;  
CL: Apply


**104. 2.** The incidence of testicular cancer is higher in men who live in rural rather than suburban areas. Testicular cancer is more common in white than black men. Men with higher socioeconomic status seem to have a greater incidence of testicular cancer. The exact cause of testicular cancer is unknown. Cancer of the testes is the leading cause of death from cancer in the 15- to 35-year-old age-group.

 CN: Health promotion and maintenance;  
CL: Analyze

**105. 3.** Because of the location of the incision in the high inguinal area, pain is a major problem during the immediate postoperative period. The incisional area and discomfort caused by movement contribute to increased pain. Bladder spasms and elimination problems are more commonly associated with prostate surgery. Nausea is not a priority problem.

 CN: Physiological adaptation;  
CL: Synthesize

**106. 2.** Unilateral orchiectomy alone does not result in impotence if the other testis is normal. The other testis should produce enough testosterone to maintain normal sexual drive, functioning, and characteristics. Sperm banking before treatment is commonly recommended because radiation or chemotherapy can affect fertility.

 CN: Psychosocial adaptation;  
CL: Synthesize

**107. 2.** When diagnosed early and treated aggressively, testicular cancer has a cure rate of about 90%. Treatment of testicular cancer is based on tumor type, and seminoma cancer has the best prognosis. Modes of treatment include combinations of orchiectomy, radiation therapy, and chemotherapy. The chemotherapeutic regimen used currently is responsible for the successful treatment of testicular cancer.

 CN: Physiological adaptation; CL: Apply

## The Client with Cancer of the Prostate

**108. 2.** Most prostate cancer is adenocarcinoma and is palpable on rectal examination because it arises from the posterior portion of the gland. Although the PSA is not a perfect screening test, the American Cancer Society recommends an annual rectal examination and blood PSA level for all men age 50 and older, or starting at age 40 if African American or if there is family history of prostate cancer. To help achieve optimal sexual function, give the client the opportunity to communicate his concerns and sexual needs. Regular sexual activity does not prevent cancer.

 CN: Health promotion and maintenance;  
CL: Synthesize

**109. 4.** Bilateral orchiectomy (removal of testes) results in reduction of the major circulating androgen, testosterone, as a palliative measure to reduce symptoms and progression of prostate cancer. A radical prostatectomy (removal of entire prostate gland, prostatic capsule, and seminal vesicles) may

include pelvic lymphadenectomy. Complications include urinary incontinence, impotence, and rectal injury with the radical prostatectomy. Cryosurgery freezes prostate tissue, killing tumor cells without prostatectomy.

 CN: Health promotion and maintenance;  
CL: Apply

**110. 1, 2, 3, 4.** Cancer of the prostate gland is the second-leading cause of cancer death among American men and is the most common carcinoma in men older than age 65. Incidence of prostate cancer is higher in African American men, and onset is earlier. Most prostate cancers are adenocarcinoma. Prostate cancer is usually multifocal, slow-growing, and can spread by local extension, by lymphatics, or through the bloodstream. Prostate-specific antigen (PSA) greater than 4 ng/mg is diagnostic; a free PSA level can help stratify the risk of elevated PSA levels. Metastatic workup may include skeletal x-ray, bone scan, and CT or MRI to detect local extension, bone, and lymph node involvement. The urine does not have prostate cancer cells.

 CN: Health promotion and maintenance;  
CL: Create

**111. 3, 4.** Hormone manipulation deprives tumor cells of androgens or their by-products and, thereby, alleviates symptoms and retards disease progression. Complications of hormonal manipulation include: hot flashes, nausea and vomiting, gynecomastia, and sexual dysfunction. As part of supportive care, provide explanations of diagnostic tests and treatment options and help the client gain some feeling of control over his disease and decisions related to it. To help achieve optimal sexual function, give the client the opportunity to communicate his concerns and sexual needs. Inform the client that decreased libido is expected after hormonal manipulation therapy, and that impotence may result from some surgical procedures and radiation. A psychiatrist is not needed.

 CN: Psychosocial adaptation;  
CL: Synthesize


**112. 3.** Manipulation of the prostate during the digital rectal examination may falsely increase the PSA levels. The PSA determination and the digital rectal examination are both necessary as screening tools for prostate cancer, and both are recommended for all men older than age 50. Prostate cancer is the most common cancer in men and the second leading killer from cancer among men in the United States. Incidence increases sharply with age, and the disease is predominant in the 60- to 70-year-old age-group.

 CN: Health promotion and maintenance;  
CL: Apply


**113. 1.** On digital rectal examination, key signs of prostate cancer are a hard prostate, induration of the prostate, and an irregular, hard nodule. Accompanying symptoms of prostate cancer can include constipation, weight loss, and lymphadenopathy. Abdominal pain usually does not accompany prostate cancer. A boggy, tender prostate is found with infection (e.g., acute or chronic prostatitis).

 CN: Health promotion and maintenance;  
CL: Analyze


**114. 2.** Loss of the prostate gland interrupts the flow of semen, so there will be no ejaculation fluid. The sensations of orgasm remain intact. The client needs to be advised that return of erectile capability is often disrupted after surgery, but within 1 year 95% of men have returned to normal erectile function with sexual intercourse.

 CN: Physiological adaptation;  
CL: Synthesize

**115. 1.** Clients who have stage IA or IIB prostate cancer have an excellent survival rate. Prostate cancer is usually slow growing, and many men who have prostate cancer do not die from it. A stage I or II tumor is confined to the prostate gland and has not spread to the extrapelvic region or bone.


 CN: Physiological adaptation;  
CL: Synthesize

**116. 2.** Diethylstilbestrol causes engorgement and tenderness of the breasts (gynecomastia). Stilbestrol is prescribed as palliative therapy for men with androgen-dependent prostatic carcinoma. An increase in blood pressure can occur. Tenderness of the scrotum and dramatic changes in secondary sexual characteristics should not occur.

 CN: Pharmacological and parenteral therapies;  
CL: Apply


### The Client with Erectile Dysfunction

**117. 2.** Sildenafil (Viagra) should not be taken more than once per day. Viagra offers no protection against sexually transmitted diseases. Viagra has no effect in the absence of sexual stimulation. The client should notify his health care provider promptly if he experiences sudden or decreased vision loss in one or both eyes.


 CN: Pharmacological and parenteral therapies;  
CL: Synthesize

**118. 2.** Antihypertensives, especially beta blockers such as propranolol (Inderal), can cause impotence. When a male client complains of impotence, the nurse should always examine his medication regimen as a potential contributing factor. Aspirin,

nonsteroidal anti-inflammatory drugs, and anticoagulants do not cause erectile dysfunction.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**119. 2.** ED is multifactorial in origin, and more than 50% of the cases can be attributed to organic causes, which include alteration in vascular supply, hormonal changes, neurologic dysfunction, medications, and associated systemic diseases, such as diabetes mellitus or alcoholism. The presence of nocturnal erections is the first evaluation to differentiate between organic and psychogenic causes. ED is a common problem among men older than age 65.

 CN: Psychosocial adaptation; CL: Apply

**120. 1.** Avoidance of alcohol can improve the outcome of therapy. Alcohol and smoking can affect a man's ability to have and maintain an erection. The client should be encouraged to follow a healthy diet, but no specific diet is associated with improvement of sexual function. The client should cease smoking, not just decrease smoking. Increasing attempts at intercourse without treatment will not facilitate improvement. The client should be reassured that ED is a common problem and that help is available.

 CN: Reduction of risk potential; CL: Synthesize

### Managing Care Quality and Safety

**121. 4.** The registered nurse is responsible for monitoring the surgical site for condition of the dressing, status of the incision, and signs and symptoms of complications. Unlicensed assistive personnel who have been trained to report abnormalities to the registered nurse supervising the care may take vital signs, record intake and output, and give perineal care.


 CN: Management of care; CL: Synthesize

**122. 4.** To determine the cause of this problem, a quality improvement study should be conducted. Before implementing solutions to a complaint, the precise issues in the hospital system must be observed and documented. Consulting with the

evening nurses may result in biased observations because the evening nurses are not conducting care under the same environment as the night nurses. Including a medication nurse is not the first step in understanding the problem and may be an unrealistic or expensive solution. The supervisor is not directly involved with the problem and should only be consulted if the problem cannot be solved by those involved.

 CN: Management of care; CL: Synthesize

**123. 3.** The nurse must clarify this order with the admitting physician to ensure medication accuracy and client safety. In health care settings without computerized medical records or computer prescribing, misinterpretation of handwriting remains a leading cause of medication errors. It is not safe practice to question the client regarding a diagnosis and assume the medication is correctly prescribed. The pharmacist will need clarification of the order as well. It is not the role of the pharmacist to interpret the order.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**124. 2.** The surgeon should be notified when a client who has had an abdominal hysterectomy develops vaginal bleeding that saturates a blue pad in 1 hour, and care should be managed so that other personnel can obtain vital signs while the nurse contacts the surgeon. The client may need to have I.V. fluids increased, but the surgeon needs to be notified first. Waiting 15 minutes while the client is having bright-red bleeding is an unsafe nursing action; the client may lose a large amount of blood.

 CN: Management of care; CL: Synthesize

**125. 3.** The nurse should follow the line of authority or chain of command by reporting the observation immediately to the nursing supervisor. The nurse should not confront the person or the medication nurse because the line of authority for reporting incidents should be followed. The RT supervisor may subsequently be involved in the incident, but the nursing supervisor should initiate and follow the policy and procedure.

 CN: Management of care; CL: Synthesize

TEST  
11

## The Client with Neurologic Health Problems

- The Client with a Head Injury
- The Client with Seizures
- The Client with a Stroke
- The Client with Parkinson's Disease
- The Client with Multiple Sclerosis
- The Unconscious Client
- The Client in Pain
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client with a Head Injury

1. Following a craniotomy, a client has been admitted to the neurologic intensive care unit. The nurse has established a goal to maintain intracranial pressure (ICP) within the normal range. What should the nurse do? Select all that apply.

- 1. Encourage the client to cough and take deep breaths.
- 2. Elevate the head of the bed 15 to 30 degrees.
- 3. Contact the health care provider if ICP is greater than 20 mm Hg.
- 4. Monitor neurologic status using the Glasgow Coma Scale.
- 5. Stimulate the client with active range-of-motion exercises.

2. The nurse is monitoring a client with increased intracranial pressure (ICP). What indicators are the **most** critical for the nurse to monitor? Select all that apply.

- 1. Systolic blood pressure.
- 2. Urine output.
- 3. Breath sounds.
- 4. Cerebral perfusion pressure.
- 5. Level of pain.

3. A nurse is assessing a client with increasing intracranial pressure. What is a client's mean arterial pressure (MAP) in mm Hg when blood pressure (BP) is 120/60 mm Hg?

\_\_\_\_\_ mm Hg.

4. A client with a contusion has been admitted for observation following a motor vehicle accident when he was driving his wife to the hospital to deliver their child. The next morning, instead of asking about his wife and baby, he asked to see the football game on television that he thinks is starting in 5 minutes. He is agitated that the nurse will not turn on the television. What should the nurse do **next**? Select all that apply.

- 1. Find a television so the client can view the football game.
- 2. Determine if the client's pupils are equal and react to light.
- 3. Ask the client if he has a headache.
- 4. Arrange for the client to be with his wife and baby.
- 5. Administer a sedative.

5. An unconscious client with multiple injuries arrives in the emergency department. Which nursing intervention receives the **highest** priority?

- 1. Establishing an airway.
- 2. Replacing blood loss.
- 3. Stopping bleeding from open wounds.
- 4. Checking for a neck fracture.

6. A client is at risk for increased intracranial pressure (ICP). Which of the following would be the **priority** for the nurse to monitor?

- 1. Unequal pupil size.
- 2. Decreasing systolic blood pressure.
- 3. Tachycardia.
- 4. Decreasing body temperature.

**7.** What should the nurse do **first** when a client with a head injury begins to have clear drainage from his nose?

- 1. Compress the nares.
- 2. Tilt the head back.
- 3. Give the client tissues to collect the fluid.
- 4. Administer an antihistamine for postnasal drip.

**8.** Which of the following respiratory patterns indicates increasing intracranial pressure in the brain stem?

- 1. Slow, irregular respirations.
- 2. Rapid, shallow respirations.
- 3. Asymmetric chest excursion.
- 4. Nasal flaring.

**9.** Which of the following nursing interventions is appropriate for a client with an increased intracranial pressure (ICP) of 20 mm Hg?

- 1. Give the client a warming blanket.
- 2. Administer low-dose barbiturates.
- 3. Encourage the client to hyperventilate.
- 4. Restrict fluids.

**10.** The nurse is assessing a client with increasing intracranial pressure (ICP). The nurse should notify the health care provider about which of the following changes in the client's condition?

- 1. Widening pulse pressure.
- 2. Decrease in the pulse rate.
- 3. Dilated, fixed pupils.
- 4. Decrease in level of consciousness (LOC).

**11.** The client has a sustained increased intracranial pressure (ICP) of 20 mm Hg. Which client position would be **most** appropriate?

- 1. The head of the bed elevated 30 to 45 degrees.
- 2. Trendelenburg's position.
- 3. Left Sims position.
- 4. The head elevated on two pillows.

**12.** The nurse administers mannitol (Osmitrol) to the client with increased intracranial pressure. Which parameter requires close monitoring?

- 1. Muscle relaxation.
- 2. Intake and output.
- 3. Widening of the pulse pressure.
- 4. Pupil dilation.

**13.** A client is being admitted with a spinal cord transection at C7. Which of the following assessments take priority upon the client's arrival? Select all that apply.

- 1. Reflexes.
- 2. Bladder function.
- 3. Blood pressure.
- 4. Temperature.
- 5. Respirations.

**14.** The nurse is assessing a client for movement after halo traction placement for a C8 fracture. The nurse should document which of the following?

- 1. The client's shoulders shrug against downward pressure of the examiner's hands.
- 2. The client's arm pulls up from a resting position against resistance.
- 3. The client's arm straightens out from a flexed position against resistance.
- 4. The client's hand-grasp strength is equal.

**15.** Four days after surgery for internal fixation of a C3 to C4 fracture, a nurse is moving a client from the bed to the wheelchair. The nurse is checking the wheelchair for correct features for this client. Which of the following features of the wheelchair are appropriate for the needs of this client? Select all that apply.

- 1. Back at the level of the client's scapula.
- 2. Back and head that are high.
- 3. Seat that is lower than normal.
- 4. Seat with firm cushions.
- 5. Chair controlled by the client's breath.

**16.** A male client with a head injury regains consciousness after several days. Which of the following nursing statements is **most** appropriate as the client awakens?

- 1. "I'll get your family."
- 2. "Can you tell me your name and where you live?"
- 3. "I'll bet you're a little confused right now."
- 4. "You are in the hospital. You were in an accident and unconscious."

**17.** A client who is regaining consciousness after a craniotomy becomes restless and attempts to pull out the I.V. line. Which nursing intervention protects the client without increasing her increased intracranial pressure (ICP)?

- 1. Place her in a jacket restraint.
- 2. Wrap her hands in soft "mitten" restraints.
- 3. Tuck her arms and hands under the drawsheet.
- 4. Apply a wrist restraint to each arm.

**18.** Which activity should the nurse encourage the client to avoid when there is a risk for increased intracranial pressure (ICP)?

- 1. Deep breathing.
- 2. Turning.
- 3. Coughing.
- 4. Passive range-of-motion (ROM) exercises.

**19.** Which of the following is **most** effective in assessing the client suspected of developing diabetes insipidus?

- 1. Taking vital signs every 2 hours.
- 2. Measuring urine output hourly.
- 3. Assessing arterial blood gas values every other day.
- 4. Checking blood glucose levels.

**20.** A client who had a serious head injury with increased intracranial pressure is to be discharged to a rehabilitation facility. Which of the following rehabilitation outcomes would be appropriate for the client? The client will:

- 1. Exhibit no further episodes of short-term memory loss.
- 2. Be able to return to his construction job in 3 weeks.
- 3. Actively participate in the rehabilitation process as appropriate.
- 4. Be emotionally stable and display pre-injury personality traits.

**21.** Which of the following describes decerebrate posturing?

- 1. Internal rotation and adduction of arms with flexion of elbows, wrists, and fingers.
- 2. Back hunched over, rigid flexion of all four extremities with supination of arms and plantar flexion of feet.
- 3. Supination of arms, dorsiflexion of the feet.
- 4. Back arched, rigid extension of all four extremities.

**22.** A client receiving vent-assisted mode ventilation begins to experience cluster breathing after recent intracranial occipital bleeding. The nurse should:

- 1. Count the rate to be sure that ventilations are deep enough to be sufficient.
- 2. Notify the physician of the client's breathing pattern.
- 3. Increase the rate of ventilations.
- 4. Increase the tidal volume on the ventilator.

**23.** In planning the care for a client who has had a posterior fossa (infratentorial) craniotomy, which of the following is **contraindicated** when positioning the client?

- 1. Keeping the client flat on one side or the other.
- 2. Elevating the head of the bed to 30 degrees.
- 3. Logrolling or turning as a unit when turning.
- 4. Keeping the neck in a neutral position.

## The Client with Seizures

**24.** The nurse sees a client walking in the hallway who begins to have a seizure. The nurse should do which of the following in priority order?

1. Maintain a patent airway.

2. Record the seizure activity observed.

3. Ease the client to the floor.

4. Obtain vital signs.

**25.** Which of the following is **contraindicated** for a client with seizure precautions?

- 1. Encouraging him to perform his own personal hygiene.
- 2. Allowing him to wear his own clothing.
- 3. Assessing oral temperature with a glass thermometer.
- 4. Encouraging him to be out of bed.

**26.** Which of the following will the nurse observe in the client in the ictal phase of a generalized tonic-clonic seizure?

- 1. Jerking in one extremity that spreads gradually to adjacent areas.
- 2. Vacant staring and abruptly ceasing all activity.
- 3. Facial grimaces, patting motions, and lip smacking.
- 4. Loss of consciousness, body stiffening, and violent muscle contractions.

**27.** It is the night before a client is to have a computed tomography (CT) scan of the head without contrast. The nurse should tell the client?

- 1. "You must shampoo your hair tonight to remove all oil and dirt."
- 2. "You may drink fluids until midnight, but after that drink nothing until the scan is completed."
- 3. "You will have some hair shaved to attach the small electrode to your scalp."
- 4. "You will need to hold your head very still during the examination."

- 28.** For breakfast on the morning a client is to have an electroencephalogram (EEG), the client is served a soft-boiled egg, toast with butter and marmalade, orange juice, and coffee. Which of the following should the nurse do?
- 1. Remove all the food.
  - 2. Remove the coffee.
  - 3. Remove the toast, butter, and marmalade only.
  - 4. Substitute vegetable juice for the orange juice.

- 29.** A 20-year-old who hit his head while playing football has a tonic-clonic seizure. Upon awakening from the seizure, the client asks the nurse, "What caused me to have a seizure? I've never had one before." Which cause should the nurse include in the response as a **primary** cause of tonic-clonic seizures in adults older than age 20?
- 1. Head trauma.
  - 2. Electrolyte imbalance.
  - 3. Congenital defect.
  - 4. Epilepsy.

- 30.** Which of the following should the nurse include in the teaching plan for a client with seizures who is going home with a prescription for gabapentin (Neurontin)?
- 1. Take all the medication until it is gone.
  - 2. Notify the physician if vision changes occur.
  - 3. Store gabapentin in the refrigerator.
  - 4. Take gabapentin with an antacid to protect against ulcers.

- 31.** What is the **priority** nursing intervention in the postictal phase of a seizure?
- 1. Reorient the client to time, person, and place.
  - 2. Determine the client's level of sleepiness.
  - 3. Assess the client's breathing pattern.
  - 4. Position the client comfortably.

- 32.** Which intervention is **most** effective in minimizing the risk of seizure activity in a client who is undergoing diagnostic studies after having experienced several episodes of seizures?
- 1. Maintain the client on bed rest.
  - 2. Administer butabarbital sodium (phenobarbital) 30 mg P.O., three times per day.
  - 3. Close the door to the room to minimize stimulation.
  - 4. Administer carbamazepine (Tegretol) 200 mg P.O., twice per day.

- 33.** What nursing assessments should be documented at the beginning of the ictal phase of a seizure?
- 1. Heart rate, respirations, pulse oximeter, and blood pressure.
  - 2. Last dose of anticonvulsant and circumstances at the time.
  - 3. Type of visual, auditory, and olfactory aura the client experienced.
  - 4. Movement of the head and eyes and muscle rigidity.

- 34.** The nurse is assessing a client in the postictal phase of generalized tonic-clonic seizure. The nurse should determine if the client has?
- 1. Drowsiness.
  - 2. Inability to move.
  - 3. Paresthesia.
  - 4. Hypotension.

- 35.** When preparing to teach a client about phenytoin sodium (Dilantin) therapy, the nurse should urge the client not to stop the drug suddenly because:
- 1. Physical dependency on the drug develops over time.
  - 2. Status epilepticus may develop.
  - 3. A hypoglycemic reaction develops.
  - 4. Heart block is likely to develop.

- 36.** A client states that she is afraid she will not be able to drive again because of her seizures. Which response by the nurse would be **best**?
- 1. A person with a history of seizures can drive only during daytime hours.
  - 2. A person with evidence that the seizures are under medical control can drive.
  - 3. A person with evidence that seizures occur no more often than every 12 months can drive.
  - 4. A person with a history of seizures can drive if he carries a medical identification card.

- 37.** The nurse is teaching a client to recognize an aura. The nurse should instruct the client to note:
- 1. A postictal state of amnesia.
  - 2. An hallucination that occurs during a seizure.
  - 3. A symptom that occurs just before a seizure.
  - 4. A feeling of relaxation as the seizure begins to subside.

- 38.** Which statement by a client with a seizure disorder taking topiramate (Topamax) indicates the client has understood the nurse's instruction?
- 1. "I will take the medicine before going to bed."
  - 2. "I will drink 6 to 8 glasses of water a day."
  - 3. "I will eat plenty of fresh fruits."
  - 4. "I will take the medicine with a meal or snack."

- 39.** Which clinical manifestation is a typical reaction to long-term phenytoin sodium (Dilantin) therapy?
- 1. Weight gain.
  - 2. Insomnia.
  - 3. Excessive growth of gum tissue.
  - 4. Deteriorating eyesight.

- 40.** A 21-year-old female client takes clonazepam (Klonopin). What should the nurse ask this client about? Select all that apply.
- 1. Seizure activity.
  - 2. Pregnancy status.
  - 3. Alcohol use.
  - 4. Cigarette smoking.
  - 5. Intake of caffeine and sugary drinks.



## The Client with a Stroke

**41.** A client is being monitored for transient ischemic attacks. She is oriented, can open her eyes spontaneously, and follows commands. What is her Glasgow Coma Scale score?

\_\_\_\_\_ points.

**42.** The nurse is teaching a client about taking prophylactic warfarin sodium (Coumadin). Which statement indicates that the client understands how to take the drug? Select all that apply.

- 1. “The drug’s action peaks in 2 hours.”
- 2. “Maximum dosage is not achieved until 3 to 4 days after starting the medication.”
- 3. “Effects of the drug continue for 4 to 5 days after discontinuing the medication.”
- 4. “Protamine sulfate is the antidote for warfarin.”
- 5. “I should have my blood levels tested periodically.”

**43.** Regular oral hygiene is essential for the client who has had a stroke. Which of the following nursing measures is **not** appropriate when providing oral hygiene?

- 1. Placing the client on the back with a small pillow under the head.
- 2. Keeping portable suctioning equipment at the bedside.
- 3. Opening the client’s mouth with a padded tongue blade.
- 4. Cleaning the client’s mouth and teeth with a toothbrush.

**44.** A client arrives in the emergency department with an ischemic stroke and receives tissue plasminogen activator (t-PA) administration. The nurse should **first**:

- 1. Ask what medications the client is taking.
- 2. Complete a history and health assessment.
- 3. Identify the time of onset of the stroke.
- 4. Determine if the client is scheduled for any surgical procedures.

**45.** During the first 24 hours after thrombolytic treatment for an ischemic stroke, the **primary** goal is to control the client’s:

- 1. Pulse.
- 2. Respirations.
- 3. Blood pressure.
- 4. Temperature.

**46.** What is a **priority** nursing assessment in the first 24 hours after admission of the client with a thrombotic stroke?

- 1. Cholesterol level.
- 2. Pupil size and pupillary response.
- 3. Bowel sounds.
- 4. Echocardiogram.

**47.** A client with a hemorrhagic stroke is slightly agitated, heart rate is 118, respirations are 22, bilateral rhonchi are auscultated, SpO<sub>2</sub> is 94%, blood pressure is 144/88, and oral secretions are noted. What order of interventions should the nurse follow when suctioning the client to prevent increased intracranial pressure (ICP) and maintain adequate cerebral perfusion?

1. Suction the airway.

2. Hyperoxygenate.

3. Suction the mouth.

4. Provide sedation.

**48.** In planning care for the client who has had a stroke, the nurse should obtain a history of the client’s functional status before the stroke because?

- 1. The rehabilitation plan will be guided by it.
- 2. Functional status before the stroke will help predict outcomes.
- 3. It will help the client recognize his physical limitations.
- 4. The client can be expected to regain much of his functioning.

**49.** Which of the following techniques does the nurse avoid when changing a client’s position in bed if the client has hemiparesis?

- 1. Rolling the client onto the side.
- 2. Sliding the client to move up in bed.
- 3. Lifting the client when moving the client up in bed.
- 4. Having the client help lift off the bed using a trapeze.

**50.** Which nursing intervention has been found to be the **most** effective means of preventing plantar flexion in a client who has had a stroke with residual paralysis?

- 1. Place the client’s feet against a firm footboard.
- 2. Reposition the client every 2 hours.
- 3. Have the client wear ankle-high tennis shoes at intervals throughout the day.
- 4. Massage the client’s feet and ankles regularly.

**51.** The nurse is planning the care of a hemiplegic client to prevent joint deformities of the arm and hand. Which of the following positions are appropriate?

- 1. Placing a pillow in the axilla so the arm is away from the body.
- 2. Inserting a pillow under the slightly flexed arm so the hand is higher than the elbow.
- 3. Immobilizing the extremity in a sling.
- 4. Positioning a hand cone in the hand so the fingers are barely flexed.
- 5. Keeping the arm at the side using a pillow.

**52.** For the client who is experiencing expressive aphasia, which nursing intervention is **most** helpful in promoting communication?

- 1. Speaking loudly.
- 2. Using a picture board.
- 3. Writing directions so client can read them.
- 4. Speaking in short sentences.

**53.** The nurse is teaching the family of a client with dysphagia about decreasing the risk of aspiration while eating. Which of the following strategies is **not** appropriate?

- 1. Maintaining an upright position.
- 2. Restricting the diet to liquids until swallowing improves.
- 3. Introducing foods on the unaffected side of the mouth.
- 4. Keeping distractions to a minimum.

**54.** Which food-related behaviors are expected in a client who has had a stroke that has left him with homonymous hemianopia?

- 1. Increased preference for foods high in salt.
- 2. Eating food on only half of the plate.
- 3. Forgetting the names of foods.
- 4. Inability to swallow liquids.

**55.** A nurse is teaching a client who had a stroke about ways to adapt to a visual disability. Which does the nurse identify as the **primary** safety precaution to use?

- 1. Wear a patch over one eye.
- 2. Place personal items on the sighted side.
- 3. Lie in bed with the unaffected side toward the door.
- 4. Turn the head from side to side when walking.

**56.** A client is experiencing mood swings after a stroke and often has episodes of tearfulness that are distressing to the family. Which is the **best** technique for the nurse to instruct family members to try when the client experiences a crying episode?

- 1. Sit quietly with the client until the episode is over.
- 2. Ignore the behavior.
- 3. Attempt to divert the client's attention.
- 4. Tell the client that this behavior is unacceptable.

**57.** The client who has had a stroke with residual physical handicaps becomes discouraged by his physical appearance. What approach to the client is **best** for the nurse to use to help the client overcome his negative self-concept? Select all that apply.

- 1. Helpfulness.
- 2. Charity.
- 3. Firmness.
- 4. Encouragement.
- 5. Patience.

**58.** When communicating with a client who has aphasia, which of the following nursing interventions is **not** appropriate?

- 1. Present one thought at a time.
- 2. Encourage the client not to write messages.
- 3. Speak with normal volume.
- 4. Make use of gestures.

**59.** What is the expected outcome of thrombolytic drug therapy for stroke?

- 1. Increased vascular permeability.
- 2. Vasoconstriction.
- 3. Dissolved emboli.
- 4. Prevention of hemorrhage.

## The Client with Parkinson's Disease

**60.** A health care provider has ordered carbidopa-levodopa (Sinemet) four times per day for a client with Parkinson's disease. The client states that he wants "to end it all now that the Parkinson's disease has progressed." What should the nurse do? Select all that apply.

- 1. Explain that the new prescription for Sinemet will treat his depression.
- 2. Encourage the client to discuss his feelings as the Sinemet is being administered.
- 3. Contact the health care provider before administering the Sinemet.
- 4. Determine if the client is on antidepressants or monoamine oxidase (MAO) inhibitors.
- 5. Determine if the client is at risk for suicide.

**61.** Which of the following is an initial sign of Parkinson's disease?

- 1. Rigidity.
- 2. Tremor.
- 3. Bradykinesia.
- 4. Akinesia.

**62.** The nurse develops a teaching plan for a client newly diagnosed with Parkinson's disease. Which of the following topics that the nurse plans to discuss is the **most** important?

- 1. Maintaining a balanced nutritional diet.
- 2. Enhancing the immune system.
- 3. Maintaining a safe environment.
- 4. Engaging in diversional activity.

**63.** The nurse observes that a client's upper arm tremors disappear as he unbuttons his shirt. Which statement **best** guides the nurse's analysis of this observation about the client's tremors?

- 1. The tremors are probably psychological and can be controlled at will.
- 2. The tremors sometimes disappear with purposeful and voluntary movements.
- 3. The tremors disappear when the client's attention is diverted by some activity.
- 4. There is no explanation for the observation; it is probably a chance occurrence.

**64.** At what time of day should the nurse encourage a client with Parkinson's disease to schedule the most demanding physical activities to minimize the effects of hypokinesia?

- 1. Early in the morning, when the client's energy level is high.
- 2. To coincide with the peak action of drug therapy.
- 3. Immediately after a rest period.
- 4. When family members will be available.

**65.** Which goal is the **most** realistic and appropriate for a client diagnosed with Parkinson's disease?

- 1. To cure the disease.
- 2. To stop progression of the disease.
- 3. To begin preparations for terminal care.
- 4. To maintain optimal body function.

**66.** What is the **primary** goal collaboratively established by the client with Parkinson's disease, nurse, and physical therapist?

- 1. To maintain joint flexibility.
- 2. To build muscle strength.
- 3. To improve muscle endurance.
- 4. To reduce ataxia.

**67.** A client with Parkinson's disease is prescribed levodopa (L-dopa) therapy. Improvement in which of the following indicates effective therapy?

- 1. Mood.
- 2. Muscle rigidity.
- 3. Appetite.
- 4. Alertness.

**68.** A client is being switched from levodopa (L-dopa) to carbidopa-levodopa (Sinemet). The nurse should monitor for which of the following possible complications during medication changes and dosage adjustment?

- 1. Euphoria.
- 2. Jaundice.
- 3. Vital sign fluctuation.
- 4. Signs and symptoms of diabetes.

**69.** A new medication regimen is ordered for a client with Parkinson's disease. At which time should the nurse make certain that the medication is taken?

- 1. At bedtime.
- 2. All at one time.
- 3. Two hours before mealtime.
- 4. At the time scheduled.

**70.** A client with Parkinson's disease needs a long time to complete her morning hygiene, but she becomes annoyed when the nurse offers assistance and refuses all help. Which action is the nurse's **best** initial response in this situation?

- 1. Tell the client firmly that she needs assistance and help her with her care.
- 2. Praise the client for her desire to be independent and give her extra time and encouragement.
- 3. Tell the client that she is being unrealistic about her abilities and must accept the fact that she needs help.
- 4. Suggest to the client that if she insists on self-care, she should at least modify her routine.

**71.** A client with Parkinson's disease asks the nurse to explain to his nephew "what the doctor said the pallidotomy would do." The nurse's **best** response includes stating that the main goal for the client after pallidotomy is improved:

- 1. Functional ability.
- 2. Emotional stress.
- 3. Alertness.
- 4. Appetite.

## The Client with Multiple Sclerosis

**72.** The nurse is reviewing the care plan of a client with Multiple Sclerosis. Which of the following nursing diagnoses should receive further validation?

- 1. Impaired mobility related to spasticity and fatigue.
- 2. Risk for falls related to muscle weakness and sensory loss.
- 3. Risk for seizures related to muscle tremors and loss of myelin.
- 4. Impaired skin integrity related bowel and bladder incontinence.

**73.** The nurse is teaching a client with bladder dysfunction from multiple sclerosis (MS) about bladder training at home. Which instructions should the nurse include in the teaching plan? Select all that apply.

- 1. Restrict fluids to 1,000 mL/24 hours.
- 2. Drink 400 to 500 mL with each meal.
- 3. Drink fluids midmorning, midafternoon, and late afternoon.
- 4. Attempt to void at least every 2 hours.
- 5. Use intermittent catheterization as needed.

**74.** Which of the following is **not** a typical clinical manifestation of multiple sclerosis (MS)?

- 1. Double vision.
- 2. Sudden bursts of energy.
- 3. Weakness in the extremities.
- 4. Muscle tremors.

**75.** A client with multiple sclerosis (MS) is receiving baclofen (Lioresal). The nurse determines that the drug is effective when it achieves which of the following?

- 1. Induces sleep.
- 2. Stimulates the client's appetite.
- 3. Relieves muscular spasticity.
- 4. Reduces the urine bacterial count.

**76.** A client has had multiple sclerosis (MS) for 15 years and has received various drug therapies. What is the **primary** reason why the nurse has found it difficult to evaluate the effectiveness of the drugs that the client has used?

- 1. The client exhibits intolerance to many drugs.
- 2. The client experiences spontaneous remissions from time to time.
- 3. The client requires multiple drugs simultaneously.
- 4. The client endures long periods of exacerbation before the illness responds to a particular drug.

**77.** When the nurse talks with a client with multiple sclerosis who has slurred speech, which nursing intervention is **contraindicated**?

- 1. Encouraging the client to speak slowly.
- 2. Encouraging the client to speak distinctly.
- 3. Asking the client to repeat indistinguishable words.
- 4. Asking the client to speak louder when tired.

**78.** The right hand of a client with multiple sclerosis trembles severely whenever she attempts a voluntary action. She spills her coffee twice at lunch and cannot get her dress fastened securely. Which is the **best** legal documentation in nurses' notes of the chart for this client assessment?

- 1. "Has an intention tremor of the right hand."
- 2. "Right-hand tremor worsens with purposeful acts."
- 3. "Needs assistance with dressing and eating due to severe trembling and clumsiness."
- 4. "Slight shaking of right hand increases to severe tremor when client tries to button her clothes or drink from a cup."

**79.** A client with multiple sclerosis (MS) is experiencing bowel incontinence and is starting a bowel retraining program. Which strategy is inappropriate?

- 1. Eating a diet high in fiber.
- 2. Setting a regular time for elimination.
- 3. Using an elevated toilet seat.
- 4. Limiting fluid intake to 1,000 mL/day.

**80.** Which of the following is **not** a realistic outcome to establish with a client who has multiple sclerosis (MS)? The client will:

- 1. Develop joint mobility.
- 2. Develop muscle strength.
- 3. Develop cognition.
- 4. Develop mood elevation.

**81.** The nurse is preparing a client with multiple sclerosis (MS) for discharge from the hospital to home. The nurse should tell the client:

- 1. "You will need to accept the necessity for a quiet and inactive lifestyle."
- 2. "Keep active, use stress reduction strategies, and avoid fatigue."
- 3. "Follow good health habits to change the course of the disease."
- 4. "Practice using the mechanical aids that you will need when future disabilities arise."

**82.** Which of the following should the nurse include in the discharge plan for a client with multiple sclerosis who has an impaired peripheral sensation? Select all that apply.

- 1. Carefully test the temperature of bath water.
- 2. Avoid kitchen activities because of the risk of injury.
- 3. Avoid hot water bottles and heating pads.
- 4. Inspect the skin daily for injury or pressure points.
- 5. Wear warm clothing when outside in cold temperatures.

**83.** Which intervention should the nurse suggest to help a client with multiple sclerosis avoid episodes of urinary incontinence?

- 1. Limit fluid intake to 1,000 mL/day.
- 2. Insert an indwelling urinary catheter.
- 3. Establish a regular voiding schedule.
- 4. Administer prophylactic antibiotics, as ordered.

**84.** A client with multiple sclerosis (MS) lives with her daughter and 3-year-old granddaughter. The daughter asks the nurse what she can do at home to help her mother. Which of the following measures would be **most** beneficial?

- 1. Psychotherapy.
- 2. Regular exercise.
- 3. Day care for the granddaughter.
- 4. Weekly visits by another person with MS.

## The Unconscious Client

**85.** A client is brought to the emergency department unconscious. An empty bottle of aspirin was found in his car, and a drug overdose is suspected. Which of the following medications should the nurse have available for further emergency treatment?

- 1. Vitamin K.
- 2. Dextrose 50%.
- 3. Activated charcoal powder.
- 4. Sodium thiosulfate.

**86.** Which clinical manifestations should the nurse expect to assess in a client diagnosed with an overdose of a cholinergic agent? Select all that apply.

- 1. Dry mucous membranes.
- 2. Urinary incontinence.
- 3. Central nervous system (CNS) depression.
- 4. Seizures.
- 5. Skin rash.

**87.** The wife and sister of a client who had attempted suicide with an overdose are distraught about his comatose condition and the possibility that he took an intentional drug overdose. Which of the following would be an appropriate initial nursing intervention with this family?

- 1. Explain that because the client was found on hospital property, he was probably asking for help and did not intentionally overdose.
- 2. Give the wife and sister a big hug and assure them that the client is in good hands.
- 3. Encourage the wife and sister to express their feelings and concerns, and listen carefully.
- 4. Allow the wife and sister to help care for the client by rubbing his back when he is turned.

**88.** Which of the following is a **priority** during the first 24 hours of hospitalization for a comatose client with suspected drug overdose?

- 1. Educate regarding drug abuse.
- 2. Minimize pain.
- 3. Maintain intact skin.
- 4. Increase caloric intake.

**89.** An unconscious intubated client does not have increased intracranial pressure. Which nursing intervention would be essential?

- 1. Monitoring the oral temperature, keep the room temperature at 70° F (21.1° C), and place the client on a cooling blanket if the client's temperature is higher than 101° F (38.3° C).
- 2. Cleaning the mouth carefully, applying a thin coat of petroleum jelly, and moving the endotracheal tube to the opposite side daily.
- 3. Positioning the client in the supine position with the head to the side and slightly elevated on two pillows.
- 4. Turning the client with a drawsheet and placing a pillow behind the back and one between the legs.

**90.** The client is to be placed in a right side-lying position. The nurse should intervene when observing a client in which of the following positions?

- 1. The head is placed on a small pillow.
- 2. The right leg is extended without pillow support.
- 3. The left arm is rested on the mattress with the elbow flexed.
- 4. The left leg is supported on a pillow with the knee flexed.

**91.** The nursing team has been performing passive range-of-motion (ROM) exercises on an unconscious client? Which of the following indicate the exercises have been successful?

- 1. Preservation of muscle mass.
- 2. Prevention of bone demineralization.
- 3. Increase in muscle tone.
- 4. Maintenance of joint mobility.

**92.** When the nurse performs oral hygiene for an unconscious client, which nursing intervention is the **priority**?

- 1. Keep a suction machine available.
- 2. Place the client in a prone position.
- 3. Wear sterile gloves while brushing the client's teeth.
- 4. Use gauze wrapped around the fingers to clean the client's gums.

**93.** The nurse observes that the right eye of an unconscious client does not close completely. Which nursing intervention is **most** appropriate?

- 1. Have the client wear eyeglasses at all times.
- 2. Lightly tape the eyelid shut.
- 3. Instill artificial tears once every shift.
- 4. Clean the eyelid with a washcloth every shift.

**94.** Which sign is an early indicator of hypoxia in the unconscious client?

- 1. Cyanosis.
- 2. Decreased respirations.
- 3. Restlessness.
- 4. Hypotension.

**95.** When administering intermittent enteral feeding to an unconscious client, the nurse should:

- 1. Heat the formula in a microwave.
- 2. Place the client in a semi-Fowler's position.
- 3. Obtain a sterile gavage bag and tubing.
- 4. Weigh the client before administering the feeding.

**96.** The client is to receive 200 mL of tube feeding every 4 hours. The nurse checks for the client's gastric residual before administering the next scheduled feeding and obtains 40 mL of gastric residual. The nurse should:

- 1. Withhold the tube feeding and notify the physician.
- 2. Dispose of the residual and continue with the feeding.
- 3. Delay feeding the client for 1 hour and then recheck the residual.
- 4. Readminister the residual to the client and continue with the feeding.

**97.** Of the following nursing interventions for catheter care, which should have the **highest** priority?

- 1. Cleaning the area around the urethral meatus.
- 2. Clamping the catheter periodically to maintain muscle tone.
- 3. Irrigating the catheter with several ounces of normal saline solution.
- 4. Changing the location where the catheter is taped to the client's leg.

**98.** A client has been pronounced brain dead. Which findings should the nurse document? Select all that apply.

- 1. Decerebrate posturing.
- 2. Nonreactive dilated pupils.
- 3. Deep tendon reflexes.
- 4. Absent corneal reflex.
- 5. Blink reflex.

### The Client in Pain

**99.** The physician orders Morphine Sulfate 2-4 mg IV push every 2 hours prn pain for a client who has postoperative pain following abdominal surgery. Prior to performing an abdominal dressing change with packing at 10 AM, the nurse assesses the client's pain level as 1 on a scale of 0 = no pain to 10 = the worst pain. The client is awake and oriented and vital signs are within normal limits. The nurse reviews the pain medication record (see chart). The nurse should:

- 1. Perform the dressing change.
- 2. Administer Morphine 2 mg IV before the dressing change.
- 3. Administer Morphine 4 mg IV after the dressing change.
- 4. Call the physician for a new medication order.

#### Medication Record

Time	Pain Level	Intervention
7 AM	8	Morphine 4 mg IV
9 AM	4	Morphine 2 mg IV
10 AM	1	

**100.** A 34-year-old Chinese man is admitted with multiple injuries from a motor vehicle accident. He complains of severe pain and requests frequent medication. One of the assistive nursing personnel expresses surprise, saying, "I thought Asian people were very stoic about pain." Which is the nurse's **best** response about pain?

- 1. Expression and perception of pain vary widely from person to person.
- 2. Tolerance of pain is the same in all people.
- 3. Tolerance of pain is determined by a person's genetic makeup.
- 4. Pain perception is the same in all people.

**101.** The nurse finds it difficult to relieve a client's pain satisfactorily. Which of the following measures should the nurse take **next** when continuing efforts to promote comfort?

- 1. Improve the nurse-client relationship.
- 2. Enlist the help of the client's family.
- 3. Allow the client additional time to work through his or her own responses to pain.
- 4. Arrange to have the client share a room with a client who has little pain.

**102.** The client's physician decides to change the analgesia medication from meperidine hydrochloride (Demerol) 75 mg I.M. every 4 hours as needed to meperidine hydrochloride by the oral route. What dosage of oral meperidine is required to provide an equivalent analgesic dose?

- 1. 25 to 50 mg.
- 2. 75 to 100 mg.
- 3. 125 to 150 mg.
- 4. 250 to 300 mg.

**103.** After administering meperidine hydrochloride (Demerol), the nurse determines its effectiveness as an analgesic was related to its ability to:

- 1. Reduce the perception of pain.
- 2. Decrease the sensitivity of pain receptors.
- 3. Interfere with pain impulses traveling along sensory nerve fibers.
- 4. Block the conduction of pain impulses along the central nervous system.

**104.** A client is arousing from a coma and keeps saying, "Just stop the pain." The nurse responds based on the knowledge that the human body typically and automatically responds to pain first with attempts to:

- 1. Tolerate the pain.
- 2. Decrease the perception of pain.
- 3. Escape the source of pain.
- 4. Divert attention from the source of pain.

**105.** Ergotamine tartrate (Gynergen) is prescribed for a client's migraine headaches. The client's report of which of the following indicates effectiveness?

- 1. Prevention of the migraine.
- 2. Reduced severity of the developing migraine.
- 3. Relief from the sleeplessness experienced in the past after a migraine.
- 4. Relief from the vision problems experienced in the past after a migraine.

**106.** The nurse explains to the client with pain that the purpose of biofeedback is to enable him to exert control over his physiologic processes by:

- 1. Regulating the body processes through electrical control.
- 2. Shocking himself when an undesirable response is elicited.
- 3. Monitoring the body processes for the therapist to interpret.
- 4. Translating the signals of his body processes into observable forms.

**107.** The nurse explains to the client that the **main** reason a back rub is used as therapy to relieve pain is because the massage:

- 1. Blocks pain impulses from the spinal cord to the brain.
- 2. Blocks pain impulses from the brain to the spinal cord.
- 3. Stimulates the release of endorphins.
- 4. Distracts the client's focus on the source of the pain.

**108.** Nursing responsibilities for the client with a patient-controlled analgesia (PCA) system should include:

- 1. Reassuring the client that pain will be relieved.
- 2. Documenting the client's response to pain medication on a routine basis.
- 3. Instructing the client to continue pressing the system's button whenever pain occurs.
- 4. Titrating the client's pain medication until the client is free from pain.

**109.** A client has an epidural catheter inserted for postoperative pain management. The client rates his pain at 4 on a 0-to-5 pain scale. What should the nurse do **first**?

- 1. Check the patient-controlled analgesia (PCA) pump function.
- 2. Adjust the epidural catheter.
- 3. Assess vital signs.
- 4. Notify the physician.

**110.** The nurse using healing touch affects a client's pain **primarily** through:

- 1. Energy fields.
- 2. Touch therapy.
- 3. Massage.
- 4. Hypnosis.

## Managing Care Quality and Safety

**111.** A nursing assistant is providing care to a client with left-sided paralysis. Which of the following actions by the nursing assistant requires the nurse to provide further instruction?

- 1. Providing passive range of motion exercises to the left extremities during the bed bath.
- 2. Elevating the foot of the bed to reduce edema.
- 3. Pulling up the client under the left shoulder when getting out of bed to a chair.
- 4. Putting high top tennis shoes on the client after bathing.

**112.** The nurse notices that a client with Parkinson's disease is coughing frequently when eating. Which one of the following interventions should the nurse consider?

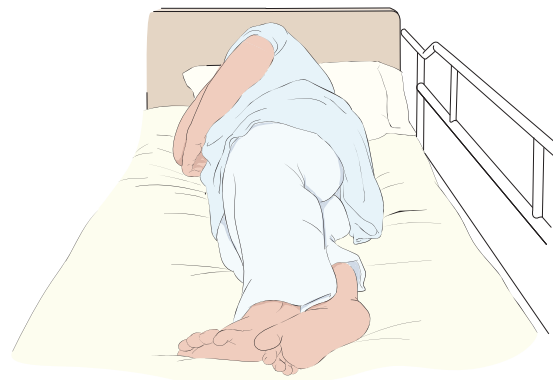
- 1. Have the client hyperextend the neck when swallowing.
- 2. Tell the client to place the chin firmly against the chest when eating.
- 3. Thicken all liquids before offering to the client.
- 4. Place the client on a clear liquid diet.

**113.** The nurse has asked the nursing assistant to ambulate a client with Parkinson's disease. The nurse observes the nursing assistant pulling on the client's arms to get the client to walk forward. The nurse should:

- 1. Have the nursing assistant keep a steady pull on the client to promote forward ambulation.
- 2. Explain how to overcome a freezing gait by telling the client to march in place.
- 3. Assist the nursing assistant with getting the client back in bed.
- 4. Give the client a muscle relaxant.

**114.** Which pressure point area(s) should the nurse monitor for an unconscious client positioned on the left side (see figure)? Choose all that apply.


- 1. Ankles.
- 2. Ear.
- 3. Greater trochanter.
- 4. Heels.
- 5. Occiput.
- 6. Sacrum.
- 7. Shoulder.



**115.** The nurse ascertains that there is a discrepancy in the records of use of a controlled substance for a client who is taking large doses of narcotic pain medication. The nurse should do which of the following **next**?

- 1. Notify the Drug Enforcement Agency (DEA).
- 2. Contact the Director of Quality and Risk Management/Legal Department.
- 3. Notify the pharmacy technician who delivered the controlled substance.
- 4. Notify the nursing supervisor of the clinical unit.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question.

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

### The Client with a Head Injury

**1, 2, 3, 4.** The nurse should maintain ICP by elevating the head of the bed and monitoring neurologic status. An ICP greater than 20 mm Hg indicates increased ICP, and the nurse should notify the health care provider. Coughing and range-of-motion exercises will increase ICP and should be avoided in the early postoperative stage.

 CN: Physiological adaptation;  
CL: Synthesize

**2, 1, 4.** The nurse must monitor the systolic and diastolic blood pressure to obtain the mean arterial pressure (MAP), which represents the pressure needed for each cardiac cycle to perfuse the brain. The nurse must also monitor the cerebral perfusion pressure (CPP), which is obtained from the ICP and the MAP. The nurse should also monitor urine output, respirations, and pain; however, crucial measurements needed to maintain CPP are ICP and MAP. When ICP equals MAP, there is no CPP.

 CN: Management of care;  
CL: Analyze

### 3. 80 mm Hg

To obtain the MAP, use this formula:

$$\text{MAP} = [\text{systolic BP} + (2 \times \text{diastolic BP})] \div 3$$

$$\text{MAP} = [120 + (2 \times 60)] \div 3$$


$$\text{MAP} = 240 \div 3 = 80.$$

 CN: Management of care; CL: Apply

**4, 2, 3.** The nurse should determine if the client's pupils are equal and react to light, and ask the client if he has a headache. Confusion, agitation, and restlessness are subtle clinical manifestations of increased intracranial pressure (ICP). At this time, it is not appropriate for the nurse to find a television or arrange for the client to see his wife and baby. Administering a sedative at this time will obscure assessment of increased ICP.

 CN: Management of care; CL: Synthesize

**5, 1.** The highest priority for a client with multiple injuries is to establish an open airway for effective ventilation and oxygenation. Unless the client has a patent airway, other care measures will be futile. Replacing blood loss, stopping bleeding from open wounds, and checking for a neck fracture are important nursing interventions to be completed after the airway and ventilation are established.

 CN: Safety and infection control;  
CL: Synthesize

**6, 1.** Increasing ICP causes unequal pupils as a result of pressure on the third cranial nerve. Increasing ICP causes an increase in the systolic pressure, which reflects the additional pressure needed to perfuse the brain. It increases the pressure on the vagus nerve, which produces bradycardia, and it causes an increase in body temperature from hypothalamic damage.


 CN: Reduction of risk potential;  
CL: Analyze

**7, 3.** The clear drainage must be analyzed to determine whether it is nasal drainage or cerebrospinal fluid (CSF). The nurse should not give the client tissues because it is important to know how much leakage of CSF is occurring. Compressing the nares will obstruct the drainage flow. It is inappropriate to tilt the head back, which would allow the fluid to drain down the throat and not be collected for a sample. It is inappropriate to administer an antihistamine because the drainage may not be from postnasal drip.


 CN: Reduction of risk potential;  
CL: Synthesize




**8. 1.** Neural control of respiration takes place in the brain stem. Deterioration and pressure produce irregular respiratory patterns. Rapid, shallow respirations, asymmetric chest movements, and nasal flaring are more characteristic of respiratory distress or hypoxia.

 CN: Physiological adaptation;  
CL: Apply

**9. 3.** Normal ICP is 15 mm Hg or less for 15 to 30 seconds or longer. Hyperventilation causes vasoconstriction, which reduces cerebrospinal fluid and blood volume, two important factors for reducing a sustained ICP of 20 mm Hg. A cooling blanket is used to control the elevation of temperature because a fever increases the metabolic rate, which in turn increases ICP. High doses of barbiturates may be used to reduce the increased cellular metabolic demands. Fluid volume and inotropic drugs are used to maintain cerebral perfusion by supporting the cardiac output and keeping the cerebral perfusion pressure greater than 80 mm Hg.

 CN: Physiological adaptation;  
CL: Synthesize


**10. 4.** A decrease in the client's LOC is an early indicator of deterioration of the client's neurologic status. Changes in level of consciousness, such as restlessness and irritability, may be subtle. Widening of the pulse pressure, decrease in the pulse rate, and dilated, fixed pupils occur later if the increased ICP is not treated.

 CN: Physiological adaptation;  
CL: Analyze

**11. 1.** The client's ICP is elevated, and the client should be positioned to avoid extreme neck flexion or extension. The head of the bed is usually elevated 30 to 45 degrees to drain the venous sinuses and thus decrease the ICP. Trendelenburg's position places the client's head lower than the body, which would increase ICP. The Sims position (side lying) and elevating the head on two pillows may extend or flex the neck, which increases ICP.

 CN: Reduction of risk potential;  
CL: Synthesize

**12. 2.** After administering mannitol, the nurse closely monitors intake and output because mannitol promotes diuresis and is given primarily to pull water from the extracellular fluid of the edematous brain. Mannitol can cause hypokalemia and may lead to muscle contractions, not muscle relaxation. Signs and symptoms, such as widening pulse pressure and pupil dilation, should not occur because mannitol serves to decrease ICP.

 CN: Pharmacological and parenteral therapies;  
CL: Analyze

**13. 3, 4, 5.** The nurse should assess the client for spinal shock, which is the immediate response to spinal cord transection. Hypotension occurs and the body loses core temperature to environmental temperature. The nurse must treat the client immediately to manage hypotension and hypothermia. The nurse should also ensure that there is an adequate airway and respirations; there may be respiratory compromise due to intercostal muscle involvement. Once the client is stable, the nurse should conduct a complete neurologic check. The nurse should take all precautions to keep the client's head, neck, and spine position in straight alignment. If the client is conscious, the nurse should briefly assess major reflexes, such as the Achilles, patellar, biceps, and triceps tendons, and sensation of the perineum for bladder function.

 CN: Management of care; CL: Analyze


**14. 4.** The correct motor function test for C8 is a hand-grasp check. The motor function check for C4 to C5 is shoulders shrugging against downward pressure of the examiner's hands. The motor function check for C5 to C6 is an arm pulling up from a resting position against resistance. The motor function check for C7 is an arm straightening out from a flexed position against resistance.

 CN: Management of care; CL: Analyze


**15. 2, 3, 5.** The client with a C3 to C4 fracture has neck control but may tire easily using sore muscles around the incision area to hold up his head. Therefore, the head and neck of his wheelchair should be high. The seat of the wheelchair should be lower than normal to facilitate transfer from the bed to the wheelchair. When a client can use his hands and arms to move the wheelchair, the placement of the back to the client's scapula is necessary. This client cannot use his arms and will need an electric chair with breath, chin, or voice control to manipulate movement of the chair. A firm or hard cushion adds pressure to bony prominences; the cushion should instead be padded to reduce the risk of pressure ulcers.

 CN: Basic care and comfort;  
CL: Synthesize

**16. 4.** It is important to first explain where a client is to orient him to time, person, and place. Offering to get his family and asking him questions to determine whether he is oriented are important, but the first comments should let the client know where he is and what happened to him. It is useful to be empathetic to the client, but making a comment such as "I'll bet you're a little confused" when he first awakens is not helpful and may cause him anxiety.

 CN: Psychosocial adaptation;  
CL: Synthesize


**17. 2.** It is best for the client to wear mitts, which help prevent the client from pulling on the I.V. without causing additional agitation. Using a jacket or wrist restraint or tucking the client's arms and hands under the drawsheet restrict movement and add to feelings of being confined, all of which would increase her agitation and increase ICP.

 CN: Physiological adaptation;  
CL: Synthesize


**18. 3.** Coughing is contraindicated for a client at risk for increased ICP because coughing increases ICP. Deep breathing can be continued. Turning and passive ROM exercises can be continued with care not to extend or flex the neck.

 CN: Reduction of risk potential;  
CL: Synthesize

**19. 2.** Diabetes insipidus results from deficiency of antidiuretic hormone (ADH). The condition may occur in conjunction with head injuries as well as with other disorders. In ADH deficiency, the client is extremely thirsty and excretes large amounts of highly diluted urine. Measuring the urine output to detect excess amount and checking the specific gravity of urine samples to determine urine concentration are appropriate measures to determine the onset of diabetes insipidus. The client may be tachycardic and hypotensive from fluid deficit; however, altered vital signs in a client with a head injury may occur for other reasons as well. Blood gas analysis and blood glucose levels will not reveal diabetes insipidus.


 CN: Physiological adaptation;  
CL: Analyze

**20. 3.** Recovery from a serious head injury is a long-term process that may continue for months or years. Depending on the extent of the injury, clients who are transferred to rehabilitation facilities most likely will continue to exhibit cognitive and mobility impairments as well as behavior and personality changes. The client would be expected to participate in the rehabilitation efforts to the extent he is capable. Family members and significant others will need long-term support to help them cope with the changes that have occurred in the client.


 CN: Physiological adaptation;  
CL: Evaluate

**21. 4.** Decerebrate posturing occurs in clients with damage to the upper brain stem, midbrain, or pons and is demonstrated clinically by arching of the back, rigid extension of the extremities, pronation of the arms, and plantar flexion of the feet. Internal rotation and adduction of arms with flexion of elbows, wrists, and fingers describes decorticate

posturing, which indicates damage to corticospinal tracts and cerebral hemispheres.

 CN: Physiological adaptation;  
CL: Apply

**22. 2.** Cluster breathing consists of clusters of irregular breaths followed by periods of apnea on an irregular basis. A lesion in the upper medulla or lower pons is usually the cause of cluster breathing. Because the client had a bleed in the occipital lobe, which is just superior and posterior to the pons and medulla, clinical manifestations that indicate a new lesion are monitored very closely in case another bleed ensues. The nurse should notify the physician immediately so that treatment can begin before respirations cease. The client is not obtaining sufficient oxygen and the depth of breathing is assisted by the ventilator. The health care provider will determine changes in the ventilator settings.

 CN: Physiological adaptation;  
CL: Synthesize

**23. 2.** Elevating the head of the bed to 30 degrees is contraindicated for infratentorial craniotomies because it could cause herniation of the brain down onto the brain stem and spinal cord, resulting in sudden death. Elevation of the head of the bed to 30 degrees with the head turned to the side opposite the incision, if not contraindicated by the increased intracranial pressure, is used for supratentorial craniotomies.

 CN: Physiological adaptation;  
CL: Synthesize

## The Client with Seizures

### 24.

3. Ease the client to the floor.

1. Maintain a patent airway.

4. Obtain vital signs.


2. Record the seizure activity observed.

To protect the client from falling, the nurse first should ease the client to the floor. It is important to protect the head and maintain a patent airway since altered breathing and excessive salivation can occur. The assessment of the postictal period should include level of consciousness and vital signs. The nurse should record details of the seizure once the client is stable. The events preceding the seizure, timing with descriptions of each phase, body parts


affected and sequence of involvement, and autonomic signs should be recorded.

 CN: Safety and infection control;  
CL: Synthesize


**25. 3.** Temperatures are not assessed orally with a glass thermometer because the thermometer could break and cause injury if a seizure occurred. The client can perform personal hygiene. There is no clinical reason to discourage the client from wearing his own clothes. As long as there are no other limitations, the client should be encouraged to be out of bed.

 CN: Physiological adaptation;  
CL: Synthesize


**26. 4.** A generalized tonic-clonic seizure involves both a tonic phase and a clonic phase. The tonic phase consists of loss of consciousness, dilated pupils, and muscular stiffening or contraction, which lasts about 20 to 30 seconds. The clonic phase involves repetitive movements. The seizure ends with confusion, drowsiness, and resumption of respiration. A partial seizure starts in one region of the cortex and may stay focused or spread (e.g., jerking in the extremity spreading to other areas of the body). An absence seizure usually occurs in children and involves a vacant stare with a brief loss of consciousness that often goes unnoticed. A complex partial seizure involves facial grimacing with patting and smacking.

 CN: Physiological adaptation;  
CL: Analyze


**27. 4.** The client will be asked to hold the head very still during the examination, which lasts about 30 to 60 minutes. In some instances, food and fluids may be withheld for 4 to 6 hours before the procedure if a contrast medium is used because the radiopaque substance sometimes causes nausea. There is no special preparation for a CT scan, so a shampoo the night before is not required. The client may drink fluids until 4 hours before the scan is scheduled. Electrodes are not used for a CT scan, nor is the head shaved.

 CN: Physiological adaptation;  
CL: Synthesize


**28. 2.** Beverages containing caffeine, such as coffee, tea, and cola drinks, are withheld before an EEG because of the stimulating effects of the caffeine on the brain waves. A meal should not be omitted before an EEG because low blood sugar could alter brain wave patterns; the client can have the entire meal except for the coffee.

 CN: Physiological adaptation;  
CL: Synthesize

**29. 1.** Trauma is one of the primary causes of brain damage and seizure activity in adults. Other common causes of seizure activity in adults include neoplasms, withdrawal from drugs and alcohol, and vascular disease. Given the history of head injury, electrolyte imbalance is not the cause of the seizure. There is no information to indicate that the seizure is related to a congenital defect. Epilepsy is usually diagnosed in younger clients.

 CN: Physiological adaptation;  
CL: Apply


**30. 2.** Gabapentin (Neurontin) may impair vision. Changes in vision, concentration, or coordination should be reported to the physician. Gabapentin should not be stopped abruptly because of the potential for status epilepticus; this is a medication that must be tapered off. Gabapentin is to be stored at room temperature and out of direct light. It should not be taken with antacids.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**31. 3.** A priority for the client in the postictal phase (after a seizure) is to assess the client's breathing pattern for effective rate, rhythm, and depth. The nurse should apply oxygen and ventilation to the client as appropriate. Other interventions, to be completed after the airway has been established, include reorientation of the client to time, person, and place. Determining the client's level of sleepiness is useful, but it is not a priority. Positioning the client comfortably promotes rest but is of less importance than ascertaining that the airway is patent.


 CN: Reduction of risk potential;  
CL: Synthesize

**32. 4.** Carbamazepine (Tegretol) is an anticonvulsant that helps prevent further seizures. Bed rest, sedation (phenobarbital), and providing privacy do not minimize the risk of seizures.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**33. 4.** During a seizure, the nurse should note movement of the client's head and eyes and muscle rigidity, especially when the seizure first begins, to obtain clues about the location of the trigger focus in the brain. Other important assessments would include noting the progression and duration of the seizure, respiratory status, loss of consciousness, pupil size, and incontinence of urine and stool. It is typically not possible to assess the client's pulse and blood pressure during a tonic-clonic seizure because the muscle contractions make assessment difficult to impossible. The last dose of anticonvulsant


medication can be evaluated later. The nurse should focus on maintaining an open airway, preventing injury to the client, and assessing the onset and progression of the seizure to determine the type of brain activity involved. The type of aura should be assessed in the preictal phase of the seizure.

 CN: Physiological adaptation;  
CL: Analyze

**34. 1.** The nurse should expect a client in the postictal phase to experience drowsiness to somnolence because exhaustion results from the abnormal spontaneous neuron firing and tonic-clonic motor response. An inability to move a muscle part is not expected after a tonic-clonic seizure because a lack of motor function would be related to a complication, such as a lesion, tumor, or stroke, in the correlating brain tissue. A change in sensation would not be expected because this would indicate a complication such as an injury to the peripheral nerve pathway to the corresponding part from the central nervous system. Hypotension is not typically a problem after a seizure.

 CN: Physiological adaptation;  
CL: Analyze

**35. 2.** Anticonvulsant drug therapy should never be stopped suddenly; doing so can lead to life-threatening status epilepticus. Phenytoin sodium does not carry a risk of physical dependency or lead to hypoglycemia. Phenytoin has antiarrhythmic properties, and discontinuation does not cause heart block.


 CN: Pharmacological and parenteral therapies; CL: Apply

**36. 2.** Specific motor vehicle regulations and restrictions for people who experience seizures vary locally. Most commonly, evidence that the seizures are under medical control is required before the person is given permission to drive. Time of day is not a consideration when determining driving restrictions related to seizures. The amount of time a person has been seizure-free is a consideration for lifting driving restrictions; however, the time frame is usually 2 years. It is recommended, not required, that a person who is subject to seizures carry a card or wear an identification bracelet describing the illness to facilitate quick identification in the event of an emergency.


 CN: Reduction of risk potential;  
CL: Synthesize

**37. 3.** An aura is a premonition of an impending seizure. Auras usually are of a sensory nature (e.g., an olfactory, visual, gustatory, or auditory sensation); some may be of a psychic nature. Evaluating an aura may help identify the area of the brain from which the seizure originates. Auras occur before a


seizure, not during or after (postictal). They are not similar to hallucinations or amnesia or related to relaxation.

 CN: Physiological adaptation;  
CL: Synthesize

**38. 2.** Toxic effects of topiramate (Topamax) include nephrolithiasis, and clients are encouraged to drink 6 to 8 glasses of water a day to dilute the urine and flush the renal tubules to avoid stone formation. Topiramate is taken in divided doses because it produces drowsiness. Although eating fresh fruits is desirable from a nutritional standpoint, this is not related to the topiramate. The drug does not have to be taken with meals.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**39. 3.** A common adverse effect of long-term phenytoin therapy is an overgrowth of gingival tissues. Problems may be minimized with good oral hygiene, but in some cases, overgrown tissues must be removed surgically. Phenytoin does not cause weight gain, insomnia, or deteriorating eyesight.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**40. 1, 2, 3.** The nurse should assess the number and type of seizures the client has experienced since starting clonazepam monotherapy for seizure control. The nurse should also determine if the client might be pregnant because clonazepam crosses the placental barrier. The nurse should also ask about the client's use of alcohol because alcohol potentiates the action of clonazepam. Although the nurse may want to check on the client's diet or use of cigarettes for health maintenance and promotion, such information is not specifically related to clonazepam therapy.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

## The Client with a Stroke

### 41. 15 points

The Glasgow Coma Scale provides three objective neurologic assessments: spontaneity of eye opening, best motor response, and best verbal response on a scale of 3 to 15. The client who scores the best on all three assessments scores 15 points.

 CN: Management of care; CL: Apply

**42. 2, 3, 5.** The maximum dosage of warfarin sodium (Coumadin) is not achieved until 3 to 4 days after starting the medication, and the effects of the drug continue for 4 to 5 days after discontinuing the medication. The client should have his blood levels


tested periodically to make sure that the desired level is maintained. Warfarin has a peak action of 9 hours. Vitamin K is the antidote for warfarin; protamine sulfate is the antidote for heparin.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**43. 1.** A helpless client should be positioned on the side, not on the back, with the head on a small pillow. A lateral position helps secretions escape from the throat and mouth, minimizing the risk of aspiration. It may be necessary to suction the client if he aspirates. Suction equipment should be nearby. It is safe to use a padded tongue blade, and the client should receive oral care, including brushing with a toothbrush.

 CN: Reduction of risk potential; CL: Synthesize

**44. 3.** Studies show that clients who receive recombinant t-PA treatment within 3 hours after the onset of a stroke have better outcomes. The time from the onset of a stroke to t-PA treatment is critical. A complete health assessment and history is not possible when a client is receiving emergency care. Upcoming surgical procedures may need to be delayed because of the administration of t-PA, which is a priority in the immediate treatment of the current stroke. While the nurse should identify which medications the client is taking, it is more important to know the time of the onset of the stroke to determine the course of action for administering t-PA.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**45. 3.** Control of blood pressure is critical during the first 24 hours after treatment because an intracerebral hemorrhage is the major adverse effect of thrombolytic therapy. Vital signs are monitored, and blood pressure is maintained as identified by the physician and specific to the client's ischemic tissue needs and risk of bleeding from treatment. The other vital signs are important, but the priority is to monitor blood pressure.

 CN: Reduction of risk potential; CL: Synthesize

**46. 2.** It is crucial to monitor the pupil size and pupillary response to indicate changes around the cranial nerves. The cholesterol level is not a priority assessment, although it may be an assessment to be addressed for long-term healthy lifestyle rehabilitation. Bowel sounds need to be assessed because an ileus or constipation can develop, but this is not a priority in the first 24 hours, when the primary concerns are cerebral hemorrhage and increased intracranial pressure. An echocardiogram is not needed

for the client with a thrombotic stroke without heart problems.

 CN: Physiological adaptation; CL: Analyze

**47.**

**4. Provide sedation.**

**2. Hyperoxygenate.**

**1. Suction the airway.**

**3. Suction the mouth.**

Increased agitation with suctioning will increase intracranial pressure (ICP), therefore sedation should be provided first. The client should be hyperoxygenated before and after suctioning to prevent hypoxia since hypoxia causes vasodilation of the cerebral vessels and increases ICP. The airway should then be suctioned for no more than 10 seconds. The mouth can be suctioned once the airway is clear to remove oral secretions. Once the mouth is suctioned the suction catheter should be discarded.

 CN: Physiological adaptation; CL: Synthesize

**48. 1.** The primary reason for the nursing assessment of a client's functional status before and after a stroke is to guide the plan. The assessment does not help to predict how far the rehabilitation team can help the client to recover from the residual effects of the stroke, only what plans can help a client who has moved from one functional level to another. The nursing assessment of the client's functional status is not a motivating factor.

 CN: Physiological adaptation; CL: Apply

**49. 2.** Sliding a client on a sheet causes friction and is to be avoided. Friction injures skin and predisposes to pressure ulcer formation. Rolling the client is an acceptable method to use when changing positions as long as the client is maintained in anatomically neutral positions and her limbs are properly supported. The client may be lifted as long as the nurse has assistance and uses proper body mechanics to avoid injury to himself or herself or the client. Having the client help lift herself off the bed with a trapeze is an acceptable means to move a client without causing friction burns or skin breakdown.

 CN: Reduction of risk potential; CL: Synthesize

**50. 3.** The use of ankle-high tennis shoes has been found to be most effective in preventing

plantar flexion (footdrop) because they add support to the foot and keep it in the correct anatomic position. Footboards stimulate spasms and are not routinely recommended. Regular repositioning and range-of-motion exercises are important interventions, but the client's foot needs to be in the correct anatomic position to prevent overextension of the muscle and tendon. Massaging does not prevent plantar flexion and, if rigorous, could release emboli.

 CN: Reduction of risk potential;  
CL: Synthesize


**51. 1, 2, 4.** Placing a pillow in the axilla so the arm is away from the body keeps the arm abducted and prevents skin from touching skin to avoid skin breakdown. Placing a pillow under the slightly flexed arm so the hand is higher than the elbow prevents dependent edema. Positioning a hand cone (not a rolled washcloth) in the hand prevents hand contractures. Immobilization of the extremity may cause a painful shoulder-hand syndrome. Flexion contractures of the hand, wrist, and elbow can result from immobility of the weak or paralyzed extremity. It is better to extend the arms to prevent contractures.

 CN: Reduction of risk potential;  
CL: Synthesize

**52. 2.** Expressive aphasia is a condition in which the client understands what is heard or written but cannot say what he or she wants to say. A communication or picture board helps the client communicate with others in that the client can point to objects or activities that he or she desires.


 CN: Physiological adaptation;  
CL: Synthesize

**53. 2.** A client with dysphagia (difficulty swallowing) commonly has the most difficulty ingesting thin liquids, which are easily aspirated. Liquids should be thickened to avoid aspiration. Maintaining an upright position while eating is appropriate because it minimizes the risk of aspiration. Introducing foods on the unaffected side allows the client to have better control over the food bolus. The client should concentrate on chewing and swallowing; therefore, distractions should be avoided.


 CN: Safety and infection control;  
CL: Synthesize

**54. 2.** Homonymous hemianopia is blindness in half of the visual field; therefore, the client would see only half of his plate. Eating only the food on half of the plate results from an inability to coordinate visual images and spatial relationships. There may be an increased preference for foods high in salt after a stroke, but this would not be related to homonymous hemianopia. Forgetting the names of

foods would be aphasia, which involves a cerebral cortex lesion. Being unable to swallow liquids is dysphagia, which involves motor pathways of cranial nerves IX and X, including the lower brain stem.

 CN: Physiological adaptation;  
CL: Analyze


**55. 4.** To expand the visual field, the partially sighted client should be taught to turn the head from side to side when walking. Neglecting to do so may result in accidents. This technique helps maximize the use of remaining sight. Covering an eye with a patch will limit the field of vision. Personal items can be placed within sight and reach, but most accidents occur from tripping over items that cannot be seen. It may help the client to see the door, but walking presents the primary safety hazard.

 CN: Reduction of risk potential;  
CL: Synthesize

**56. 3.** A client who has brain damage may be emotionally labile and may cry or laugh for no explainable reason. Crying is best dealt with by attempting to divert the client's attention. Ignoring the behavior will not affect the mood swing or the crying and may increase the client's sense of isolation. Telling the client to stop is inappropriate.

 CN: Psychosocial adaptation;  
CL: Synthesize

**57. 4, 5.** When offering emotional support to a client who is discouraged and has a negative self-concept because of physical handicaps, the nurse should approach the client with encouragement and patience. The client should be praised when he or she shows progress in efforts to overcome handicaps. An attitude of helpfulness and sympathy allows the client to assume a role of someone not ordinary, someone who is not like others. Regardless of the handicap, the client still feels the same on the inside and has the same innate needs for his or her growth and developmental age-group. An attitude of charity tends to make the client feel like a "charity case" or like someone who is given something free because of his "condition." The client feels unequal to his peers or unable to fulfill the role relationships that were obtained before the stroke. An approach using firmness is inappropriate because it implies that the client can do better if he just tries harder and leaves no room for softness in the approach to overcoming a negative self-concept.


 CN: Psychosocial adaptation;  
CL: Synthesize

**58. 2.** The nurse should encourage the client to write messages or use alternative forms of communication to avoid frustration. Presenting one thought at a time decreases stimuli that may distract

the client, as does speaking in a normal volume and tone. The nurse should ask the client to “show me” and should encourage the use of gestures to assist in getting the message across with minimal frustration and exhaustion for the client.

 CN: Psychosocial adaptation;  
CL: Synthesize

**59. 3.** Thrombolytic enzyme agents are used for clients with a thrombotic stroke to dissolve emboli, thus reestablishing cerebral perfusion. They do not increase vascular permeability, cause vasoconstriction, or prevent further hemorrhage.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

### The Client with Parkinson's Disease


**60. 3, 4, 5.** The nurse should contact the health care provider before administering Sinemet because this medication can cause further symptoms of depression. Suicide threats in clients with chronic illness should be taken seriously. The nurse should also determine if the client is on an MAO inhibitor because concurrent use with Sinemet can cause a hypertensive crisis. Sinemet is not a treatment for depression. Having the client discuss his feelings is appropriate when the prescription is finalized.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**61. 2.** The first sign of Parkinson's disease is usually tremors. The client commonly is the first to notice this sign because the tremors may be minimal at first. Rigidity is the second sign, and bradykinesia is the third sign. Akinesia is a later stage of bradykinesia.


 CN: Physiological adaptation;  
CL: Analyze

**62. 3.** The primary focus is on maintaining a safe environment because the client with Parkinson's disease usually has a propulsive gait, characterized by a tendency to take increasingly quicker steps while walking. This type of gait commonly causes the client to fall or to have trouble stopping. The client should maintain a balanced diet, enhance the immune system, and enjoy diversional activities; however, safety is the primary concern.


 CN: Reduction of risk potential;  
CL: Synthesize

**63. 2.** Voluntary and purposeful movements often temporarily decrease or stop the tremors associated with Parkinson's disease. In some clients, however, tremors may increase with voluntary effort. Tremors associated with Parkinson's disease


are not psychogenic but are related to an imbalance between dopamine and acetylcholine. Tremors cannot be reduced by distracting the client.

 CN: Physiological adaptation;  
CL: Analyze


**64. 2.** Demanding physical activity should be performed during the peak action of drug therapy. Clients should be encouraged to maintain independence in self-care activities to the greatest extent possible. Although some clients may have more energy in the morning or after rest, tremors are managed with drug therapy.

 CN: Physiological adaptation;  
CL: Synthesize


**65. 4.** Helping the client function at his or her best is most appropriate and realistic. There is no known cure for Parkinson's disease. Parkinson's disease progresses in severity, and there is no known way to stop its progression. Many clients live for years with the disease, however, and it would not be appropriate to start planning terminal care at this time.

 CN: Physiological adaptation;  
CL: Synthesize

**66. 1.** The primary goal of physical therapy and nursing interventions is to maintain joint flexibility and muscle strength. Parkinson's disease involves a degeneration of dopamine-producing neurons; therefore, it would be an unrealistic goal to attempt to build muscles or increase endurance. The decrease in dopamine neurotransmitters results in ataxia secondary to extrapyramidal motor system effects. Attempts to reduce ataxia through physical therapy would not be effective.


 CN: Physiological adaptation;  
CL: Synthesize

**67. 2.** Levodopa is prescribed to decrease severe muscle rigidity. Levodopa does not improve mood, appetite, or alertness in a client with Parkinson's disease.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**68. 3.** Vital signs should be monitored, especially during periods of adjustment. Changes, such as orthostatic hypotension, cardiac irregularities, palpitations, and light-headedness, should be reported immediately. The client may actually experience suicidal or paranoid ideation instead of euphoria. The nurse should monitor the client for elevated liver enzyme levels, such as lactate dehydrogenase, aspartate aminotransferase, alanine aminotransferase, blood urea nitrogen, and alkaline phosphatase, but the client should not be jaundiced. The client should not experience signs and symptoms of


diabetes or a low serum glucose level, but the nurse should check the hemoglobin and hematocrit levels.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**69. 4.** While the client is hospitalized for adjustment of medication, it is essential that the medications be administered exactly at the scheduled time, for accurate evaluation of effectiveness. For example, levodopa-carbidopa (Sinemet) is taken in divided doses over the day, not all at one time, for optimum effectiveness.

 CN: Pharmacological and parenteral therapies; CL: Apply

**70. 2.** Ongoing self-care is a major focus for clients with Parkinson's disease. The client should be given additional time as needed and praised for her efforts to remain independent. Firmly telling the client that she needs assistance will undermine her self-esteem and defeat her efforts to be independent. Telling the client that her perception is unrealistic does not foster hope in her ability to care for herself. Suggesting that the client modify her routine seems to put the hospital or the nurse's time schedule before the client's needs. This will only decrease the client's self-esteem and her desire to try to continue self-care, which is obviously important to her.

 CN: Psychosocial adaptation; CL: Synthesize

**71. 1.** The goal of a pallidotomy is to improve functional ability for the client with Parkinson's disease. This is a priority. The pallidotomy creates lesions in the globus pallidus to control extrapyramidal disorders that affect control of movement and gait. If functional ability is improved by the pallidotomy, the client may experience a secondary response of an improved emotional response, but this is not the primary goal of the surgical procedure. The procedure will not improve alertness or appetite.

 CN: Basic care and comfort; CL: Apply

### The Client with Multiple Sclerosis

**72. 3.** Symptoms that can occur with multiple sclerosis are muscle spasticity and weakness, fatigue, visual disturbances, hearing loss, and bowel and bladder incontinence. Seizures are not associated with myelin destruction.

 CN: Management of care; CL: Evaluate

**73. 2, 3, 4, 5.** Maintaining urinary function in a client with neurogenic bladder dysfunction from MS is an important goal. The client should ideally drink 400 to 500 mL with each meal; 200 mL


midmorning, midafternoon, and late afternoon; and attempt to void at least every 2 hours to prevent infection and stone formation. The client may need to catheterize herself to drain residual urine in the bladder. Restricting fluids during the day will not produce sufficient urine. However, in bladder training for nighttime continence, the client may restrict fluids for 1 to 2 hours before going to bed. The client should drink at least 2,000 mL every 24 hours.

 CN: Physiological adaptation; CL: Create


**74. 2.** With MS, hyperexcitability and euphoria may occur, but because of muscle weakness, sudden bursts of energy are unlikely. Visual disturbances, weakness in the extremities, and loss of muscle tone and tremors are common symptoms of MS.

 CN: Physiological adaptation; CL: Analyze


**75. 3.** Baclofen is a centrally acting skeletal muscle relaxant that helps relieve the muscle spasms common in MS. Drowsiness is an adverse effect, and driving should be avoided if the medication produces a sedative effect. Baclofen does not stimulate the appetite or reduce bacteria in the urine.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**76. 2.** Evaluating drug effectiveness is difficult because a high percentage of clients with MS exhibit unpredictable episodes of remission, exacerbation, and steady progress without apparent cause. Clients with MS do not necessarily have increased intolerance to drugs, nor do they endure long periods of exacerbation before the illness responds to a particular drug. Multiple drug use is not what makes evaluation of drug effectiveness difficult.

 CN: Physiological adaptation; CL: Analyze

**77. 4.** Asking a client to speak louder even when tired may aggravate the problem. Asking the client to speak slowly and distinctly and to repeat hard-to-understand words helps the client to communicate effectively.

 CN: Psychosocial adaptation; CL: Synthesize


**78. 4.** The nurses' notes should be concise, objective, clearly stated, and relevant. This client trembles when she attempts voluntary actions, such as drinking a beverage or fastening clothing. This activity should be described exactly as it occurs so that others reading the note will have no doubt about the nurse's observation of the client's behavior. Identifying the "intentional" activity of daily living will help the interdisciplinary team individualize the client's plan of care. Clarifying what is meant by "worsening" with a purposeful act will facilitate



the inter-rater reliability of the team. It is better to state what the client did than to give vague nursing orders in the nurses' notes.

 CN: Management of care; CL: Apply


**79. 4.** Limiting fluid intake is likely to aggravate rather than relieve symptoms when a bowel retraining program is being implemented. Furthermore, water imbalance, as well as electrolyte imbalance, tends to aggravate the signs and symptoms of MS. A diet high in fiber helps keep bowel movements regular. Setting a regular time each day for elimination helps train the body to maintain a schedule. Using an elevated toilet seat facilitates transfer of the client from the wheelchair to the toilet or from a standing to a sitting position.

 CN: Physiological adaptation;  
CL: Synthesize

**80. 3.** MS is a progressive, chronic neurologic disease characterized by patchy demyelination throughout the central nervous system. This interferes with the transmission of electrical impulses from one nerve cell to the next. MS affects speech, coordination, and vision, but not cognition. Care for the client with MS is directed toward maintaining joint mobility, preventing deformities, maintaining muscle strength, rehabilitation, preventing and treating depression, and providing client motivation.

 CN: Reduction of risk potential;  
CL: Synthesize

**81. 2.** The nurse's most positive approach is to encourage a client with MS to keep active, use stress reduction strategies, and avoid fatigue because it is important to support the immune system while remaining active. A quiet, inactive lifestyle is not necessarily indicated. Good health habits are not likely to alter the course of the disease, although they may help minimize complications. Practicing using aids that will be needed for future disabilities may be helpful but also can be discouraging.


 CN: Physiological adaptation;  
CL: Synthesize

**82. 1, 3, 4, 5.** A client with impaired peripheral sensation does not feel pain as readily as someone whose sensation is unimpaired; therefore, water temperatures should be tested carefully. The client should be advised to avoid using hot water bottles or heating pads and to protect against cold temperatures. Because the client cannot rely on minor pain as an indicator of damaged skin or sore spots, the client should carefully inspect the skin daily to visualize any injuries that he cannot feel. The client should not be instructed to avoid kitchen activities out of fear of injury; independence and self-care are also important. However, the client should meet with an occupational therapist to learn about


assistive devices and techniques that can reduce injuries, such as burns and cuts that are common in kitchen activities.

 CN: Reduction of risk potential;  
CL: Create

**83. 3.** Maintaining a regular voiding pattern is the most appropriate measure to help the client avoid urinary incontinence. Fluid intake is not related to incontinence. Incontinence is related to the strength of the detrusor and urethral sphincter muscles. Inserting an indwelling catheter would be a treatment of last resort because of the increased risk of infection. If catheterization is required, intermittent self-catheterization is preferred because of its lower risk of infection. Antibiotics do not influence urinary incontinence.


 CN: Physiological adaptation;  
CL: Synthesize

**84. 2.** An individualized regular exercise program helps the client to relieve muscle spasms. The client can be trained to use unaffected muscles to promote coordination because MS is a progressive, debilitating condition. The data do not indicate that the client needs psychotherapy, day care for the granddaughter, or visits from other clients.


 CN: Physiological adaptation;  
CL: Synthesize

## The Unconscious Client

**85. 3.** Activated charcoal powder is administered to absorb remaining particles of salicylate. Vitamin K is an antidote for warfarin sodium (Coumadin). Dextrose 50% is used to treat hypoglycemia. Sodium thiosulfate is an antidote for cyanide.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**86. 2, 3, 4.** An excess of cholinergic agents produce urinary and fecal incontinence, increased salivation, diarrhea, and diaphoresis. In a severe overdose, CNS depression, seizures and muscle fasciculations, bradycardia or tachycardia, weakness, and respiratory arrest due to respiratory muscle paralysis occur. Anticholinergics produce dry mucous membranes. Skin rash is not a sign of overdose with a cholinergic agent.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**87. 3.** The initial response to crisis is high anxiety. Anxiety must dissipate before a person can deal with the actual situation. Allowing family members to ventilate their feelings can help diffuse their anxiety. The reasons for the client's actions are

unknown; assumptions must be validated before they become facts. Touch can be appropriate but not when it is used as false reassurance. Helping with the client's care is appropriate at a later time.

 CN: Psychosocial adaptation;  
CL: Synthesize


**88. 3.** Maintaining intact skin is a priority for the unconscious client. Unconscious clients need to be turned every hour to prevent complications of immobility, which include pressure ulcers and stasis pneumonia. The unconscious client cannot be educated at this time. Pain is not a concern. During the first 24 hours, the unconscious client will mostly likely be on nothing-by-mouth status.

 CN: Reduction of risk potential;  
CL: Synthesize

**89. 2.** The nurse must clean the unconscious client's mouth carefully, apply a thin coat of petroleum jelly, and move the endotracheal tube to the opposite side daily to prevent dryness, crusting, inflammation, and parotiditis. The unconscious client's temperature should be monitored by a route other than the oral route (e.g., rectal, tympanic) because oral temperatures will be inaccurate. The client should be positioned in a lateral or semiprone position, not a supine position, to allow for drainage of secretions and for the jaw and tongue to fall forward. The client should not be dragged when turned, as may happen when a drawsheet is used. Care should be taken to lift the client's heels, buttocks, arms, and head off of the sheets when turning. Trochanter rolls, splints, foam boot aids, specialty beds, and so on—not just two pillows—should be used to keep the client in correct body position and to decrease pressure on bony prominences.


 CN: Reduction of risk potential;  
CL: Synthesize

**90. 3.** The client is not in proper body alignment if, when in the right side-lying position, the client's left arm rests on the mattress with the elbow flexed. This positioning of the arm pulls the left shoulder out of good alignment, restricting respiratory movements. The arm should be supported on a pillow. The client's head also should be placed on a small pillow to keep it in alignment with the body. The right leg should be extended on the mattress without a pillow to avoid hyperrotation of the hip. A pillow should be placed between the left and right legs with the left knee flexed so that on no parts of the legs is skin touching skin.


 CN: Physiological adaptation;  
CL: Synthesize

**91. 4.** The goal of performing passive ROM exercises is to maintain joint mobility. Active exercise is needed to preserve bone and muscle mass. Passive

ROM movements do not prevent bone demineralization or have a positive effect on the client's muscle tone.

 CN: Physiological adaptation;  
CL: Evaluate


**92. 1.** Maintaining a patent airway is the priority. Therefore, the nurse should keep suction equipment available to remove secretions. The client should be placed in a side-lying, not prone, position. Performing oral hygiene is a clean procedure; therefore, the nurse wears clean gloves, not sterile gloves. The nurse should never place any fingers in an unconscious client's mouth; the client may bite down. Padded tongue blades, swabs, or a toothbrush should be used instead; but maintaining the airway is the priority.

 CN: Physiological adaptation;  
CL: Synthesize


**93. 2.** When the blink reflex is absent or the eyes do not close completely, the cornea may become dry and irritated. Corneal abrasion can occur. Taping the eye closed will prevent injury. Having the client wear eyeglasses or cleaning the eyelid will not protect the cornea from dryness or irritation. Artificial tears instilled once per shift are not frequent enough for preventing dryness.

 CN: Reduction of risk potential;  
CL: Synthesize

**94. 3.** Restlessness is an early indicator of hypoxia. The nurse should suspect hypoxia in the unconscious client who becomes restless. The most accurate method for determining the presence of hypoxia is to evaluate the pulse oximeter value or arterial blood gas values. Cyanosis and decreased respirations are late indicators of hypoxia. Hypertension, not hypotension, is a sign of hypoxia.

 CN: Physiological adaptation;  
CL: Apply

**95. 2.** The client should be placed in a semi-Fowler's position to reduce the risk of aspiration. The formula should be at room temperature, not heated. Administering enteral tube feedings is a clean procedure, not a sterile one; therefore, sterile supplies are not required. Clients receiving enteral feedings should be weighed regularly, but not necessarily before each feeding.

 CN: Reduction of risk potential;  
CL: Synthesize

**96. 4.** Gastric residuals are checked before administration of enteral feedings to determine whether gastric emptying is delayed. A residual of less than 50% of the previous feeding volume is usually considered acceptable. In this case, the amount is not excessive and the nurse should

reinstall the aspirate through the tube and then administer the feeding. If the amount of gastric residual is excessive, the nurse should notify the physician and withhold the feeding. Disposing of the residual can cause electrolyte and fluid losses.

 CN: Reduction of risk potential;  
CL: Synthesize

**97. 1.** Good catheter care, including meticulous cleaning of the area around the urethral meatus, is the highest priority for the client with an indwelling catheter. Clamping an indwelling catheter is not recommended. Irrigation of the catheter, which requires breaking the closed system, is not recommended. Manipulation of the catheter taped to the client's leg causes trauma to the urethral meatus, which can predispose the client to an infection and is also not recommended.

 CN: Reduction of risk potential;  
CL: Synthesize

**98. 2, 3, 4.** A client who is brain dead typically demonstrates nonreactive dilated pupils and nonreactive or absent corneal and gag reflexes. The client may still have spinal reflexes, such as deep tendon and Babinski reflexes, in brain death. Decerebrate or decorticate posturing would not be seen. Clients who are brain dead do not have a blink reflex.


 CN: Physiological adaptation;  
CL: Apply

### The Client in Pain

**99. 2.** Morphine 2 mg was given 1 hour ago and the client can have up to 4 mg every 2 hours. Although the pain level is at 1, the nurse should give medication prior to the dressing change with packing that is likely to cause discomfort. A 4 mg dose of morphine would exceed the 2 hour limit and, if given after the dressing change, would not manage pain during the procedure. The client has been responding to the pain medication dosing and a new order is not required at this time.


 CN: Management of care;  
CL: Synthesize

**100. 1.** Pain perception is an individual experience. Research indicates that pain tolerance and perception vary widely among individuals, even within cultures.


 CN: Psychosocial adaptation;  
CL: Synthesize

**101. 1.** Experience has demonstrated that clients who feel confidence in the persons who are caring for them do not require as much therapy for pain relief as those who have less confidence. Without


the client's confidence, developed in an effective nurse-client relationship, other interventions may be less effective. The client's family can be an important source of support, but it is the nurse who plans strategies for pain relief. The client may require time to adjust to the pain, but the nurse and client can collaborate to try to evaluate a variety of pain relief strategies. Arranging for the client to share a room with another client who has little pain may have negative effects on the client who has pain that is difficult to relieve.

 CN: Basic care and comfort;  
CL: Synthesize

**102. 4.** Although meperidine hydrochloride can be given orally, it is more effective when given intramuscularly. The equianalgesic dose of oral meperidine is up to four times the I.M. dose ( $75 \times 4 = 300$ ).

 CN: Pharmacological and parenteral therapies; CL: Apply


**103. 1.** Opioid analgesics relieve pain by reducing or altering the perception of pain. Meperidine hydrochloride does not decrease the sensitivity of pain receptors, interfere with pain impulses traveling along sensory nerve fibers, or block the conduction of pain impulses in the central nervous system.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**104. 3.** The client's innate responses to pain are directed initially toward escaping from the source of pain. Variations in tolerance and perception of pain are apparent only in conscious clients, and only conscious clients can employ distraction to help relieve pain.

 CN: Physiological adaptation; CL: Apply


**105. 1.** Ergotamine tartrate is used to help abort a migraine attack. It should be taken as soon as prodromal symptoms appear. Reduced migraine severity and relief from sleeplessness and vision problems address symptoms that occur after the migraine has occurred and are not effects of ergotamine.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**106. 4.** Biofeedback translates body processes into observable signs so that the client can develop some control over certain body processes. Biofeedback does not involve electrical stimulation. Use of unpleasant stimuli such as electrical shock is a form of aversion therapy. Biofeedback does not involve monitoring body processes for the therapist to interpret; rather, it is a self-directed, self-care activity that reinforces learning because the client can see the results of his actions.

 CN: Psychosocial adaptation; CL: Apply


**107. 1.** A back rub stimulates the large-diameter cutaneous fibers, which block transmission of pain impulses from the spinal cord to the brain. It does not block the transmission of pain impulses or stimulate the release of endorphins. A back rub may distract the client, but the physiologic process of fiber stimulation is the main reason a back rub is used as therapy for pain relief.

 CN: Basic care and comfort;  
CL: Apply


**108. 2.** It is essential that the nurse document the client's response to pain medication on a routine, systematic basis. Reassuring the client that pain will be relieved is often not realistic. A client who continually presses the PCA button may not be getting adequate pain relief, but through careful assessment and documentation, the effectiveness of pain relief interventions can be evaluated and modified. Pain medication is not titrated until the client is free from pain but rather until an acceptable level of pain management is reached.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**109. 1.** An epidural catheter is used for postoperative pain management to block the pain sensation below the point of insertion. If the client is rating pain high, the PCA pump may be malfunctioning, the catheter may have become misplaced, or the amount of medication may not be sufficient. The nurse should first check the PCA pump to determine if it is functioning properly. Assessing vital signs would be important to provide additional data about the possible cause of pain. The catheter placement, including removing the dressing or manipulating the catheter, and drug dosage are the responsibility of the physician, usually an anesthesiologist, who inserted the catheter. This person should be contacted if the PCA pump is functioning appropriately. The epidural catheter lies just above the dura of the spinal space. Infection, hypotension, and loss of mental alertness are just a few of the complications that can occur if the catheter is pushed through the dura.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**110. 1.** The nurse using healing touch affects a client's pain primarily through assessing and directing the flow of energy fields. Healing touch can involve touching, but it does not have to involve body contact. Massage and hypnosis are not parts of healing touch.


 CN: Physiological adaptation;  
CL: Apply

## Managing Care Quality and Safety

**111. 3.** Pulling the client up under the arm can cause shoulder displacement. A belt around the waist should be used to move the client. Passive range of motion exercises prevents contractures and atrophy. Raising the foot of the bed assists in venous return to reduce edema. High top tennis shoes are used to prevent foot drop.

 CN: Management of care; CL: Synthesize


**112. 3.** Clients with Parkinson's disease can experience dysphagia. Thickening liquids assists with swallowing, preventing aspiration. Hyperextending the neck opens the airway and can increase risk of aspiration. Pressing the chin firmly on the chest makes swallowing more difficult. The chin should be slightly tucked to promote swallowing. The nurse should suggest a speech therapy consult for evaluation of the client's ability to swallow.

 CN: Safety and infection control;  
CL: Synthesize


**113. 2.** Clients with Parkinson's disease may experience a freezing gait when they are unable to move forward. Instructing the client to march in place, step over lines in the flooring, or visualize stepping over a log allows them to move forward. It is important to ambulate the client and not keep them on bedrest. A muscle relaxant is not indicated.

 CN: Management of care; CL: Synthesize

**114. 1, 2, 3, 7.** Pressure points in the side-lying position include the ears, shoulders, ribs, greater trochanter, medial or lateral condyles, and ankles. The sacrum, occiput, and heels are pressure point areas affected in the supine position.

 CN: Safety and infection control;  
CL: Analyze

**115. 4.** All health care facilities in which controlled medications (Schedules II, III, and IV) are stored for dispensing and/or administration to clients are required to follow procedures for the proper maintenance of narcotic inventory. Narcotic inventory maintenance includes, but is not limited to, all discrepancies will have thorough and appropriate documentation with accompanying reasons (i.e., tablet/amp/vial breakage, additional medication volume, etc.), timely resolution of inventory discrepancies, and timely notification regarding controlled substance inventory discrepancies of persons in oversight areas (i.e., Pharmacy, Security, Nursing House Supervisor). In the event of a significant incident, the proper external authorities will be notified (i.e., DEA, local police department) by the Quality and Risk Management/Legal Department.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

TEST  
12

# The Client with Musculoskeletal Health Problems

- The Client with Rheumatoid Arthritis
- The Client with Osteoarthritis
- The Client with a Hip Fracture
- The Client having Joint Replacement Surgery
- The Client with a Herniated Disk
- The Client with an Amputation due to Peripheral Vascular Disease
- The Client with Fractures
- The Client with a Femoral Fracture
- The Client with a Spinal Cord Injury
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Rheumatoid Arthritis

1. On a visit to the clinic, a client reports the onset of early symptoms of rheumatoid arthritis. The nurse should conduct a focused assessment for:

- 1. Limited motion of joints.
- 2. Deformed joints of the hands.
- 3. Early morning stiffness.
- 4. Rheumatoid nodules.

2. A client with rheumatoid arthritis states, "I can't do my household chores without becoming tired. My knees hurt whenever I walk." Which nursing diagnosis would be **most** appropriate?

- 1. *Activity intolerance* related to fatigue and pain.
- 2. *Self-care deficit* related to increasing joint pain.
- 3. *Ineffective coping* related to chronic pain.
- 4. *Disturbed body image* related to fatigue and joint pain.

3. Of the clients listed below, who is at risk for developing rheumatoid arthritis (RA)? Select all that apply.

- 1. Adults between the ages of 20 and 50 years.
- 2. Adults who have had an infectious disease with the Epstein-Barr virus.
- 3. Adults that are of the male gender.
- 4. Adults who possess the genetic link, specifically HLA-DR4.
- 5. Adults who also have osteoarthritis.

4. A client is in the acute phase of rheumatoid arthritis. Which of the following should the nurse identify as **lowest** priority in the plan of care?

- 1. Relieving pain.
- 2. Preserving joint function.
- 3. Maintaining usual ways of accomplishing tasks.
- 4. Preventing joint deformity.

5. The nurse teaches a client about heat and cold treatments to manage arthritis pain. Which of the following client statements indicates that the client still has a knowledge deficit?

- 1. "I can use heat and cold as often as I want."
- 2. "With heat, I should apply it for no longer than 20 minutes at a time."
- 3. "Heat-producing liniments can be used with other heat devices."
- 4. "Ten to 15 minutes per application is the maximum time for cold applications."

6. The client with rheumatoid arthritis tells the nurse, "I have a friend who took gold shots and had a wonderful response. Why didn't my physician let me try that?" Which of the following responses by the nurse would be **most** appropriate?

- 1. "It's the physician's prerogative to decide how to treat you. The physician has chosen what is best for your situation."
- 2. "Tell me more about your friend's arthritic condition. Maybe I can answer that question for you."
- 3. "That drug is used for cases that are worse than yours. It wouldn't help you, so don't worry about it."
- 4. "Every person is different. What works for one client may not always be effective for another."

**7.** The teaching plan for the client with rheumatoid arthritis includes rest promotion. Which of the following would the nurse expect to instruct the client to avoid during rest periods?

- 1. Proper body alignment.
- 2. Elevating the part.
- 3. Prone lying positions.
- 4. Positions of flexion.

**8.** After teaching the client with rheumatoid arthritis about measures to conserve energy in activities of daily living involving the small joints, which of the following, if stated by the client, would indicate the need for additional teaching?

- 1. Pushing with palms when rising from a chair.
- 2. Holding packages close to the body.
- 3. Sliding objects.
- 4. Carrying a laundry basket with clinched fingers and fists.

**9.** After teaching the client with severe rheumatoid arthritis about prescribed methotrexate (Rheumatrex), which of the following statements indicates the need for further teaching?

- 1. "I will take my vitamins while I'm on this drug."
- 2. "I must not drink any alcohol while I'm taking this drug."
- 3. "I should brush my teeth after every meal."
- 4. "I will continue taking my birth control pills."

**10.** A 25-year-old client taking hydroxychloroquine (Plaquenil) for rheumatoid arthritis reports difficulty seeing out of her left eye. Correct interpretation of this assessment finding indicates which of the following?

- 1. Development of a cataract.
- 2. Possible retinal degeneration.
- 3. Part of the disease process.
- 4. A coincidental occurrence.

**11.** A client with rheumatoid arthritis tells the nurse, "I know it is important to exercise my joints so that I won't lose mobility, but my joints are so stiff and painful that exercising is difficult." Which of the following responses by the nurse would be **most** appropriate?

- 1. "You are probably exercising too much. Decrease your exercise to every other day."
- 2. "Tell the physician about your symptoms. Maybe your analgesic medication can be increased."
- 3. "Stiffness and pain are part of the disease. Learn to cope by focusing on activities you enjoy."
- 4. "Take a warm tub bath or shower before exercising. This may help with your discomfort."

**12.** Which of the following statements should the nurse include in the teaching session when preparing a client for arthrocentesis? Select all that apply.

- 1. "A local anesthetic agent may be injected into the joint site for your comfort."
- 2. "A syringe and needle will be used to withdraw fluid from your joint."
- 3. "The procedure, although not painful, will provide immediate relief."
- 4. "We'll want you to keep your joint active after the procedure to increase blood flow."
- 5. "You will need to wear a compression bandage for several days after the procedure."

### The Client with Osteoarthritis

**13.** A client with osteoarthritis will undergo an arthrocentesis on his painful edematous knee. What should be included in the nursing plan of care? Select all that apply.

- 1. Explain the procedure.
- 2. Administer preoperative medication 1 hour before surgery.
- 3. Instruct the client to immobilize the knee for 2 days after the surgery.
- 4. Assess the site for bleeding.
- 5. Offer pain medication.

**14.** A postmenopausal client is scheduled for a bone-density scan. To plan for the client's test, what should the nurse communicate to the client?

- 1. Request that the client remove all metal objects on the day of the scan.
- 2. Instruct the client to consume foods and beverages with a high content of calcium for 2 days before the test.
- 3. Inform the client that she will need to ingest 600 mg of calcium gluconate by mouth for 2 weeks before the test.
- 4. Tell the client that she should report any significant pain to her physician at least 2 days before the test.

**15.** A physician orders a lengthy X-ray examination for a client with osteoarthritis. Which of the following actions by the nurse would demonstrate client advocacy?

- 1. Contact the X-ray department and ask the technician if the lengthy session can be divided into shorter sessions.
- 2. Contact the physician to determine if an alternative examination could be scheduled.
- 3. Provide a dose of acetaminophen (Tylenol).
- 4. Cancel the examination because of the hard X-ray table.

**16.** Which of the following should the nurse assess when completing the history and physical examination of a client diagnosed with osteoarthritis?

- 1. Anemia.
- 2. Osteoporosis.
- 3. Weight loss.
- 4. Local joint pain.

**17.** A client with osteoporosis needs education about diet and ways to increase bone density. Which of the following should be included in the teaching plan? Select all that apply.

- 1. Maintain a diet with adequate amounts of vitamin D, as found in fortified milk and cereals.
- 2. Choose good calcium sources, such as figs, broccoli, and almonds.
- 3. Use alcohol in moderation because a moderate intake has no known negative effects.
- 4. Try swimming as a good exercise to maintain bone mass.
- 5. Avoid the use of high-fat foods, such as avocados, salad dressings, and fried foods.

**18.** Which of the following statements indicates that the client with osteoarthritis understands the effects of capsaicin (Zostrix) cream?

- 1. "I always wash my hands right after I apply the cream."
- 2. "After I apply the cream, I wrap my knee with an elastic bandage."
- 3. "I keep the cream in the cabinet above the stove in the kitchen."
- 4. "I also use the same cream when I get a cut or a burn."

**19.** At which of the following times should the nurse instruct the client to take ibuprofen (Motrin), prescribed for left hip pain secondary to osteoarthritis, to minimize gastric mucosal irritation?

- 1. At bedtime.
- 2. On arising.
- 3. Immediately after a meal.
- 4. On an empty stomach.

**20.** The client diagnosed with osteoarthritis states, "My friend takes steroid pills for her rheumatoid arthritis. Why don't I take steroids for my osteoarthritis?" Which of the following is the **best** explanation?

- 1. Intra-articular corticosteroid injections are used to treat osteoarthritis.
- 2. Oral corticosteroids can be used in osteoarthritis.
- 3. A systemic effect is needed in osteoarthritis.
- 4. Rheumatoid arthritis and osteoarthritis are two similar diseases.

**21.** After teaching a group of clients with osteoarthritis about using regular exercise, which of the following client statements indicates effective teaching?

- 1. "Performing range-of-motion exercises will increase my joint mobility."
- 2. "Exercise helps to drive synovial fluid through the cartilage."
- 3. "Joint swelling should determine when to stop exercising."
- 4. "Exercising in the outdoors year-round promotes joint relaxation."

### The Client with a Hip Fracture

**22.** A client in a double hip spica cast is constipated. The surgeon cuts a window into the cast. Which of the following outcomes should the nurse anticipate?

- 1. The window will allow the nurse to palpate the superior mesenteric artery.
- 2. The window will allow the surgeon to manipulate the fracture site.
- 3. The window will allow the nurses to reposition the client.
- 4. The window will provide some relief from pressure due to abdominal distention as a result of constipation.

**23.** A client has an intracapsular hip fracture. The nurse should conduct a focused assessment to detect:

- 1. Internal rotation.
- 2. Muscle flaccidity.
- 3. Shortening of the affected leg.
- 4. Absence of pain in the fracture area.

**24.** The nurse is developing the plan of care for an older adult client with a hip fracture. Which of the following chronic health problems would the nurse be **least** likely to assess in the client?

- 1. Hypertension.
- 2. Cardiac decompensation.
- 3. Pulmonary disease.
- 4. Multiple sclerosis.

**25.** When teaching a client with an extracapsular hip fracture scheduled for surgical internal fixation with the insertion of a pin, the nurse bases the teaching on the understanding that this surgical repair is the treatment of choice. Which of the following explains the reason?

- 1. Hemorrhage at the fracture site is prevented.
- 2. Neurovascular impairment risk is decreased.
- 3. The risk of infection at the site is lessened.
- 4. The client is able to be mobilized sooner.

**26.** A client with an extracapsular hip fracture returns to the nursing unit after internal fixation and pin insertion with a drainage tube at the incision site. Her husband asks, “Why does she have this tube inserted in her hip?” Which of the following responses would be **best**?

- 1. “The tube helps us to detect a wound infection early on.”
- 2. “This way we won’t have to irrigate the wound.”
- 3. “Fluid won’t be allowed to accumulate at the site.”
- 4. “We have a way to administer antibiotics into the wound.”

**27.** A client had a posterolateral total hip replacement 2 days ago. What should the nurse include in the client’s plan of care? Select all that apply.

- 1. When using a walker, encourage the client to point the toes inward.
- 2. Position a pillow between the legs to maintain abduction.
- 3. Allow the client to be in the supine position or in the lateral position on the unoperated side.
- 4. Do not allow the client to bend down to tie or slip on shoes.
- 5. Place ice on the incision after physical therapy.

**28.** Which information should the nurse include when performing discharge teaching with a client who had an anterolateral approach for a total hip replacement? Select all that apply.

- 1. Avoid turning the toes or knee outward.
- 2. Use an abduction pillow between the legs when in bed.
- 3. Use an elevated toilet seat and shower chair.
- 4. Do not extend the operative leg backwards.
- 5. Restrict motion for 2 weeks after surgery.

**29.** The nurse is assessing a client for neurologic impairment after a total hip replacement. Which of the following would indicate impairment in the affected extremity?

- 1. Decreased distal pulse.
- 2. Inability to move.
- 3. Diminished capillary refill.
- 4. Coolness to the touch.

**30.** A client with a hip fracture has undergone surgery for insertion of a femoral head prosthesis. Which of the following activities should the nurse instruct the client to avoid?

- 1. Crossing the legs while sitting down.
- 2. Sitting on a raised commode seat.
- 3. Using an abductor splint while lying on the side.
- 4. Rising straight from a chair to a standing position.

**31.** The nurse advises the client who has had a femoral head prosthesis placement on the type of chair to sit in during the first 6 to 8 weeks after surgery. Which would be the correct type to recommend?

- 1. A desk-type swivel chair.
- 2. A padded upholstered chair.
- 3. A high-backed chair with armrests.
- 4. A recliner with an attached footrest.

**32.** The nurse is assessing the home environment of an elderly client who is using crutches during the postoperative recovery phase after hip pinning. Which of the following would pose the **greatest** hazard to the client as a risk for falling at home?

- 1. A 4-year-old cocker spaniel.
- 2. Scatter rugs.
- 3. Snack tables.
- 4. Rocking chairs.

### The Client Having Joint Replacement Surgery

**33.** In preparation for total knee surgery, a 200-lb client with osteoarthritis must lose weight. Which of the following exercises should the nurse recommend as **best** if the client has no contraindications?

- 1. Weight lifting.
- 2. Walking.
- 3. Aquatic exercise.
- 4. Tai chi exercise.

**34.** Prior to surgery, the nurse is instructing a client who will have a total hip replacement tomorrow. Which of the following information is **most** important to include in the teaching plan at this time?

- 1. Teaching how to prevent hip flexion.
- 2. Demonstrating coughing and deep-breathing techniques.
- 3. Showing the client what an actual hip prosthesis looks like.
- 4. Assessing the client’s fears about the procedure.

**35.** The client has just had a total knee replacement for severe osteoarthritis. Which of the following assessment findings should lead the nurse to suspect possible nerve damage?

- 1. Numbness.
- 2. Bleeding.
- 3. Dislocation.
- 4. Pinkness.

**36.** After surgery and insertion of a total joint prosthesis, a client develops severe sudden pain and an inability to move the extremity. The nurse correctly interprets these findings as indicating which of the following?

- 1. A developing infection.
- 2. Bleeding in the operative site.
- 3. Joint dislocation.
- 4. Glue seepage into soft tissue.



**37.** A client who had a total hip replacement 2 days ago has developed an infection with a fever. The nursing diagnosis of fluid volume deficit related to diaphoresis is made. Which of the following is the **most** appropriate outcome?

- 1. The client drinks 2,000 mL of fluid per day.
- 2. The client understands how to manage the incision.
- 3. The client's bed linens are changed as needed.
- 4. The client's skin remains cool throughout hospitalization.

**38.** After knee arthroplasty, the client has a sequential compression device (SCD). The nurse should do which of the following?

- 1. Elevate the sequential compression device (SCD) on two pillows.
- 2. Change the settings on the SCD to make the client more comfortable.
- 3. Stop the SCD to remove dressings and bathe the leg.
- 4. Discontinue the SCD when the client is ambulatory.

**39.** The nurse is preparing the discharge of a client who has had a knee replacement with a metal joint. The nurse should instruct the client about which of the following? Select all that apply.

- 1. Notify health care providers about the joint prior to invasive procedures.
- 2. Avoid use of Magnetic Resonance Imaging (MRI) scans.
- 3. Notify airport security that the joint may set off alarms on metal detectors.
- 4. Refrain from carrying items weighing more than 5 lb.
- 5. Limit fluid intake to 1,000 mL/day.

**40.** Following a total hip replacement, the nurse should position the client in which of the following ways?

- 1. Place weights alongside of the affected extremity to keep the extremity from rotating.
- 2. Elevate both feet on two pillows.
- 3. Keep the lower extremities adducted by use of an immobilization binder around both legs.
- 4. Keep the extremity in slight abduction using an abduction splint or pillows placed between the thighs.

**41.** Following a total hip replacement, the nurse should do which of the following? Select all that apply.

- 1. With the aid of a coworker, turn the client from the supine to the prone position every 2 hours.
- 2. Encourage the client to use the overhead trapeze to assist with position changes.
- 3. For meals, elevate the head of the bed to 90 degrees.
- 4. Use a fracture bedpan when needed by the client.
- 5. When the client is in bed, prevent thromboembolism by encouraging the client to do toe-pointing exercises.

**42.** A client is to have a total hip replacement. The preoperative plan should include which of the following? Select all that apply.

- 1. Administer antibiotics as prescribed to ensure therapeutic blood levels.
- 2. Apply leg compression device.
- 3. Request a trapeze be added to the bed.
- 4. Teach isometric exercises of quadriceps and gluteal muscles.
- 5. Demonstrate crutch walking with a 3-point gait.
- 6. Place Buck's traction on the bed.

**43.** The nurse is teaching the client to administer enoxaparin (Lovenox) following a total hip arthroplasty? The nurse should instruct the client about which of the following? Select all that apply.

- 1. Report promptly any difficulty breathing, rash, or itching.
- 2. Notify the health care provider of unusual bruising.
- 3. Avoid all aspirin-containing medications.
- 4. Wear or carry medical identification.
- 5. Expel the air bubble from the syringe before the injection.
- 6. Remove needle immediately after medication is injected.

**44.** A client who had a total hip replacement 4 days ago is worried about dislocation of the prosthesis. The nurse should respond by saying which of the following?

- 1. "Don't worry. Your new hip is very strong."
- 2. "Use of a cushioned toilet seat helps to prevent dislocation."
- 3. "Activities that tend to cause adduction of the hip tend to cause dislocation, so try to avoid them."
- 4. "Decreasing use of the abductor pillow will strengthen the muscles to prevent dislocation."

**45.** The nurse is assessing a client who had a left hip replacement 36 hours ago. Which of the following indicates the prosthesis is dislocated? Select all that apply.

- 1. The client reported a “popping” sensation in the hip.
- 2. The left leg is shorter than the right leg.
- 3. The client has sharp pain in the groin.
- 4. The client cannot move his right leg.
- 5. The client cannot wiggle the toes on the left leg.

**46.** A client who has had a total hip replacement has a dislocated hip prosthesis. The nurse should first?

- 1. Stabilize the leg with Buck’s traction.
- 2. Apply an ice pack to the affected hip.
- 3. Position the client toward the opposite side of the hip.
- 4. Notify the orthopedic surgeon.

**47.** The nurse is planning care for a group of clients who have had total hip replacement. Of the clients listed below, which is at **highest** risk for infection and should be assessed first?

- 1. A 55-year-old client who is 6 feet tall and weighs 180 lb.
- 2. A 90-year-old who lives alone.
- 3. A 74-year-old who has periodontal disease with periodontitis.
- 4. A 75-year-old who has asthma and uses an inhaler.

**48.** The nurse has established a goal with a client to improve mobility following hip replacement. Which of the following is a realistic outcome at the time of discharge from the surgical unit?

- 1. The client can walk throughout the entire hospital with a walker.
- 2. The client can walk the length of a hospital hallway with minimal pain.
- 3. The client has increased independence in transfers from bed to chair.
- 4. The client can raise the affected leg 6 inches with assistance.

**49.** The nurse is assessing a client’s left leg for neurovascular changes following a total left knee replacement. Which of the following are expected normal findings? Select all that apply.

- 1. Reduced edema of the left knee.
- 2. Skin warm to touch.
- 3. Capillary refill response.
- 4. Moves toes.
- 5. Pain absent.
- 6. Pulse on left leg weaker than right leg.

**50.** On the evening of surgery for total knee replacement, a client wants to get out of bed. To safely assist the client the nurse should do which of the following?

- 1. Encourage the client to apply full weight-bearing.
- 2. Order a walker for the client.
- 3. Place a straight-backed chair at the foot of the bed.
- 4. Apply a knee immobilizer.

**51.** When preparing a client for discharge from the hospital after a total knee replacement, the nurse should include which of the following information in the discharge plan? Select all that apply.

- 1. Report signs of infection to health care provider.
- 2. Keep the affected leg and foot on the floor when sitting in a chair.
- 3. Remove anti-embolism stockings when sleeping.
- 4. The physical therapist will encourage progressive ambulation with use of assistive devices.
- 5. Change the dressing daily.

**52.** Following a total joint replacement, which of the following complications has the **greatest** likelihood of occurring?

- 1. Deep vein thrombosis (DVT).
- 2. Polyuria.
- 3. Intussusception of the bowel.
- 4. Wound evisceration.

### The Client with a Herniated Disk

**53.** The nurse is observing a client who is recovering from back strain lift a box as shown below. What should the nurse do?

- 1. Praise the client for using correct body mechanics.
- 2. Suggest to the client that she put both knees on the floor before attempting to lift the box.
- 3. Advise the client to bend from the waist rather than stretching her back in this position.
- 4. Inform the client that she should keep her back straight by squatting with both knees parallel.



**54.** Which of the following activities should the nurse instruct the client with low back pain to avoid?

- 1. Keeping light objects below the level of the elbows when lifting.
- 2. Leaning forward while bending the knees.
- 3. Exceeding the prescribed exercise program.
- 4. Sleeping on the side with legs flexed.

**55.** A client attempting to get out of bed stops midway because of low back pain radiating down to the right heel and lateral foot. What should the nurse do in order of priority from first to last?

1. Apply a warm compress to the client's back.

2. Notify the physician.

3. Assist the client to lie down.

4. Administer the prescribed celecoxib (Celebrex).





**56.** A client with a ruptured intervertebral disc at L4–5 stands with a flattened spine slightly tilted forward and slightly flexed to the affected side. The nurse interprets this finding as indicating which of the following?

- 1. Motor changes.
- 2. Postural deformity.
- 3. Alteration of reflexes.
- 4. Sensory changes.

**57.** Which of the following positions would be **most** comfortable for a client with a ruptured disc at L5–S1 right?

- 1. Prone.
- 2. Supine with the legs flexed.
- 3. High Fowler's.
- 4. Right Sims.

**58.** The client with a herniated intervertebral disc scheduled for a myelogram asks the nurse about the procedure. The nurse explains that radiographs will be taken of the client's spine after an injection of which of the following?

- 1. Sterile water.
- 2. Normal saline solution.
- 3. Liquid nitrogen.
- 4. Radiopaque dye.

**59.** Which of the following would **not** be appropriate to include when preparing a client for magnetic resonance imaging (MRI) to evaluate a ruptured disc?

- 1. Informing the client that the procedure is painless.
- 2. Taking a thorough history of past surgeries.
- 3. Checking for previous complaints of claustrophobia.
- 4. Starting an I.V. line at keep-open rate.

**60.** A client complaining of numbness from the back of his left buttock to the dorsum of his foot and big toe is scheduled to undergo a laminectomy. The operative consent form states, "a left lumbar laminectomy of L3–4." Which of the following should the nurse do **next**?

- 1. Have the client sign the consent form.
- 2. Call the surgeon.
- 3. Change the consent form.
- 4. Review the client's history.

**61.** Immediately after a lumbar laminectomy, the nurse administers ondansetron hydrochloride (Zofran) to the client as ordered. The nurse determines that the drug is effective when which of the following is controlled?

- 1. Muscle spasms.
- 2. Nausea.
- 3. Shivering.
- 4. Dry mouth.

**62.** After a laminectomy, the client states, "The physician said that I can do anything I want to." Which of the following client-stated activities indicates the need for further teaching?

- 1. Drying the dishes.
- 2. Sitting outside on firm cushions.
- 3. Making the bed walking from side to side.
- 4. Sweeping the front porch.

**63.** The nurse is developing the discharge teaching plan for a client after a lumbar laminectomy L4–5 who will be returning to work in 6 weeks. Which of the following actions should the nurse encourage the client to avoid?

- 1. Placing one foot on a stepstool during prolonged standing.
- 2. Sleeping on the back with support under the knees.
- 3. Maintaining average body weight for height.
- 4. Sitting whenever possible.

**64.** A male client underwent a spinal fusion yesterday. Which of the following nursing assessments should alert the nurse to the development of a possible complication?

- 1. Lateral rotation of the head and neck.
- 2. Clear yellowish fluid on the dressing.
- 3. Use of the standing position to void.
- 4. Nonproductive cough.

**65.** The nurse is assisting a client who has had a spinal fusion apply a back brace. In which order of priority should the nurse assist the client applying the brace?

1. Have the client in a side-lying position.
2. Verify the order for the settings for the brace.
3. Ask the client to stand with arms held away from the body.
4. Assist the client to log roll and rise to a sitting position.

**66.** After the nurse teaches a client about wearing a back brace after a spinal fusion, which of the following client statements indicates effective teaching?

- 1. "I will apply lotion before putting on the brace."
- 2. "I will be sure to pad the area around my iliac crest."
- 3. "I can use baby powder under the brace to absorb perspiration."
- 4. "I should wear a thin cotton undershirt under the brace."

**67.** The nurse develops a teaching plan for a client scheduled for a spinal fusion. Which of the following should the nurse expect to include?

- 1. The client typically experiences more pain at the donor site than at the fusion site.
- 2. The surgeon will apply a simple gauze dressing to the donor site.
- 3. Neurovascular checks are unnecessary if the fibula is the donor site.
- 4. The client's level of activity restriction is determined by the amount of pain.

**68.** A client who has had a lumbar laminectomy with a spinal fusion is sitting in a chair. In which position are his feet if he is complying with his postoperative instructions?

- 1. On the floor with the feet flat.
- 2. On a low footstool.
- 3. In any comfortable position with legs uncrossed.
- 4. On a high footstool so the feet are level with the chair seat.

**69.** The nurse develops a plan of care for a client in the initial postoperative period following a lumbar laminectomy. Which of the following activities is contraindicated?

- 1. Assisting with her daily hygiene activities.
- 2. Lying flat in bed.
- 3. Walking in the hall.
- 4. Sitting all afternoon in her room.

**70.** Which of the following exercises should the nurse advise the client to avoid after a lumbar laminectomy?

- 1. Knee-to-chest lifts.
- 2. Hip tilts.
- 3. Sit-ups.
- 4. Pelvic tilts.

### The Client with an Amputation due to Peripheral Vascular Disease

**71.** Which of the following should the nurse identify as the **least** likely factor contributing to a client's peripheral vascular disease?

- 1. Uncontrolled diabetes mellitus for 15 years.
- 2. A 20-pack-year history of cigarette smoking.
- 3. Current age of 39 years.
- 4. A serum cholesterol concentration of 275 mg/dL.

**72.** A client has severe arterial occlusive disease and gangrene of the left great toe. Which of the following findings is expected?

- 1. Edema around the ankle.
- 2. Loss of hair on the lower leg.
- 3. Thin, soft toenails.
- 4. Warmth in the foot.

**73.** A client with absent peripheral pulses and pain at rest is scheduled for an arterial Doppler study of the affected extremity. When preparing the client for this test, the nurse should:

- 1. Have the client sign a consent form for the procedure.
- 2. Administer a pretest sedative as appropriate.
- 3. Keep the client tobacco-free for 30 minutes before the test.
- 4. Wrap the client's affected foot with a blanket.

**74.** The client with peripheral arterial disease says, "I've really tried to manage my condition well." Which of the following should the nurse determine as appropriate for this client?

- 1. Resting with the legs elevated above the level of the heart.
- 2. Walking slowly but steadily for 30 minutes twice a day.
- 3. Minimizing activity as much and as often as possible.
- 4. Wearing antiembolism stockings at all times when out of bed.

**75.** Which of the following should the nurse include in the teaching plan for a client with arterial insufficiency to the feet that is being managed conservatively?

- 1. Daily lubrication of the feet.
- 2. Soaking the feet in warm water.
- 3. Applying antiembolism stockings.
- 4. Wearing firm, supportive leather shoes.

**76.** A client says, “I hate the idea of being an invalid after they cut off my leg.” Which of the following would be the nurse’s **most** therapeutic response?

- 1. “At least you will still have one good leg to use.”
- 2. “Tell me more about how you’re feeling.”
- 3. “Let’s finish the preoperative teaching.”
- 4. “You’re lucky to have a wife to care for you.”

**77.** The client asks the nurse, “Why can’t the physician tell me exactly how much of my leg he’s going to take off? Don’t you think I should know that?” On which of the following should the nurse base the response?

- 1. The need to remove as much of the leg as possible.
- 2. The adequacy of the blood supply to the tissues.
- 3. The ease with which a prosthesis can be fitted.
- 4. The client’s ability to walk with a prosthesis.

**78.** A client who has had an above-the-knee amputation develops a dime-sized bright red spot on the dressing after 45 minutes in the postanesthesia recovery unit. The nurse should:

- 1. Elevate the stump.
- 2. Reinforce the dressing.
- 3. Call the surgeon.
- 4. Draw a mark around the site.

**79.** A client in the postanesthesia care unit with a left below-the-knee amputation has pain in her left big toe. Which of the following should the nurse do **first**?

- 1. Tell the client it is impossible to feel the pain.
- 2. Show the client that the toes are not there.
- 3. Explain to the client that her pain is real.
- 4. Give the client the prescribed opioid analgesic.

**80.** The client with an above-the-knee amputation is to use crutches while his prosthesis is being adjusted. In which of the following exercises should the nurse instruct the client to **best** prepare him for using crutches?

- 1. Abdominal exercises.
- 2. Isometric shoulder exercises.
- 3. Quadriceps setting exercises.
- 4. Triceps stretching exercises.

**81.** The nurse teaches a client about using the crutches, instructing the client to support her weight **primarily** on which of the following body areas?

- 1. Axillae.
- 2. Elbows.
- 3. Upper arms.
- 4. Hands.

**82.** The client is to be discharged on a low-fat, low-cholesterol, low-sodium diet. Which of the following should be the nurse’s **first** step in planning the dietary instructions?

- 1. Determining the client’s knowledge level about cholesterol.
- 2. Asking the client to name foods that are high in fat, cholesterol, and salt.
- 3. Explaining the importance of complying with the diet.
- 4. Assessing the client’s and family’s typical food preferences.

### The Client with Fractures

**83.** A client has a leg immobilized in traction. Which of the following activities demonstrated by the client indicate that the client understands actions to take to prevent muscle atrophy?

- 1. The client adducts the affected leg every 2 hours.
- 2. The client rolls the affected leg away from the body’s midline twice per day.
- 3. The client performs isometric exercises to the affected extremity three times per day.
- 4. The client asks the nurse to add a 5-lb weight to the traction for 30 minutes/day.

**84.** The client with a fractured tibia has been taking methocarbamol (Robaxin). Which of the following indicate that the drug is having the intended effect?

- 1. Lack of infection.
- 2. Reduction in itching.
- 3. Relief of muscle spasms.
- 4. Decrease in nervousness.

**85.** When developing a teaching plan for a client who is prescribed acetaminophen (Tylenol) for muscle pain, which information should the nurse expect to include? Select all that apply.

- 1. The drug can be used if the person is allergic to aspirin.
- 2. Acetaminophen does not affect platelet aggregation.
- 3. This drug causes little or no gastric distress.
- 4. Acetaminophen exerts a strong anti-inflammatory effect.
- 5. The client should have the International Normalized Ratio (INR) checked regularly.

**86.** A client who has been taking carisoprodol (Soma) at home for a fractured arm is admitted with a blood pressure of 80/50 mm Hg, a pulse rate of 115 bpm, and respirations of 8 breaths/minute and shallow. The nurse interprets these findings as indicating which of the following?

- 1. Expected common adverse effects.
- 2. Hypersensitivity reaction.
- 3. Possible habituating effect.
- 4. Hemorrhage from gastrointestinal irritation.

**87.** When admitting a client with a fractured extremity, the nurse should **first** focus the assessment on which of the following?

- 1. The area proximal to the fracture.
- 2. The actual fracture site.
- 3. The area distal to the fracture.
- 4. The opposite extremity for baseline comparison.

**88.** Which of the following client statements identifies a knowledge deficit about cast care?

- 1. "I'll elevate the cast above my heart initially."
- 2. "I'll exercise my joints above and below the cast."
- 3. "I can pull out cast padding to scratch inside the cast."
- 4. "I'll apply ice for 10 minutes to control edema for the first 24 hours."

**89.** Which of the following interventions would be **least** appropriate for a client who is in a double hip spica cast?

- 1. Encouraging the intake of cranberry juice.
- 2. Advising the client to eat large amounts of cheese.
- 3. Establishing regular times for elimination.
- 4. Having the client dangle at the bedside.

**90.** The nurse prepares a teaching plan for a client about crutch walking using a two-point gait pattern. Which of the following should the nurse include?

- 1. Advance a crutch on one side and then advance the opposite foot; repeat on the opposite side.
- 2. Advance a crutch on one side and simultaneously advance and bear weight on the opposite foot; repeat on the opposite side.
- 3. Advance both crutches together and then follow by lifting both lower extremities to the level of the crutches.
- 4. Advance both crutches together and then follow by lifting both lower extremities past the level of the crutches.

**91.** A client returned from surgery with a debrided open tibial fracture and has a three-way drainage system. The nurse should first:

- 1. Review the results of culture and sensitivity testing of the wound.
- 2. Look for the presence of a pressure dressing over the wound.
- 3. Determine if the client has increased pain from exposed nerve endings.
- 4. Check the client's blood pressure for hypotension resulting from additional vessel bleeding.

**92.** A client has a tibial fracture that required casting. Approximately 5 hours later, the client has increasing pain distal to the left tibial fracture despite the morphine injection administered 30 minutes previously. Which of the following should be the nurse's **next** assessment?

- 1. Presence of a distal pulse.
- 2. Pain with a pain rating scale.
- 3. Vital sign changes.
- 4. Potential for drug tolerance.

**93.** A client with a fracture develops compartment syndrome. Which of the following signs should alert the nurse to impending organ failure?

- 1. Crackles.
- 2. Jaundice.
- 3. Generalized edema.
- 4. Dark, scanty urine.

### The Client with a Femoral Fracture

**94.** A client with a fractured right femur has not had any immunizations since childhood. Which of the following biologic products should the nurse administer to provide the client with passive immunity for tetanus?

- 1. Tetanus toxoid.
- 2. Tetanus antigen.
- 3. Tetanus vaccine.
- 4. Tetanus antitoxin.

**95.** After teaching the client with a femoral fracture about the purpose of treatment with skeletal traction, which of the following, if stated by the client, would indicate the need for additional teaching?

- 1. To align injured bones.
- 2. To provide long-term pull.
- 3. To apply 25 lb of traction.
- 4. To pull weight with a boot.

**96.** The nurse is planning care for the client with a femoral fracture who is in balanced suspension traction. Which of the following would the nurse be **least** likely to include in the plan of care?

- 1. Use of a fracture bedpan.
- 2. Checks for redness over the ischial tuberosity.
- 3. Elevation of the head of bed no more than 25 degrees.
- 4. Personal hygiene with a complete bed bath.

**97.** A client is in balanced suspension traction using a half-ring Thomas splint with a Pearson attachment that suspends the lower extremity and applies direct skeletal traction for a hip fracture. Which of the following nursing assessments would **not** be appropriate?

- 1. Greater trochanter skin checks.
- 2. Pin site inspection.
- 3. Neurovascular checks proximal to the splint.
- 4. Foot movement evaluation.

**98.** The client in balanced suspension traction is transported to surgery for closed reduction and internal fixation of his fractured femur. Which of the following should the nurse do when transporting the client to the operating room?

- 1. Transfer the client to a cart with manually suspended traction.
- 2. Call the surgeon to request an order to temporarily remove the traction.
- 3. Send the client on his bed with extra help to stabilize the traction.
- 4. Remove the traction and send the client on a cart.

**99.** A client has a Pearson attachment on the traction setup. Which of the following is the purpose of this attachment?

- 1. To support the lower portion of the leg.
- 2. To support the thigh and upper leg.
- 3. To allow attachment of the skeletal pin.
- 4. To prevent flexion deformities in the ankle and foot.

**100.** Which of the following should lead the nurse to suspect that a client with a fracture of the right femur may be developing a fat embolus?

- 1. Acute respiratory distress syndrome.
- 2. Migraine-like headaches.
- 3. Numbness in the right leg.
- 4. Muscle spasms in the right thigh.

**101.** The client with a fractured femur is upset and agitated about her injury and its treatment. She says, “How can I stay like this for weeks? I can’t even move!” Which of the following is the **most** appropriate nursing diagnosis?

- 1. *Impaired physical mobility* related to traction.
- 2. *Ineffective coping* related to prolonged immobility.
- 3. *Deficient diversional activity* related to prolonged hospitalization.
- 4. *Activity intolerance* related to impaired mobility.

**102.** The client asks the nurse what his activity limitations are while he is in Buck’s traction. The nurse should tell the client:

- 1. “You can sit up whenever you want.”
- 2. “You must lie flat on your back most of the time.”
- 3. “You can turn your body.”
- 4. “You must lie on your stomach.”

**103.** Because a client has a Thomas splint, the nurse should assess the client regularly for which of the following?

- 1. Signs of skin pressure in the groin area.
- 2. Evidence of decreased breath sounds.
- 3. Skin breakdown behind the heel.
- 4. Urine retention.

**104.** The client has a nursing diagnosis of *Self-care deficit* related to the confinement of traction. Which of the following would indicate a successful outcome for this diagnosis?

- 1. The client assists as much as possible in his care, demonstrating increased participation over time.
- 2. The client allows the nurse to complete his care in an efficient manner without interfering.
- 3. The client allows his wife to assume total responsibility for his care.
- 4. The client allows his wife to complete his care to promote feelings of usefulness.

**105.** The client who had an open femoral fracture was discharged to her home where she developed fever, night sweats, chills, restlessness, and restrictive movement of the fractured leg. Which of the following reflects the **best** interpretation of these findings?

- 1. Pulmonary emboli.
- 2. Osteomyelitis.
- 3. Fat emboli.
- 4. Urinary tract infection.

**106.** The nurse is planning care for a client with osteomyelitis. The client is taking an antibiotic, but the infection has not resolved. The nurse should advise the client to do which of the following?

- 1. Use herbal supplements.
- 2. Eat a diet high in protein and vitamins C and D.
- 3. Ask the health care provider for a change of antibiotics.
- 4. Encourage frequent passive range-of-motion to the affected extremity.

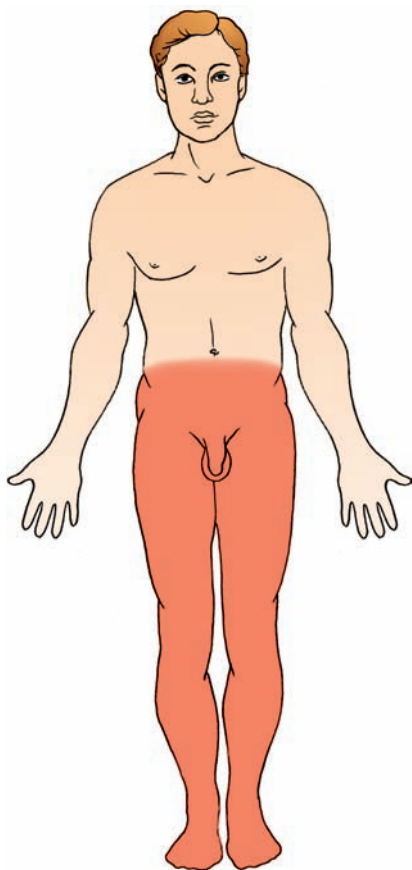
### The Client with a Spinal Cord Injury

**107.** When planning to move a person with a possible spinal cord injury, the nurse should direct the team to:

- 1. Limit movement of the arms by wrapping them next to the body.
- 2. Move the person gently to help reduce pain.
- 3. Immobilize the head and neck to prevent further injury.
- 4. Cushion the back with pillows to ensure comfort.

**108.** The nurse is taking care of a client with a spinal cord injury. The extent of the client's injury is shown below. Which of the following findings is expected when assessing this client?

- 1. Inability to move his arms.
- 2. Loss of sensation in his hands and fingers.
- 3. Dysfunction of bowel and bladder.
- 4. Difficulty breathing.



**109.** When the client has a cord transection at T4, which of the following is the **primary** focus of the nursing assessment?

- 1. Renal status.
- 2. Vascular status.
- 3. Gastrointestinal function.
- 4. Biliary function.

**110.** When assessing the client with a cord transection above T5 for possible complications, which of the following should the nurse expect as **least** likely to occur?

- 1. Diarrhea.
- 2. Paralytic ileus.
- 3. Stress ulcers.
- 4. Intra-abdominal bleeding.

**111.** The nurse is planning to teach the client with spinal cord injury and intermittent nasogastric suctioning about interventions to protect her integumentary system. The nurse should tell the client to:

- 1. Eat enough calories to maintain desired weight.
- 2. Stay in cool environments to avoid sweating.
- 3. Stay in warm environments to avoid chilling.
- 4. Eat low-sodium foods to avoid edema.

**112.** Which of the following should the nurse use as the **best** method to assess for the development of deep vein thrombosis in a client with a spinal cord injury?

- 1. Homans' sign.
- 2. Pain.
- 3. Tenderness.
- 4. Leg girth.

**113.** During the period of spinal shock, the nurse should expect the client's bladder function to be which of the following?

- 1. Spastic.
- 2. Normal.
- 3. Atonic.
- 4. Uncontrolled.

**114.** After 1 month of therapy, the client in spinal shock begins to experience muscle spasms in his legs. He calls the nurse in excitement to report the leg movement. Which of the following responses by the nurse would be the **most** accurate?

- 1. "These movements indicate that the damaged nerves are healing."
- 2. "This is a good sign. Keep trying to move all the affected muscles."
- 3. "The return of movement means that eventually you should be able to walk again."
- 4. "The movements occur from muscle reflexes that can't be initiated or controlled by the brain."



**115.** The client with a spinal cord injury asks the nurse why the dietitian has recommended to decrease the total daily intake of calcium. Which of the following responses by the nurse would provide the **most** accurate information?

- 1. “Excessive intake of dairy products makes constipation more common.”
- 2. “Immobility increases calcium absorption from the intestine.”
- 3. “Lack of weight bearing causes demineralization of the long bones.”
- 4. “Dairy products likely will contribute to weight gain.”

**116.** As a first step in teaching a woman with a spinal cord injury and quadriplegia about her sexual health, the nurse assesses her understanding of her current sexual functioning. Which of the following statements by the client indicates she understands her current ability?

- 1. “I won’t be able to have sexual intercourse until the urinary catheter is removed.”
- 2. “I can participate in sexual activity but might not experience orgasm.”
- 3. “I can’t have sexual intercourse because it causes hypertension, but other sexual activity is okay.”
- 4. “I should be able to participate in sexual activity, but I will be infertile.”

**117.** A client with a spinal cord injury who has been active in sports and outdoor activities talks almost obsessively about his past activities. In tears, one day he asks the nurse, “Why can’t I stop talking about these things? I know those days are gone forever.” Which of the following responses by the nurse conveys the **best** understanding of the client’s behavior?

- 1. “Be patient. It takes time to adjust to such a massive loss.”
- 2. “Talking about the past is a form of denial. We have to help you focus on today.”
- 3. “Reviewing your losses is a way to help you work through your grief and loss.”
- 4. “It’s a simple escape mechanism to go back and live again in happier times.”

### Managing Care Quality and Safety

**118.** The nurse is documenting care of a client who is restrained in bed with bilateral wrist restraints. Following assessment of the restraints, the nurse’s documentation should include which of the following? Select all that apply.

- 1. Nutrition and hydration needs.
- 2. Capillary refill.
- 3. Continued need for restraints.
- 4. Need for medication.
- 5. Skin integrity.

**119.** The nurse on an orthopedic unit is instituting a falls prevention program. Which of the following personnel should be involved in the program? Select all that apply.

- 1. Registered nurses.
- 2. Physicians.
- 3. Unlicensed personnel.
- 4. Housekeeping services.
- 5. Family members.
- 6. Client.

**120.** The nurse unit manager is making rounds on a team of clients and notices a client who is wearing red slipper socks and a color-coded armband that indicates the client is at risk for falling walking down the hall unassisted. The nurse should do which of the following **first**?

- 1. Encourage the client to keep walking until he becomes tired.
- 2. Walk with the client back to his room and assist him to get in bed.
- 3. Accompany the client while using the lapel microphone to call for the unlicensed nursing personnel (UAP) to walk with the client.
- 4. Instruct the client to walk only in his room.

**121.** The physician has written an order for a client to begin anticoagulant therapy with 5 mg Coumadin (warfarin) orally. In planning care for this client, the nurse should verify that which of the following services have been contacted? Check all that apply.

- 1. Pharmacy.
- 2. Dietary.
- 3. Laboratory.
- 4. Discharge planning.
- 5. Chaplain.

**122.** The nurse on the orthopedic unit is going to lunch and is conducting a “hand-off” to the charge nurse. The goal of the “hand-off” communication is to do which of the following?

- 1. To insure the charge nurse understands that the nurse is going to lunch.
- 2. To be sure the charge nurse assigns someone else to take care of the client.
- 3. To provide accurate information about client’s care to the next caregiver.
- 4. To provide in-depth information about the client’s history.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Rheumatoid Arthritis

**1. 3.** Initially, most clients with early symptoms of rheumatoid arthritis complain of early morning stiffness or stiffness after sitting still for a while. Later symptoms of rheumatoid arthritis include limited joint range of motion; deformed joints, especially of the hand; and rheumatoid nodules.

🔑 CN: Physiological adaptation;  
CL: Analyze

**2. 1.** Based on the client's complaints, the most appropriate nursing diagnosis would be *Activity intolerance* related to fatigue and pain. Nursing interventions would focus on helping the client conserve energy and decrease episodes of fatigue. Although the client may develop a self-care deficit related to the activity intolerance and increasing joint pain, the client is voicing concerns about household chores and difficulty around the house and yard, not self-care issues. Over time, the client may develop ineffective coping or body image disturbance as the disorder becomes chronic with increasing pain and fatigue.

🔑 CN: Basic care and comfort; CL: Analyze

**3. 1, 2, 4.** Rheumatoid arthritis (RA) affects women three times more often than men, between the ages of 20 and 55 years. Research has determined that RA occurs in clients who have had infectious disease, such as the Epstein-Barr virus. The genetic link, specifically HLA-DR4, has been found in 65% of clients with RA. People with osteoarthritis are not necessarily at risk for developing rheumatoid arthritis.

🔑 CN: Reduction of risk potential;  
CL: Analyze

**4. 3.** Maintaining usual ways of accomplishing tasks would be the lowest priority during the acute phase. Rather, the focus is on developing less stressful ways of accomplishing routine tasks. Pain relief is a high priority during the acute phase because pain is typically severe and interferes with the client's ability to function. Preserving joint function

and preventing joint deformity are high priorities during the acute phase to promote an optimal level of functioning and reduce the risk of contractures.

🔑 CN: Physiological adaptation;  
CL: Synthesize

**5. 3.** Heat-producing liniment can produce a burn if used with other heat devices that could intensify the heat reaction. Heat and cold can be used as often as the client desires. However, each application of heat should not exceed 20 minutes, and each application of cold should not exceed 10 to 15 minutes. Application for longer periods results in the opposite of the intended effect: vasoconstriction instead of vasodilation with heat, and vasodilation instead of vasoconstriction with cold.

🔑 CN: Reduction of risk potential;  
CL: Evaluate

**6. 4.** The nurse's most appropriate response is one that is therapeutic. The basic principle of therapeutic communication and a therapeutic relationship is honesty. Therefore, the nurse needs to explain truthfully that each client is different and that there are various forms of arthritis and arthritis treatment. To state that it is the physician's prerogative to decide how to treat the client implies that the client is not a member of his or her own health care team and is not a participant in his or her care. The statement also is defensive, which serves to block any further communication or questions from the client about the physician. Asking the client to tell more about the friend presumes that the client knows correct and complete information, which is not a valid assumption to make. The nurse does not know about the client's friend and should not make statements about another client's condition. Stating that the drug is for cases that are worse than the client's demonstrates that the nurse is making assumptions that are not necessarily valid or appropriate. Also, telling the client not to worry ignores the underlying emotions associated with the question, totally discounting the client's feelings.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**7. 4.** Positions of flexion should be avoided to prevent loss of functional ability of affected joints. Proper body alignment during rest periods is encouraged to maintain correct muscle and joint placement. Lying in the prone position is encouraged to avoid further curvature of the spine and internal rotation of the shoulders.


🔑 CN: Physiological adaptation;  
CL: Synthesize

**8. 4.** Carrying a laundry basket with clinched fingers and fists is not an example of conserving energy of small joints. The laundry basket should be held with both hands opened as wide as possible

and with outstretched arms so that pressure is not placed on the small joints of the fingers. When rising from a chair, the palms should be used instead of the fingers so as to distribute weight over the larger area of the palms. Holding packages close to the body provides greater support to the shoulder, elbow, and wrist joints because muscles of the arms and hands are used to stabilize the weight against the body. This decreases the stress and weight or pull on small joints such as the fingers. Objects can be slid with the palm of the hand, which distributes weight over the larger area of the palms instead of stressing the small joints of the fingers to pick up the weight of the object to move it to another place.

 CN: Basic care and comfort; CL: Evaluate


**9. 1.** Because some over-the-counter vitamin supplements contain folic acid, the client should avoid self-medication with vitamins while taking methotrexate, a folic acid antagonist. Because methotrexate is hepatotoxic, the client should avoid the intake of alcohol, which could increase the risk for hepatotoxicity. Methotrexate can cause bone marrow depression, placing the client at risk for infection. Therefore, meticulous mouth care is essential to minimize the risk of infection. Contraception should be used during methotrexate therapy and for 8 weeks after the therapy has been discontinued because of its effect on mitosis. Methotrexate is considered teratogenic.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**10. 2.** Difficulty seeing out of one eye, when evaluated in conjunction with the client's medication therapy regimen, leads to the suspicion of possible retinal degeneration. The possibility of an irreversible retinal degeneration caused by deposits of hydroxychloroquine (Plaquenil) in the layers of the retina requires an ophthalmologic examination before therapy is begun and at 6-month intervals. Although cataracts may develop in young adults, they are less likely, and damage from the hydroxychloroquine is the most obvious at-risk factor. Eyesight is not affected by the disease process of rheumatoid arthritis.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**11. 4.** Superficial heat applications, such as tub baths, showers, and warm compresses, can be helpful in relieving pain and stiffness. Exercises can be performed more comfortably and more effectively after heat applications. The client with rheumatoid arthritis must balance rest with exercise every day, not every other day. Typically, large doses of analgesics, which can lead to hepatotoxic effects, are not necessary. Learning to cope with the pain by refocusing is inappropriate.

 CN: Basic care and comfort;  
CL: Synthesize

**12. 1, 2, 5.** An arthrocentesis is performed to aspirate excess synovial fluid, pus, or blood from a joint cavity to relieve pain or to diagnosis inflammatory diseases such as rheumatoid arthritis. A local agent may be used to decrease the pain of the needle insertion through the skin and into the joint cavity. Aspiration of the fluid into the syringe can be very painful because of the size and inflammation of the joint. Usually a steroid medication is injected locally to alleviate the inflammation; a compression bandage is applied to help decrease swelling; and the client is asked to rest the joint for up to 24 hours afterwards to help relieve the pain and promote rest to the inflamed joint. The client may experience pain during this time until the inflammation begins to resolve and swelling decreases.

 CN: Reduction of risk potential;  
CL: Create

### The Client with Osteoarthritis


**13. 1, 4, 5.** To prepare a client for an arthrocentesis, the nurse should tell the client that a local anesthetic administered by the physician will decrease discomfort. There may be bleeding after the procedure, so the nurse should check the dressing. The client may experience pain. The nurse should offer pain medication and evaluate outcomes for pain relief. Because a local anesthetic is used, the client will not require preoperative medication. The client will rest the knee for 24 hours and then should begin range-of-motion and muscle strengthening exercises.

 CN: Management of care; CL: Create


**14. 1.** Metal will interfere with the test. Metallic objects within the examination field, such as jewelry, earrings, and dental amalgams, may inhibit organ visualization and can produce unclear images. Ingesting foods and beverages days before the test will not affect bone mineral status. Short-term calcium gluconate intake will also not influence bone mineral status. The client may already have had chronic pain as a result of a bone fracture or from osteoporosis.

 CN: Management of care; CL: Synthesize

**15. 1.** Shorter sessions will allow the client to rest between the sessions. Changing the physician's order to a different examination will not provide the information needed for this client's treatment. Acetaminophen is a nonopioid analgesic and an antipyretic, not an anti-inflammatory agent. Thus, it would not help this client avoid the adverse effects of a lengthy X-ray examination. Although the X-ray table is hard, there are other options for making the client comfortable, rather than canceling the examination.

 CN: Management of care; CL: Synthesize


**16. 4.** Osteoarthritis is a degenerative joint disease with local manifestations such as local joint pain, unlike rheumatoid arthritis, which has systemic manifestation such as anemia and osteoporosis. Weight loss occurs in rheumatoid arthritis, whereas most clients with osteoarthritis are overweight.

 CN: Physiological adaptation;  
CL: Analyze


**17. 1, 2, 3.** A diet with adequate amounts of vitamin D aids in the regulation, absorption, and subsequent utilization of calcium and phosphorus, which are necessary for the normal calcification of bone. Figs, broccoli, and almonds are very good sources of calcium. Moderate intake of alcohol has no known negative effects on bone density but excessive alcohol intake does reduce bone density. Swimming, biking, and other non-weight-bearing exercises do not maintain bone mass. Walking and running, which are weight-bearing exercises, do maintain bone mass. The client should eat a balanced diet but does not need to avoid the use of high-fat foods.

 CN: Reduction of risk potential;  
CL: Create


**18. 1.** Capsaicin cream, which produces analgesia by preventing the reaccumulation of substance P in the peripheral sensory neurons, is made from the active ingredients of hot peppers. Therefore, clients should wash their hands immediately after applying capsaicin cream if they do not wear gloves, to avoid possible contact between the cream and mucous membranes. Clients are instructed to avoid wearing tight bandages over areas where capsaicin cream has been applied because swelling may occur from inflammation of the arthritis in the joint and lead to constriction on the peripheral neurovascular system. Capsaicin cream should be stored in areas between 59° F and 86° F (15° C and 30° C). The cabinet over the stove in the kitchen would be too warm. Capsaicin cream should not come in contact with irritated and broken skin, mucous membranes, or eyes. Therefore it should not be used on cuts or burns.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**19. 3.** Drugs that cause gastric irritation, such as ibuprofen, are best taken after or with a meal, when stomach contents help minimize the local irritation. Taking the medication on an empty stomach at any time during the day will lead to gastric irritation. Taking the drug at bedtime with food may cause the client to gain weight, possibly aggravating the osteoarthritis. When the client arises, he is stiff from immobility and should use warmth and stretching until he gets food in his stomach.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**20. 1.** Corticosteroids are used for clients with osteoarthritis to obtain a local effect. Therefore, they are given only via intra-articular injection. Oral corticosteroids are avoided because they can cause an acceleration of osteoarthritis. Rheumatoid arthritis and osteoarthritis are two different diseases.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**21. 2.** Weight-bearing exercise plays a very important role in stimulating regeneration of cartilage, which lacks blood vessels, by driving synovial fluid through the joint cartilage. Joint mobility is increased by weight-bearing exercises, not range-of-motion exercises, because surrounding muscles, ligaments, and tendons are strengthened. Pain is an early sign of degenerative joint bone problems. Swelling may not occur for some time after pain, if at all. Osteoarthritic pain is worsened in cold, damp weather; therefore, exercising outdoors is not recommended year round in all settings.


 CN: Health promotion and maintenance;  
CL: Evaluate

## The Client with a Hip Fracture

**22. 4.** The hip spica cast is used for treatment of femoral fractures; it immobilizes the affected extremity and the trunk securely. It extends from above the nipple line to the base of the foot of both extremities in a double hip spica. Constipation, possible due to lack of mobility, can cause abdominal distention or bloating. When the spica cast becomes too tight due to distention, the cast will compress the superior mesenteric artery against the duodenum. The compression produces abdominal pain, abdominal pressure, nausea, and vomiting. The nurse should assess the abdomen for decreased bowel sounds, not the superior mesenteric artery. The surgeon cannot manipulate a fracture through a small window in a double hip spica cast. The nurse cannot use the window to aid in repositioning because the window opening can break and cause cast disruption.

 CN: Reduction of risk potential;  
CL: Evaluate

**23. 3.** With an intracapsular hip fracture, the affected leg is shorter than the unaffected leg because of the muscle spasms and external rotation. The client also experiences severe pain in the region of the fracture.

 CN: Physiological adaptation;  
CL: Analyze

**24. 4.** Multiple sclerosis would be the least likely chronic health problem for an older client with a hip fracture. Typically, multiple sclerosis is considered a

severe crippling disorder of young clients. Hypertension is a common chronic health problem in older clients. Cardiac decompensation is common in older clients; it arises from cardiac musculature changes and age-related changes in the heart. This comorbid condition can complicate the treatment and care when the older client experiences a hip fracture. Pulmonary disease commonly arises from age-related changes in the respiratory system. These comorbid conditions can complicate the treatment and care when the older client experiences a hip fracture.

 CN: Reduction of risk potential;  
CL: Analyze

**25. 4.** Insertion of a pin for the internal fixation of an extracapsular fractured hip provides good fixation of the fracture. The fracture site is stabilized and fractured bone ends are well approximated. As a result, the client is able to be mobilized sooner, thus reducing the risks of complications related to immobility. Internal fixation with a pin insertion does not prevent hemorrhage or decrease the risk of neurovascular impairment, potential complications associated with any joint or bone surgery. It does not lessen the client's risk of infection at the site.

 CN: Reduction of risk potential;  
CL: Apply

**26. 3.** The primary purpose of the drainage tube is to prevent fluid accumulation in the wound. Fluid, when it accumulates, creates dead space. Elimination of the dead space by keeping the wound free of fluid greatly enhances wound healing and helps prevent abscess formation. Although the characteristics of the drainage from the tube, such as a change in color or appearance, may suggest a possible infection, this is not the tube's primary purpose. The drainage tube does not eliminate the need for wound irrigation or provide a way to instill antibiotics into the wound.

 CN: Reduction of risk potential;  
CL: Apply

**27. 2, 3, 4, 5.** A client who has had a posterolateral total hip replacement should not adduct the hip joint, which would lead to dislocation of the ball out of the socket; therefore, the client should be encouraged to keep the toes pointed slightly outward when using a walker. An abduction pillow should be kept between the legs to keep the hip joint in an abducted position. The client should rotate between lying supine and lateral on the unoperated side, but not on the operated side. Ice is used to reduce swelling on the operative side. The client should not flex the operated hip beyond a 90-degree angle, such as when bending down to tie or slip on shoes. Doing so could lead to joint dislocation.

 CN: Reduction of risk potential;  
CL: Create

**28. 1, 3, 4.** A client who has had a total hip replacement via an anterolateral approach has almost the opposite precautions as those for a client who has had a total hip replacement through the posterolateral approach. The hip joint should not be actively abducted. The client should avoid turning the toes or knee outward. The client should keep the legs side by side without a pillow or wedge. The client should use an elevated toilet seat and shower chair and should not extend the operative leg backwards. The client should perform range-of-motion exercises as directed by the physical therapist.

 CN: Reduction of risk potential;  
CL: Create

**29. 2.** Being unable to move the affected leg suggests neurologic impairment. A decrease in the distal pulse, diminished capillary refill, and coolness to touch of the affected extremity suggest vascular compromise.

 CN: Reduction of risk potential;  
CL: Analyze

**30. 1.** Any activity or position that causes flexion, adduction, or internal rotation of greater than 90 degrees should be avoided until the soft tissue surrounding the prosthesis has stabilized, at approximately 6 weeks. Crossing the legs while sitting down can lead to dislocation of the femoral head from the hip socket. Sitting on a raised commode seat prevents hip flexion and adduction. Using an abductor splint while side-lying keeps the hip joint in abduction, thus preventing adduction and possible dislocation. Rising straight from a chair to a standing position is acceptable for this client because this action avoids hip flexion, adduction, and internal rotation of greater than 90 degrees.


 CN: Reduction of risk potential;  
CL: Synthesize

**31. 3.** A high-backed straight chair with armrests is recommended to help keep the client in the best possible alignment after surgery for a femoral head prosthesis placement. Use of this type of chair helps to prevent dislocation of the prosthesis from the socket. A desk-type swivel chair, padded upholstered chair, or recliner should be avoided because it does not provide for good body alignment and can cause the overly flexed femoral head to dislocate.

 CN: Reduction of risk potential;  
CL: Synthesize


**32. 2.** Although pets and furniture, such as snack tables and rocking chairs, may pose a problem, scatter rugs are the single greatest hazard in the home,

especially for elderly people who are unsure and unsteady with walking. Falls have been found to account for almost half the accidental deaths that occur in the home. The risk of falls is further compounded by the client's need for crutches.


 CN: Safety and infection control;  
CL: Synthesize

### The Client Having Joint Replacement Surgery

**33. 3.** When combined with a weight loss program, aquatic exercise would be best because it cushions the joints and allows the client to burn off calories. Aquatic exercise promotes circulation, muscle toning, and lung expansion, which promote healthy preoperative conditioning. Weight lifting and walking are too stressful to the joints, possibly exacerbating the client's osteoarthritis. Although tai chi exercise is designed for stretching and coordination, it would not be the best exercise for this client to help with weight loss.

 CN: Physiological adaptation;  
CL: Synthesize

**34. 4.** Before implementing a teaching plan, the nurse should determine the client's fears about the procedure. Only then can the client begin to hear what the nurse has to share about the individualized teaching plan designed to meet the client's needs. In the preoperative period, the client needs to learn how to correctly prevent hip flexion and to demonstrate coughing and deep breathing. However, this teaching can be effective only after the client's fears have been assessed and addressed. Although the client may appreciate seeing what a hip prosthesis looks like, so as to understand the new body part, this is not a necessity.

 CN: Psychosocial adaptation;  
CL: Synthesize


**35. 1.** The nurse should suspect nerve damage if numbness is present. However, whether the damage is short-term and related to edema or long-term and related to permanent nerve damage would not be clear at this point. The nurse needs to continue to assess the client's neurovascular status, including pain, pallor, pulselessness, paresthesia, and paralysis (the five P's). Bleeding would suggest vascular damage or hemorrhage. Dislocation would suggest malalignment. Pink color would suggest adequate circulation to the area. Numbness would suggest neurologic damage.

 CN: Reduction of risk potential;  
CL: Analyze


**36. 3.** The joint has dislocated when the client with a total joint prosthesis develops severe sudden pain and an inability to move the extremity. Clinical manifestations of an infection would include inflammation, redness, erythema, and possibly drainage and separation of the wound. Bleeding could be external (e.g., blood visible from the wound or on the dressing) or internal and manifested by signs of shock (e.g., pallor, coolness, hypotension, tachycardia). The seepage of glue into soft tissue would have occurred in the operating room, when the glue is still in the liquid form. The glue dries into the hard, fixed form before the wound is closed.

 CN: Reduction of risk potential;  
CL: Analyze

**37. 1.** An average adult requires approximately 1,100–1,400 mL of fluids per day. In some instances, such as when a person has an increase in body temperature or has increased perspiration, additional water may be necessary. With an increase in body temperature, there is also an increase in insensible fluid loss. The increased loss of fluid causes an increased need for fluid replacement. If the loss is significant and/or goes untreated, an individual's intake will not be balanced with output. Managing the incision, changing the bed linens, or keeping the client's skin cool are not outcomes indicative of resolution of a fluid volume deficit.

 CN: Physiological adaptation;  
CL: Synthesize

**38. 4.** After knee arthroplasty, the knee will be extended and immobilized with a firm compression dressing and an adjustable soft extension splint in place. A sequential compression device (SCD) will be applied. The SCD can be discontinued when the client is ambulatory, but while the client is in bed the SCD needs to be maintained to prevent thromboembolism. The SCD should be positioned on the bed, but not on two pillows. Settings for the SCD are ordered by the orthopedic surgeon. Initial dressing changes are completed by the orthopedic surgeon and changed as needed per physician order.

 CN: Reduction of risk potential;  
CL: Synthesize

**39. 1, 2, 3.** The nurse should instruct the client to notify the dentist and other health care providers of the need to take prophylactic antibiotics if undergoing any procedure (e.g., tooth extraction) due to the potential of bacteremia. The nurse should also advise the client that the metal components of the joint may set off the metal-detector alarms in airports. The client should also avoid MRI studies because the implanted metal components will be pulled toward the large magnet core of the MRI. Any weight bearing that is permitted is prescribed by the

orthopedic surgeon and is usually not limited to 5 lb. Post surgery, the client can resume a normal diet with regular fluid intake.

 CN: Health promotion and maintenance;  
CL: Create

**40. 4.** After total hip replacement, proper positioning by the nurse prevents dislocation of the prosthesis. The nurse should place the client in a supine position and keep the affected extremity in slight abduction using an abduction splint or pillows or Buck's extension traction. The client must not abduct or flex the operated hip because this may produce dislocation.

 CN: Reduction of risk potential;  
CL: Synthesize

**41. 2, 4, 5.** Following total hip replacement, the client should use the overhead trapeze to assist with position changes. The head of the bed should not be elevated more than 45 degrees; any height greater than 45 degrees puts a strain on the hip joint and may cause dislocation. To use a fracture bedpan, instruct the client to flex the unoperated hip and knee to lift buttocks onto pan. Toe-pointing exercises stimulate circulation in the lower extremities to prevent the formation of thrombi and potential emboli. The prone position is avoided shortly after a total hip replacement.

 CN: Reduction of risk potential;  
CL: Synthesize

**42. 1, 3, 4.** Administration of antibiotics as prescribed will aid in the acquisition of therapeutic blood levels during and immediately after surgery to prevent osteomyelitis. The nurse can request that a trapeze be added to the bed so the client can assist with lifting and turning. The nurse should also demonstrate and have the client practice isometric exercises (muscle setting) of quadriceps and gluteal muscles. The client will not use crutches after surgery; a physical therapy assistant will initially assist the client with walking by using a walker. The client will not use Buck's traction. The client will require anti-embolism stockings and use of a leg compression device to minimize the risk of thrombus formation and potential emboli; the leg compression device is applied during surgery and maintained per physician order.


 CN: Physiological adaptation; CL: Create

**43. 1, 2, 3, 4.** Client/family teaching should include advising the client to report any symptoms of unusual bleeding or bruising, dizziness, itching, rash, fever, swelling, or difficulty breathing to healthcare provider immediately. Instruct the client not to take aspirin or nonsteroidal anti-inflammatory drugs without consulting health care provider while on therapy. A low-molecular weight heparin is considered to be a high-risk medication and the client

should wear or carry medical identification. The air bubble should not be expelled from the syringe because the bubble insures the client receives the full dose of the medication. The client should allow 5 seconds to pass before withdrawing the needle to prevent seepage of the medication out of the site.

 CN: Pharmacological and parenteral therapies; CL: Create

**44. 3.** Dislocation precautions include: avoid extremes of internal rotation, adduction, and 90-degree flexion of affected hip for at least 4 to 6 weeks after the procedure. Use of an abduction pillow prevents adduction. Decreasing use of the abductor pillow does not strengthen the muscles to prevent dislocation. Informing a client to "not worry" is not therapeutic. A cushioned toilet seat does not prevent hip dislocation.

 CN: Psychosocial adaptation;  
CL: Synthesize

**45. 1, 2, 3.** Dislocation of a hip prosthesis may occur with positioning that exceeds the limits of the prosthesis. The nurse must recognize dislocation of the prosthesis. Signs of prosthesis dislocation include: acute groin pain in the affected hip, shortening of the affected leg, restricted ability or inability to move the affected leg, and reported "popping" sensation in the hip. Toe wiggling is not a test for potential hip dislocation.

 CN: Reduction of risk potential;  
CL: Analyze


**46. 4.** If a prosthesis becomes dislocated, the nurse should immediately notify the surgeon. This is done so the hip can be reduced and stabilized promptly to prevent nerve damage and to maintain circulation. After closed reduction, the hip may be stabilized with Buck's traction or a brace to prevent recurrent dislocation. If ordered by the surgeon, an ice pack may be applied post reduction to limit edema, although caution must be utilized due to potential muscle spasms. Some orthopedic surgeons may order the client be turned toward the side of the reduced hip but that is not the nurse's first response.

 CN: Reduction of risk potential;  
CL: Synthesize

**47. 3.** Infection is a serious complication of total hip replacement and may necessitate removal of the implant. Clients who are obese, poorly nourished, elderly, have poorly controlled diabetes, rheumatoid arthritis, or concurrent infections (e.g., dental, urinary tract) are at high risk for infection. Clients who are of normal weight and have well-controlled chronic diseases are not at risk for infection. Living alone is not a risk factor for infection.

 CN: Reduction of risk potential;  
CL: Synthesize

**48. 3.** Expected outcomes at the time of discharge from the surgical unit after a hip replacement include the following: increased independence in transfers, participates in progressive ambulation without pain or assistance, and raises the affected leg without assistance. The client will not be able to walk throughout the hospital, walk for a distance without some postoperative pain, or raise the affected leg more than several inches. The client may be referred to a rehabilitation unit in order to achieve the additional independence, strength, and pain relief.

 CN: Physiological adaptation;  
CL: Evaluate

**49. 1, 2, 3, 4.** Postoperatively, the knee in a total knee replacement is dressed with a compression bandage and ice may be applied to control edema and bleeding. Recurrent assessment by the nurse for neurovascular changes can prevent loss of limb. Normal neurovascular findings include: color normal, extremity warm, capillary refill less than 3 seconds, moderate edema, tissue not palpably tense, pain controllable, normal sensations, no paresthesia, normal motor abilities, no paresis or paralysis, and pulses strong and equal.

 CN: Reduction of risk potential;  
CL: Analyze

**50. 4.** The knee is usually protected with a knee immobilizer (splint, cast, or brace) and is elevated when the client sits in a chair. Pre- and post-surgery, the physician prescribes weight-bearing limits and use of assistive devices for progressive ambulation. Positioning a straight-backed chair at the foot of the bed is not an action conducive for getting the client out of bed on the evening of surgery for a total knee replacement.


 CN: Reduction of risk potential;  
CL: Synthesize

**51. 1, 4.** After a total knee replacement, efforts are directed at preventing complications, such as thromboembolism, infection, limited range of motion, and peroneal nerve palsy. The nurse should instruct the client to report signs of infection, such as an increased temperature. To prevent edema, the affected leg must remain elevated when the client sits in a chair. After discharge, the client may undergo physical therapy on an outpatient basis per physician order. The client should leave the dressing in place until the follow-up visit with the surgeon.

 CN: Reduction of risk potential;  
CL: Create

**52. 1.** Deep vein thrombosis is a complication of total joint replacement and may occur during hospitalization or develop later when the client is home. Clients who are obese or have previous history of

a DVT or PE are at high risk. Immobility produces venous stasis, increasing the client's chance to develop a venous thromboembolism. Signs of a DVT include: unilateral calf tenderness, warmth, redness, and edema (increased calf circumference). Findings should be reported promptly to the physician for definitive evaluation and therapy. Polyuria may be indicative of diabetes mellitus. Intussusception of the bowel and wound evisceration tend to occur after abdominal surgeries.

 CN: Reduction of risk potential;  
CL: Analyze

### The Client with a Herniated Disk

**53. 1.** The client is using correct body mechanics for lifting because she is keeping her back as straight as possible and is holding the box close to her body. She is using her large leg muscles to lift the box. She is using a broad base of support by placing her feet as wide apart as possible. The other suggestions would cause the client to put a strain on her back.

 CN: Reduction of risk potential;  
CL: Synthesize

**54. 3.** The client with low back pain should not exceed the prescribed exercises even though they may think, "If this will make me well, double will make me well quicker." When exceeding prescribed exercise programs, the client's muscle may be unconditioned and easily tired, leading to injury and increased pain. To use proper body mechanics when lifting light objects, the client should bring the item close to the center of gravity, which occurs when the object is kept below the level of the elbows. Leaning forward while bending the knees allows for the muscles of the thigh to be used instead of those of the lower back. Sleeping on the side with the legs flexed is appropriate because the spine is kept in a neutral position without twisting or pulling on muscles.

 CN: Reduction of risk potential;  
CL: Synthesize

**55.**

3. Assist the client to lie down.

4. Administer the prescribed celecoxib (Celebrex).

1. Apply a warm compress to the client's back.

2. Notify the physician.


When the client is not entirely able to get out of bed, the nurse should first assist the client to lie down for comfort/safety before administering the prescribed




Celebrex. Applying a warm compress will further promote relaxation of skeletal muscles. The physician should be kept informed of the client's status and nursing actions already taken.

 CN: Basic care and comfort;  
CL: Synthesize

**56. 2.** Standing with a flattened spine slightly tilted forward and slightly flexed to the affected side indicates a postural deformity. Motor changes would include findings such as hypotonia or muscle weakness. Absent or diminished reflexes related to the level of herniation would indicate alteration in reflexes. Sensory changes would include findings such as paresthesia and numbness related to the specific tract of the herniation.

 CN: Physiological adaptation;  
CL: Analyze

**57. 2.** A supine position with the client's legs flexed is the most comfortable position because it allows for the disc to recess off of the nerve, thus alleviating the pressure and pain. The prone position causes hyperextension of the spine and increased pressure of the disc on the nerve root on the right. A ruptured disc at L5–S1 right is a term commonly used in the analysis of a history and physical examination, magnetic resonance image, or myelogram to identify a ruptured disc compressing the right nerve root exiting the L5–S1 spinous process, as opposed to the central area or the left nerve root of that spinous process. If the ruptured area of the disc were in the central area of the spinous process, the prone position and hyperextension might relieve the disc pressure on the nerve. A high Fowler's or sitting position increases the pressure of the disc on the nerve root because of gravity, as does a right Sims position.

 CN: Physiological adaptation;  
CL: Synthesize

**58. 4.** Myelography, used to determine the exact location of a herniated disk, involves the use of a radiopaque dye (usually an iodized oil, but in some instances a water-soluble compound). In some instances, air is used for an air-contrast study.

 CN: Reduction of risk potential;  
CL: Apply

**59. 4.** An I.V. line is not required for an MRI. If a client has an I.V. line, it is usually converted to an intermittent infusion device, such as a saline lock, to avoid infiltration during transport of the client and completion of the procedure. When a contrast agent is used, the client is moved out of the cylinder, the contrast material is injected, and the client is moved back in. An MRI scan is painless. Typically the staff positions the client with pillows, blankets, earplugs, and music, to ensure client comfort, before


the procedure is started. A history of past surgeries is important, especially if the surgery involved implantation of any metallic devices (e.g., implants, clips, pacemakers). Additionally, the nurse needs to assess for hearing aids, electronic devices, shrapnel, bra hooks, necklaces, jewelry, credit cards, zippers, or any type of metal that the magnet of the MRI unit would attract. Although open MRI units are now available, they are not in widespread use. Therefore, the nurse needs to determine whether the client is claustrophobic because the unit is a closed cylinder in which the client hears pops of noise. A number of clients develop claustrophobia that causes the procedure to be cancelled. If the client is claustrophobic, the procedure may need to be rescheduled after an open MRI unit is located or made available.

 CN: Reduction of risk potential;  
CL: Synthesize


**60. 2.** Based on the client's complaints, the nurse should call the surgeon to verify the location of the surgery. The client's complaints indicate radiculopathy of L4 to L5, but the consent form states L3 to L4. Radiculopathy of L3 to L4 involves pain radiating from the back to the buttocks to the posterior thigh to the inner calf. The nurse must act as a client advocate and not ask the client to sign the consent until the correct procedure is identified and confirmed on the consent. The nurse has no legal authority or responsibility to change the consent. The history is a source of information, but when the client is coherent and the history is contradictory, the physician should be contacted to clarify the situation. Ultimately, it is the surgeon's responsibility to identify the site of surgery specified on the surgical consent form.

 CN: Management of care; CL: Synthesize


**61. 2.** Ondansetron hydrochloride (Zofran) is a selective serotonin receptor antagonist that acts centrally to control the client's nausea in the postoperative phase. It does not control muscle spasms, shivering, or dry mouth.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**62. 4.** Sweeping causes a twisting motion, which should be avoided because twisting can cause undue stress on the recently ruptured disc site, muscle spasms, and a potential recurrent disc rupture. Although the client should not bend at the waist, such as when washing dishes at the sink, the client can dry dishes because no bending is necessary. The client can sit in a firm chair that keeps the back anatomically aligned. The client should not twist and pull, so when making the bed, the client should pull the covers up on one side and then walk around to the other side before trying to pull the covers up there.

 CN: Physiological adaptation;  
CL: Evaluate

**63. 4.** After a lumbar laminectomy L4–5, a client who is returning to work should avoid sitting whenever possible. If the client must sit, he or she should sit only in chairs that allow the knees to be higher than the hips and support the arms to maintain correct body alignment and reduce undue stress on the spine. Maintaining good body postures is most important after a lumbar laminectomy L4–5. By 6 weeks after the surgery, the client should have regained stamina. To maintain correct body posture, the client should also place one foot on a stepstool during prolonged standing. Sleeping on the back with a support under the knees is effective in maintaining correct body posture. Maintaining an average weight for height is important in maintaining a healthy back because carrying extra weight causes undue stress on back muscles.

 CN: Physiological adaptation;  
CL: Synthesize

**64. 2.** Clear yellowish fluid on the dressing may be cerebrospinal fluid (CSF). This fluid must be tested for glucose to determine whether it is CSF. If so, the client is at great risk for an infection of the central nervous system, which has a high mortality rate. The client should be able to laterally rotate the head and neck, which is above the surgical site in the spinal column. During the nursing postoperative neuromuscular-vascular assessment of movement of the head and neck, the nurse should find results consistent with the preoperative baseline status. Using the standing position to void is normal for a male client. Coughing is the body's defense mechanism to help clear the lungs of the anesthetic agents and to ventilate the lungs in response to a sustained deep inspiration for ventilation of the lower lobes of the lungs. A frequent cough could place a strain on the incision site and should be avoided. Also, a productive cough of thick, yellow sputum would indicate the complication of a respiratory infection.

 CN: Reduction of risk potential;  
CL: Analyze

**65.**

2. Verify the order for the settings for the brace.


1. Have the client in a side-lying position.

4. Assist the client to log roll and rise to a sitting position.

3. Ask the client to stand with arms held away from the body.

The nurse should first verify the settings for the brace and activity orders. Next, the client should be in a side-lying position; explain that the spine


should be kept aligned and in a neutral position. Teach not to pull on objects with arms. For getting out of bed, log roll client to side, splint back, and rise to a sitting position by pushing against mattress while swinging legs over the side of the bed. Finally, the client should stand with the arms outstretched so the nurse can apply the brace.

 CN: Physiological adaptation;  
CL: Synthesize

**66. 4.** The client should wear a thin cotton undershirt under the brace to prevent the brace from abrading directly against the skin. The cotton material also aids in absorbing any moisture, such as perspiration, that could lead to skin irritation and breakdown. Applying lotion is not recommended before applying the brace because further skin breakdown can result (related to the collection of moisture where microorganisms can grow) and irritants from the lotion can cause further irritation. Applying extra padding (e.g., to the iliac crests) is not recommended because the padding can become wrinkled, producing more pressure sites and skin breakdown. Use of baby or talcum powder is not recommended because the irritation from the talcum also can cause irritation and skin breakdown.

 CN: Reduction of risk potential;  
CL: Evaluate


**67. 1.** Typically, the donor site causes more pain than the fused site does because inflammation, swelling, and venous oozing around the nerve endings in the donor site, where the subcutaneous tissue was removed, occur during the first 24 to 48 hours postoperatively. After surgery, the surgeon applies a pressure dressing to the donor site to compress the veins that were transected for the removal of subcutaneous tissue but that did not stop oozing blood after surgical cauterization during the surgical procedure. Pressure on a transected vein, which is low pressure, stops the oozing and loss of blood from the venous site. When the donor site is the fibula, neurovascular checks must be performed every hour to ensure adequate neurologic function of and circulation to the area. The surgeon, not the degree or amount of pain, specifies activity restrictions.

 CN: Physiological adaptation;  
CL: Synthesize

**68. 1.** A client who has had back surgery should place his feet flat on the floor to avoid strain on the incision. Placing the feet on a low or high footstool or in any other position of comfort with the legs uncrossed increases the pressure on the suture line and increases the inflammation around the involved nerve root, thereby increasing the risk of possible reupture of the disc site.

 CN: Reduction of risk potential;  
CL: Evaluate

**69. 4.** After a lumbar laminectomy, a client should not sit for prolonged periods in a chair because of the increased pressure against the nerve root and incision site. Assisting with daily hygiene is an appropriate activity during the initial postoperative period because, as with any surgical procedure, the client needs to return to her optimal level of functioning as soon as possible. There is no limitation on the client's participation in daily hygiene activities except for her individual response of pain, nausea, vomiting, or weakness. Lying flat in bed is appropriate because it does not cause stress on the spinal column where the laminectomy was performed and the disc tissue was removed. Positions that should be avoided are those that would cause twisting and flexion of the spine. Walking in the hall is an acceptable activity. It promotes good postoperative ventilation, circulation, and return of peristalsis, which are needed for all surgical clients. In addition, walking provides the postoperative lumbar laminectomy client an opportunity to build up endurance and muscle strength and to promote circulation to the operative and incision sites for healing without twisting or stressing them.


 CN: Physiological adaptation;  
CL: Synthesize

**70. 3.** Sit-ups are not recommended for the client who has had a lumbar laminectomy because these exercises place too great a stress on the back. Knee-to-chest lifts, hip tilts, and pelvic tilt exercises are recommended to strengthen back and abdominal muscles.


 CN: Reduction of risk potential;  
CL: Synthesize

### The Client with an Amputation due to Peripheral Vascular Disease

**71. 3.** Typically, peripheral vascular disease is considered to be a disorder affecting older adults. Therefore, an age of 39 years would not be considered as a risk factor contributing to the development of peripheral vascular disease. Uncontrolled diabetes mellitus is considered a risk factor for peripheral vascular disease because of the macroangiopathic and microangiopathic changes that result from poor blood glucose control. Cigarette smoking is a known risk factor for peripheral vascular disease. Nicotine is a potent vasoconstrictor. Serum cholesterol levels greater than 200 mg/dL are considered a risk factor for peripheral vascular disease.

 CN: Health promotion and maintenance;  
CL: Analyze


**72. 2.** The client with severe arterial occlusive disease and gangrene of the left great toe would have lost the hair on the leg due to decreased circulation to the skin. Edema around the ankle and lower leg would indicate venous insufficiency of the lower extremity. Thin, soft toenails (i.e., not thickened and brittle) are a normal finding. Warmth in the foot indicates adequate circulation to the extremity. Typically, the foot would be cool to cold if a severe arterial occlusion were present.

 CN: Physiological adaptation;  
CL: Analyze

**73. 3.** The client should be tobacco-free for 30 minutes before the test to avoid false readings related to the vasoconstrictive effects of smoking on the arteries. Because this test is noninvasive, the client does not need to sign a consent form. The client should receive an opioid analgesic, not a sedative, to control the pain as the blood pressure cuffs are inflated during the Doppler studies to determine the ankle-to-brachial pressure index. The client's ankle should not be covered with a blanket because the weight of the blanket on the ischemic foot will cause pain. A bed cradle should be used to keep even the weight of a sheet off the affected foot.

 CN: Reduction of risk potential;  
CL: Synthesize

**74. 2.** Slow, steady walking is a recommended activity for the client with peripheral arterial disease because it stimulates the development of collateral circulation needed to ensure adequate tissue oxygenation. The client with peripheral arterial disease should not minimize activity. Activity is necessary to foster the development of collateral circulation. Elevating the legs above the heart is an appropriate strategy for reducing venous congestion. Wearing antiembolism stockings promotes the return of venous circulation, which is important for clients with venous insufficiency. However, their use in clients with peripheral arterial disease may cause the disease to worsen.


 CN: Physiological adaptation;  
CL: Evaluate

**75. 1.** Daily lubrication, inspection, cleaning, and patting dry of the feet should be performed to prevent cracking of the skin and possible infection. Soaking the feet in warm water should be avoided because soaking can lead to maceration and subsequent skin breakdown. Additionally, the client with arterial insufficiency typically experiences sensory changes, so the client may be unable to detect water that is too warm, thus placing the client at risk for burns. Antiembolism stockings, appropriate for clients with venous insufficiency, are inappropriate for clients with arterial insufficiency and could lead


to a worsening of the condition. Footwear should be roomy, soft, and protective and allow air to circulate. Therefore, firm, supportive leather shoes would be inappropriate.

 CN: Reduction of risk potential;  
CL: Synthesize

**76. 2.** Encouraging the client who will be undergoing amputation to verbalize his feelings is the most therapeutic response. Asking the client to tell more about how he is feeling helps to elicit information, providing insight into his view of the situation and also providing the nurse with ideas to help him cope. The nurse should avoid value-laden responses, such as, “At least you will still have one good leg to use,” that may make the client feel guilty or hostile, thereby blocking further communication. Furthermore, stating that the client still has one good leg ignores his expressed concerns. The client has verbalized feelings of helplessness by using the term “invalid.” The nurse needs to focus on this concern and not try to complete the teaching first before discussing what is on the client’s mind. The client’s needs, not the nurse’s needs, must be met first. It is inappropriate for the nurse to assume to know the relationship between the client and his wife or the roles they now must assume as dependent client and caregiver. Additionally, the response about the client’s wife caring for him may reinforce the client’s feelings of helplessness as an invalid.


 CN: Psychosocial adaptation;  
CL: Synthesize

**77. 2.** The level of amputation often cannot be accurately determined until during surgery, when the surgeon can directly assess the adequacy of the circulation of the residual limb. From a moral, ethical, and legal viewpoint, the surgeon attempts to remove as little of the leg as possible. Although a longer residual limb facilitates prosthesis fitting, unless the stump is receiving a good blood supply the prosthesis will not function properly because tissue necrosis will occur. Although the client’s ability to walk with a prosthesis is important, it is not a determining factor in the decision about the level of amputation required. Blood supply to the tissue is the primary determinant.


 CN: Physiological adaptation;  
CL: Synthesize

**78. 4.** The priority action is to draw a mark around the site of bleeding to determine the rate of bleeding. Once the area is marked, the nurse can determine whether the bleeding is increasing or decreasing by the size of the area marked. Because the spot is bright red, the bleeding is most likely arterial in origin. Once the rate and source of bleeding are identified, the surgeon should be notified. The stump is not elevated because adhesions may

occur, interfering with the ability to fit a prosthesis. The dressing would be reinforced if the bleeding is determined to be of venous origin, characterized by slow oozing of darker blood that ceases with the application of a pressure dressing. Typically, operative dressings are not changed for 24 hours. Therefore, the dressing is reinforced to prevent organisms from penetrating through the blood-soaked areas of the initial postoperative dressing.

 CN: Physiological adaptation;  
CL: Synthesize

**79. 4.** The nurse’s first action should be to administer the prescribed opioid analgesic to the client, because this phenomenon is phantom sensation and interventions should be provided to relieve it. Pain relief is the priority. Phantom sensation is a real sensation. It is incorrect and inappropriate to tell a client that it is impossible to feel the pain. Although it does relieve the client’s apprehensions to be told that phantom sensations are a real phenomenon, the client needs prompt treatment to relieve the pain sensation. Usually phantom sensation will go away. However, showing the client that the toes are not there does nothing to provide the client with relief.

 CN: Physiological adaptation;  
CL: Synthesize


**80. 4.** Use of crutches requires significant strength from the triceps muscles. Therefore, efforts are focused on strengthening these muscles in anticipation of crutch walking. Bed and wheelchair push-ups are excellent exercises targeted at the triceps muscles. Abdominal exercises, range-of-motion and isometric exercises of the shoulders, and quadriceps and gluteal setting exercises are not helpful in preparing for crutch walking.

 CN: Reduction of risk potential;  
CL: Synthesize

**81. 4.** When using crutches, the client is taught to support her weight primarily on the hands. Supporting body weight on the axillae, elbows, or upper arms must be avoided to prevent nerve damage from excessive pressure.

 CN: Reduction of risk potential;  
CL: Synthesize

**82. 4.** Before beginning dietary instructions and interventions, the nurse must first assess the client’s and family’s food preferences, such as pattern of food intake, life style, food preferences, and ethnic, cultural, and financial influences. Once this information is obtained, the nurse can begin teaching based on the client’s current knowledge level and then building on this knowledge base.


 CN: Physiological adaptation;  
CL: Synthesize

## The Client with Fractures

**83. 3.** Isometric contractions increase the tension within a muscle but do not produce movement. Repeated isometric contractions make muscles grow larger and stronger. Adduction of the leg puts work onto the hip joint as well as altering the pull of traction. Rolling the leg, or *external rotation*, alters the pull of traction. Additional weight should not be added to traction unless ordered by the physician; it will not prevent muscle atrophy.

 CN: Reduction of risk potential;  
CL: Evaluate


**84. 3.** Methocarbamol is a muscle relaxant and acts primarily to relieve muscle spasms. It has no effect on microorganisms, does not reduce itching, and has no effect on nervousness.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**85. 1, 2, 3.** Acetaminophen is an alternative for a client who is allergic to aspirin. It does not affect platelet aggregation and the client does not need to have coagulation studies (such as INR). Acetaminophen causes little or no gastric distress. Acetaminophen exerts no anti-inflammatory effects.


 CN: Pharmacological and parenteral therapies; CL: Create

**86. 3.** Hypotension, tachycardia, and depressed respirations are signs of high levels of ingestion of muscle relaxants, and the client may be developing a habit of taking this drug for a prolonged period. The potential for abuse should be considered when large doses of a muscle relaxant such as carisoprodol are taken for prolonged periods. Expected common adverse effects would include drowsiness, fatigue, lassitude, blurred vision, headache, ataxia, weakness, and gastrointestinal upset. Hemorrhage from gastrointestinal irritation is not associated with this drug. Hypersensitivity reactions would be manifested by pruritus and rashes.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**87. 3.** The nursing assessment is first focused on the region distal to the fracture for neurovascular injury or compromise. When a nerve or blood vessel is severed or obstructed at the actual fracture site, innervation to the nerve or blood flow to the vessel is disrupted below the site; therefore, the area distal to the fracture site is the area of compromised neurologic input or vascular flow and return, not the area above the fracture site or the fracture site itself. The nurse may assess the opposite extremity at the area proximal to the fracture site for a baseline comparison of pulse quality, color, temperature, size,


and so on, but the comparison would be made after the initial neurovascular assessment.

 CN: Physiological adaptation;  
CL: Analyze

**88. 3.** Clients should not pull out cast padding to scratch inside the cast because of the hazard of skin breakdown and subsequent potential for infection. Clients are encouraged to elevate the casted extremity above the level of the heart to reduce edema and to exercise or move the joints above and below the cast to promote and maintain flexibility and muscle strength. Applying ice for 10 minutes during the first 24 hours helps to reduce edema.

 CN: Reduction of risk potential;  
CL: Evaluate

**89. 2.** The client in a double hip spica cast should avoid eating foods that can be constipating, such as cheese. Rather, fresh fruits and vegetables should be encouraged and the client should be encouraged to drink at least 2,500 mL/day. Drinking cranberry juice, which helps keep urine acidic, thereby avoiding the development of renal calculi, is encouraged. The client should be encouraged to establish regular times for elimination to promote regularity in bowel and bladder habits. The client will develop orthostatic hypotension unless the circulatory system is reconditioned slowly through dangling and standing exercises.


 CN: Physiological adaptation;  
CL: Synthesize

**90. 2.** A two-point gait involves partial weight bearing on each foot, with each crutch advancing simultaneously with the opposing leg. Advancing a crutch on one side and then advancing the opposite foot, and repeating on the opposite side, illustrates the four-point gait. When the client advances both crutches together and follows by lifting both lower extremities to the same level as the crutches, the gait is called a “swing to” gait. When the client advances both crutches together and follows by lifting both lower extremities past the level of the crutches, the gait is called a “swing through” gait. The “swing through” gait is often used by paraplegic clients because it allows them to place weight on their legs while the crutches are moved one stride ahead.


 CN: Reduction of risk potential;  
CL: Synthesize

**91. 1.** The wound was left open with a three-way drainage system in place to irrigate the debrided wound with normal saline or an antibiotic. Before the debridement, a sample of the wound would be taken for culture and sensitivity testing so that an organism-specific antibiotic could be administered to prevent possible serious sequelae of osteomyelitis. Therefore, the nurse should review the results of

the culture and sensitivity report. A pressure dressing would not be applied to an open wound. Rather, a wet-to-dry dressing most likely would be used. There should not be increased pain related to the exposure of nerve endings in the subcutaneous tissue of the wound that was left open to the environment. The bleeding of vessels should be controlled as it would have been if the wound had been closed. Therefore, additional vessel bleeding should not be a problem.

 CN: Physiological adaptation;  
CL: Synthesize

**92. 1.** The nurse should assess the client's ability to move her toes and for the presence of distal pulses, including a neurovascular assessment of the area below the cast. Increasing pain unrelieved by usual analgesics and occurring 4 to 12 hours after the onset of casting or trauma may be the first sign of compartment syndrome, which can lead to permanent damage to nerves and muscles. Although the nurse can use a pain rating scale or assess for changes in vital signs to objectively assess the client's pain, the client's complaints suggest early and important signs of compartment syndrome requiring immediate intervention. The nurse should not confuse these signs with the potential for drug tolerance. This assessment might be appropriate once the suspicion of compartment syndrome has been ruled out.


 CN: Physiological adaptation;  
CL: Analyze

**93. 4.** The client with compartment syndrome may release myoglobin from damaged muscle cells into the circulation. This becomes trapped in the renal tubules, resulting in dark, scanty urine, possibly leading to acute renal failure. Crackles may suggest respiratory complications; jaundice suggests liver failure; and generalized edema may suggest heart failure. However, these are not associated with compartment syndrome.

 CN: Reduction of risk potential;  
CL: Analyze

### The Client with a Femoral Fracture

**94. 4.** Passive immunity for tetanus is provided in the form of tetanus antitoxin or tetanus immune globulin. An antitoxin is an antibody to the toxin of an organism. Administering tetanus toxoid, antigen, or vaccine would provide active immunity by stimulating the body to produce its own antibodies.

 CN: Pharmacological and parenteral therapies; CL: Apply

**95. 4.** Skeletal traction is not used to pull weight with a boot. Skeletal traction involves the insertion of a wire or a pin into the bone to maintain a pull of 5 to 45 lb on the area, promoting proper alignment of the fractured bones over a long term.

 CN: Reduction of risk potential;  
CL: Evaluate

**96. 4.** The client with a femoral fracture in balanced suspension traction should not be given a complete bed bath. Rather, the client is encouraged to participate in self-care and movement in bed, such as with a trapeze triangle. Use of a fracture bedpan is appropriate. A fracture bedpan is lower, and it is easier for the client to move on and off the bedpan without altering the line of traction. Checking for areas of redness or pressure over all areas in contact with the traction or bed, including the ischial tuberosity, is important to prevent possible skin breakdown. The client should be positioned so that the feet do not press against the footboard. Therefore, elevating the head of the bed no more than 25 degrees is recommended to keep the client from moving down in the bed.

 CN: Reduction of risk potential;  
CL: Synthesize

**97. 3.** Neurovascular checks should be performed distal or past the site of the splint, not proximal or above the site of the splint, at least every 4 hours. An injury or compromise to the peripheral nervous innervation or blood flow will reflect a change on the site of the splint after the pathway from the heart and brain. Checking the skin over the greater trochanter is appropriate because the half-ring of the Thomas splint can slide around the greater trochanter area where the traction is applied; it should be checked routinely along with other areas at high risk for pressure necrosis, such as the fibular head, ischial tuberosity, malleoli, and hamstring tendons. Inspecting the pin site is appropriate because any drainage or redness might indicate an infection in the bone in which the pin is inserted. Immediate treatment is imperative to avoid osteomyelitis and possible loss of the limb. Evaluation of the foot for movement is important to obtain neuromuscular-vascular data for assessment in comparison with the baseline data of the affected extremity and with the opposite extremity to detect any compromise of the client's condition.

 CN: Reduction of risk potential;  
CL: Synthesize

**98. 3.** The nurse should send the client to the operating room on his bed with extra help to keep the traction from moving to maintain the femur in the proper alignment before surgery. Transferring the client to a cart with manually suspended traction is

inappropriate because doing so places the client at risk for additional trauma to the surrounding neurovascular and soft tissues, as would removing the traction. The surgeon need not be called because the decision about transferring the client is an independent nursing action.

 CN: Reduction of risk potential;  
CL: Synthesize


**99. 1.** The Pearson attachment supports the lower leg and provides increased stability in the overall traction setup. It also makes it easier to maintain correct alignment. It does not support the thigh and upper leg or prevent flexion deformities in the ankle and foot. It is not attached to the skeletal pin.

 CN: Reduction of risk potential;  
CL: Apply

**100. 1.** Fat emboli usually result in symptoms of acute respiratory distress syndrome, such as apprehension, chest pain, cyanosis, dyspnea, tachypnea, tachycardia, and decreased partial pressure of arterial oxygen resulting from poor oxygen exchange. Migraine-like headaches are not a symptom of a fat embolism, but mental confusion, memory loss, and a headache from poor oxygen exchange may be seen with central nervous system involvement. Numbness in the right leg is a peripheral neurovascular response that most likely is related to the femoral fracture. Muscle spasms in the right thigh are a symptom of a neuromuscular response affecting the local muscle around the femoral fracture site.

 CN: Reduction of risk potential;  
CL: Analyze

**101. 2.** Based on the client's statements, *Ineffective coping* is the most appropriate nursing diagnosis because the client is voicing frustration about the current situation and her inability to move. The nurse should seek ways to help the client adjust to and cope with her present state of immobility. Emphasis should be placed on what the client can do to care for herself, such as participating in her daily care and exercises to maintain muscle strength, to help her maintain some control over her situation. The data do not support a diagnosis of *Impaired mobility*, *Deficient diversional activities*, or *Activity intolerance*.

 CN: Psychosocial adaptation;  
CL: Analyze

**102. 1.** The client can sit up in bed, remaining in the supine position so that an even, sustained amount of traction is maintained under the bandage used in the Buck's traction. Maintenance of even, sustained traction decreases the chance that the bandage or traction strap might slip and cause compression or stress on the nerves or vascular tracts,

resulting in permanent damage. The client does not have to remain flat but may adjust the head of the bed to varying degrees of elevation while remaining in the supine position. The client should not turn his body to another position because the bandage may slip.

 CN: Reduction of risk potential;  
CL: Synthesize

**103. 1.** The nurse should assess for signs of skin pressure in the groin area because the Thomas splint, which is a half-ring that slips over the thigh and suspends the lower extremity in direct skeletal traction, may cause discomfort, pressure, or skin irritation in the groin. The nurse always assesses respirations as part of routine vital signs, but assessing for evidence of decreased breath sounds is not a routine assessment related directly to the Thomas splint. The head of the bed can be elevated to facilitate breathing, but not more than 25 degrees, to avoid continually moving the client toward the foot of the bed from the weight of the traction. The nurse always assesses for pressure areas on dependent parts, but assessing for skin breakdown behind the heel is not a routine assessment related directly to the Thomas splint, in which the heel is free of any contact with padding or metal parts of the Pearson attachment for the balanced suspension traction. The client who is in a Thomas splint is able to use a bedpan to urinate, especially the fracture bedpan for a female client and the urinal for a male. Urine retention should not be a special assessment directly related to the Thomas splint, but it may be a client-specific assessment.

 CN: Reduction of risk potential;  
CL: Analyze

**104. 1.** The client's assisting as much as possible in his care and increasing participation over time indicate that the client has accomplished self-care by gaining a sense of control. If the client lets the nurse complete his care without interfering, his behavior would indicate passivity, possibly from denial or depression. If the client allows his wife to assume total responsibility for his care or to complete his care, he still has a self-care deficit and a successful outcome has not been reached.


 CN: Basic care and comfort; CL: Evaluate

**105. 2.** Fever, night sweats, chills, restlessness, and restrictive movement of the fractured leg are clinical manifestations of osteomyelitis, which is a pyogenic bone infection caused by bacteria (usually staphylococci), a virus, or a fungus. The bone is inaccessible to macrophages and antibodies for protection against infections, so an infection in this site can become serious quickly. The client with a pulmonary or fat embolus would develop symptoms of pulmonary compromise, such as shortness

of breath, chest pain, angina, and mental confusion. Signs and symptoms of urinary tract infection would include pain over the suprapubic, groin, or back region with fever and chills, with no restrictive movement of the leg.

 CN: Reduction of risk potential;  
CL: Analyze

**106. 2.** The goal of care for this client is healing and tissue growth while the client continues on long-term antibiotic therapy to clear the infection. A diet high in protein and vitamins C and D promotes healing. Herbal supplements may potentiate bleeding (e.g., ginkgo, ginger, tumeric, chamomile, kelp, horse chestnut, garlic, and dong quai) and have not been proven through research to promote healing. Frequent passive motion will increase circulation but may also aggravate localized bone pain. It is not appropriate to advise the client to change antibiotics as treatment may take time.

 CN: Physiological adaptation;  
CL: Synthesize

### The Client with a Spinal Cord Injury


**107. 3.** The priority concern is to immobilize the head and neck to prevent further trauma when a fractured vertebra is unstable and easily displaced. Although wrapping and supporting the extremities is important, it does not take priority over immobilizing the head and neck. Pain usually is not a significant consideration with this type of injury. Cushioning is contraindicated. The neck should be kept in a neutral position and immobilized. Flexion of the neck is avoided.

 CN: Safety and infection control;  
CL: Synthesize

**108. 3.** This client has a spinal cord injury of the sacral region of the spinal cord and will have bladder and bowel dysfunction, as well as loss of sensation and muscle control below the injury. The other options are true of a client who has quadriplegia.

 CN: Physiological adaptation;  
CL: Analyze

**109. 2.** Although assessment of renal status, gastrointestinal function, and biliary function is important, with the spinal cord transection at T4 the client's vascular status is the primary focus of the nursing assessment because the sympathetic feedback system is lost and the client is at risk for hypotension and bradycardia.

 CN: Physiological adaptation;  
CL: Analyze

**110. 1.** The client with a spinal cord transection above T5 is least likely to develop diarrhea. Rather, constipation due to atonia would be possible. The client with a spinal cord transection above T5 is at risk for development of a paralytic ileus because the sympathetic nerve innervation to the vagus nerve, which dominates all the vessels and organs below T5 (e.g., the intestinal tract), has been disrupted and therefore so has movement or peristalsis. The client is at risk for development of stress ulcers because the sympathetic nerve innervation to the stomach has been disrupted, which results in an excessive release of hydrochloric acid in the stomach, allowing contact of hydrochloric acid with the stomach mucosa. The client does not feel subjective signs of stress ulcers (e.g., pain, guarding, tenderness) and therefore is at increased risk for bleeding because complications of an ulcer can develop before early diagnosis.

 CN: Reduction of risk potential;  
CL: Synthesize

**111. 1.** The client should eat enough calories to maintain her desired weight, a positive nitrogen balance, and enough protein to help decrease the rate of muscle atrophy and prevent skin breakdown and infection. The client with a spinal cord injury does not have poikilothermy, the ability to adjust body temperature to the environmental temperature. The client should add additional clothes or coverage below the level of transection in cool environments. The client does not sweat below the level of transection and should be sensitive to the possibility of overheating in extremely hot climates and the need for sprinkling or moving into an air-conditioned environment. The client with intermittent nasogastric suctioning is at risk for development of metabolic alkalosis and an electrolyte imbalance that leads to decreased tissue perfusion; therefore, the client needs to increase the sodium and potassium in her diet, not decrease the sodium.

 CN: Reduction of risk potential;  
CL: Synthesize

**112. 4.** Measuring the leg girth is the most appropriate method because the usual signs, such as a positive Homans' sign, pain, and tenderness, are not present. Other means of assessing for deep vein thrombosis in a client with a spinal cord injury are through a Doppler examination and impedance plethysmography.

 CN: Reduction of risk potential;  
CL: Analyze


**113. 3.** During the period of spinal shock, the bladder is completely atonic and will continue to fill passively unless the client is catheterized. The




bladder will not go into spasms or cause uncontrolled urination. Bladder function will not be normal during the period of spinal shock.

 CN: Reduction of risk potential;  
CL: Analyze

**114. 4.** The movements occur from muscle reflexes and cannot be initiated or controlled by the brain. After the period of spinal shock, the muscles gradually become spastic owing to an increased sensitivity of the lower motor neurons. It is an expected occurrence and does not indicate that healing is taking place or that the client will walk again. The movement is not voluntary and cannot be brought under voluntary control.

 CN: Physiological adaptation;  
CL: Synthesize

**115. 3.** Long-bone demineralization is a serious consequence of the loss of weight bearing. An excessive calcium load is brought to the kidneys, and precipitation may occur, predisposing to stone formation. Excessive intake of dairy products may promote constipation. However, this is not the most accurate reason for decreasing calcium intake. Immobility does not increase calcium absorption from the intestine. Dairy products do not necessarily contribute to weight gain.


 CN: Basic care and comfort;  
CL: Synthesize

**116. 2.** The woman with spinal cord injury can participate in sexual activity but might not experience orgasm. Cessation in the nerve pathway may occur in spinal cord injury, but this does not negate the client's mental and emotional needs to creatively participate with her partner in a sexual relationship and to reach orgasm. An indwelling urinary catheter may be left in place during intercourse and need not be removed because the indwelling urinary catheter is placed in the urethra, which is not the channel used for sexual intercourse. There are no contraindications, such as hypertension, to sexual activity in a woman with spinal cord injury. Sexual intercourse is allowed, and hypertension should be manageable. Because a spinal cord injury does not affect fertility, the client should have access to family planning information so that an unplanned pregnancy can be avoided.

 CN: Basic care and comfort; CL: Evaluate

**117. 3.** Spinal cord injury represents a physical loss; grief is the normal response to this loss. Working through grief entails reviewing memories and eventually letting go of them. The process may take as long as 2 years. Telling the client to be patient and that adjustment takes time is a clichéd type of response, one that is not empathetic or responsive

to the client's needs. Telling the client to focus on today does not allow time for the grief process, which is necessary for the client to work through and adjust to the loss. The client is not escaping but is reminiscing on what is lost, to work through the grieving process.

 CN: Psychosocial adaptation;  
CL: Synthesize

## Managing Care Quality and Safety

**118. 1, 2, 3, 5.** A restraint is a method of involuntary physical restriction of a client's freedom of movement, physical activity, or normal access to his/her body. The nurse must monitor and provide care to optimize the physical and psychological well-being of the client including, but not limited to, respiratory and circulatory status, skin integrity, and vital signs. With each assessment, the nurse needs to ascertain that restraints are still required for client safety. The least restrictive intervention based on an individualized assessment of the client's medical or behavioral status or condition is needed.

 CN: Safety and infection control;  
CL: Analyze

**119. 1, 2, 3, 4, 5, 6.** Client safety is a priority for the client, the client's family, and all of the personnel working on this unit. All of these persons must be engaged in using strategies to prevent falls.

 CN: Safety and infection control;  
CL: Create

**120. 3.** The client is identified as being at risk for falling and a staff member or family member should accompany the client when walking. The nurse can delegate the task of ambulating the client to the unlicensed assistive personnel (UAP), but should remain with the client until the UAP arrives. Walking only in the room will not provide an opportunity for the client to gain strength and improve ambulation. The client should not walk beyond the point of being fatigued; the UAP should observe for fatigue and the nurse should set appropriate goals for distance to be walked.

 CN: Reduction of risk potential;  
CL: Synthesize

**121. 1, 2, 3.** To assure client safety when using anticoagulants, the nurse should coordinate care at this time with the pharmacist, dietician and laboratory. The pharmacist will collaborate in teaching

the client about using the drug; dietary services will plan a diet that limits foods which have high amounts of vitamin K (spinach, cabbage, blueberries) that will interfere with anticoagulation, and the laboratory will draw daily INR levels to assure accurate dosing. Although the nurse coordinates discharge planning at the time of admission to the hospital, at this point it is too soon for discharge planning services to be involved because it is not known if the client will continue to take the coumadin when discharged. There is no indication a chaplain is needed at this time.

 CN: Management of care; CL: Synthesize

**122. 3.** Hand-off communication is an interactive communication allowing the opportunity for questioning between the giver and receiver of client information including up-to-date information regarding the client's care, treatment, and services; current condition; and any recent or anticipated changes. "Hand off" communication does occur when a nurse is leaving the nursing unit, but the purpose is not to let the charge nurse know that the nurse is going to lunch or to have someone else assigned to care for the client. "Hand-off" communication focuses on current information, not the client's history.

 CN: Management of care; CL: Synthesize

**TEST  
13**

## The Client with Cancer

- The Client at Risk for Cancer
- The Client with Pain
- The Client Who Is Receiving Chemotherapy
- The Client Who Is Receiving Radiation Therapy
- The Client Who Requires Symptom Management
- The Client Who Is Coping with Loss, Grief, Bereavement, and Spiritual Distress
- The Client Who Is Experiencing Problems with Sexuality
- Ethical and Legal Issues Related to Clients with Cancer
- End-of-Life Care
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client at Risk for Cancer

**1.** The nurse is preparing an educational program on breast cancer for women at an African American community center. What information is important for the nurse to consider for the discussion?

- 1. African American women have the lowest rate of breast cancer.
- 2. Most African American women are diagnosed early in the disease process.
- 3. Breast cancer concerns vary between socio-economic levels of African American women.
- 4. African American women believe breast cancer is inevitable.

**2.** Which of the following clients is at **highest** risk for colorectal cancer?

- 1. The client who smokes.
- 2. The client who eats a vegetarian diet.
- 3. The client who has been treated for Crohn's disease for 20 years.
- 4. The client who has a family history of lung cancer.

**3.** A 21-year-old client undergoes bone marrow aspiration at the clinic to establish a diagnosis of possible lymphoma. Which statement made by the client demonstrates proper understanding of discharge teaching? Select all that apply.

- 1. "I will take Tylenol for pain."
- 2. "I do not need to inspect the puncture site."
- 3. "I will not be able to play basketball for the next 2 days."
- 4. "I will take aspirin if I have pain."
- 5. "I can apply an ice pack or a cold compress to the puncture site."

**4.** A nurse is conducting a cancer risk screening program. Which of the following clients is at **greatest** risk for skin cancer?

- 1. 45-year-old physician.
- 2. 15-year-old high school student.
- 3. 30-year-old butcher.
- 4. 60-year-old mountain biker.

**5.** A client diagnosed with testicular cancer expresses concerns about fertility. The couple desires to eventually have a family and the nurse discusses the option of sperm banking. The nurse should inform the couple that sperm banking would need to be performed:

- 1. Before treatment is started.
- 2. Once the client is tolerating the treatment.
- 3. Upon completion of treatment.
- 4. When tumor markers drop to normal levels.

**6.** Carcinogenesis is irreversible in which of the following stages?

- 1. Progression stage.
- 2. Promotion stage.
- 3. Initiation stage.
- 4. Regression stage.

**7.** Cancer prevalence is defined as:

- 1. The likelihood cancer will occur in a lifetime.
- 2. The number of persons with cancer at a given point in time.
- 3. The number of new cancers in a year.
- 4. All cancer cases more than 5 years old.

**8.** Which of the following groups would benefit **most** from education regarding potential risk factors for melanoma?

- 1. Adults older than age 35.
- 2. Senior citizens who have been repeatedly exposed to the effects of ultraviolet A and ultraviolet B rays.
- 3. Parents with children.
- 4. Employees of a chemical factory.

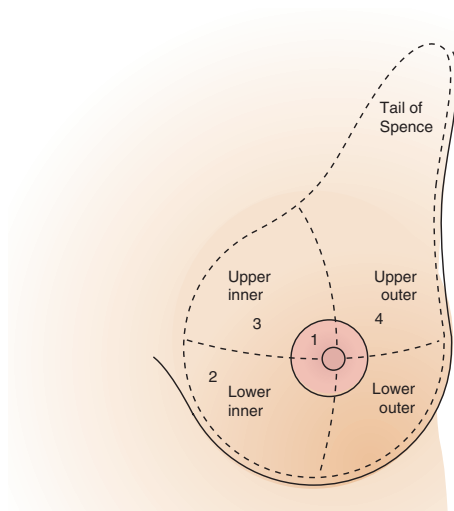
**9.** A nurse is providing education in a community setting about general measures to avoid excessive sun exposure. Which of the following recommendations is appropriate?

- 1. Apply sunscreen only after going into the water.
- 2. Avoid peak exposure hours from 9 a.m. to 1 p.m.
- 3. Wear loosely woven clothing for added ventilation.
- 4. Apply sunscreen with a sun protection factor (SPF) of 15 or more before sun exposure.

**10.** A 29-year-old woman is concerned about her personal risk factors for malignant melanoma. She is upset because her 49-year-old sister was recently diagnosed with the disease. After gathering information about the client's history of sun exposure, the nurse's **best** response would be to explain that:

- 1. Some melanomas have a familial component and she should seek medical advice.
- 2. Her personal risk is low because most melanomas occur at age 60 or later.
- 3. Her personal risk is low because melanoma does not have a familial component.
- 4. She should not worry because she did not experience severe sunburn as a child.

**11.** A nurse is palpating a female client's breast while assessing for breast disease. In the illustration below, indicate the area of the breast in which tumors are **most** commonly found.



**12.** A 17-year-old, sexually active female client is seen in the family planning clinic and requests hormonal contraceptives. Before examination, the nurse should explain the importance of regular Papanicolaou (Pap) smears. This recommendation is based on the current screening guidelines of the American Cancer Society for Pap smears, which state that:

- 1. Pap smears are recommended every other year.
- 2. If four consecutive annual Pap smears are negative, the client should schedule repeat Pap smears every 3 years.
- 3. The initial Pap smear should be done at age 21 or earlier if the woman is sexually active.
- 4. If four consecutive smears are negative, the client should request a colposcopy.

**13.** A client with a family history of cancer asks the nurse what the single most important risk factor is for cancer. Which of the following risk factors should the nurse discuss?

- 1. Family history.
- 2. Lifestyle choices.
- 3. Age.
- 4. Menopause or hormonal events.

**14.** Experimental and epidemiologic evidence suggests that a high-fat diet increases the risk of several cancers. Which of the following cancers is linked to a high-fat diet?

- 1. Ovarian.
- 2. Lung.
- 3. Colon.
- 4. Liver.

**15.** A 42-year-old female highway construction worker is concerned about her cancer risks. She reveals that she has been married for 18 years, has two children, smokes one pack of cigarettes per day, and drinks one to two beers with her husband after work almost every day. She is 30 lb overweight, eats fast food often, and rarely eats fresh fruits and vegetables. Her mother was diagnosed with breast cancer 2 years ago. Her father and an aunt both died of lung cancer. She had a basal cell carcinoma removed from her cheek 3 years earlier. What combination of behavioral changes should the nurse instruct this client to make **first**?

- 1. Decrease fat in the diet, decrease alcohol consumption, and use sunscreen every day.
- 2. Decrease intake of salt-cured food, lose weight, and stop smoking.
- 3. Stop drinking beer, decrease fiber in the diet, and use sun protection.
- 4. Stop smoking, use sun protection, and lose weight.

**16.** The incidence and risk of cancer increase when smoking is combined with:

- 1. Asbestos exposure and alcohol consumption.
- 2. Ultraviolet radiation exposure and alcohol consumption.
- 3. Asbestos exposure and ultraviolet radiation exposure.
- 4. Alcohol consumption and human papillomavirus (HPV) infection.

**17.** The nurse is assessing a 60-year-old male who has hoarseness. The nurse should conduct a focused assessment to determine:

- 1. Patterns of medication use and history of alcohol consumption.
- 2. Exposure to sun and family history of head and neck cancers.
- 3. Exposure to wood dust and a high-fat diet.
- 4. History of tobacco use and alcohol consumption.

**18.** A 42-year-old female is interested in making dietary changes to reduce her risk of colon cancer. What dietary selections should the nurse suggest?

- 1. Croissant, granola and peanut butter squares, whole milk.
- 2. Bran muffin, skim milk, stir-fried broccoli.
- 3. Granola, bagel with cream cheese, cauliflower salad.
- 4. Oatmeal, raisin cookies, baked potato with sour cream, turkey sandwich.

**19.** Which of the following is an environmental factor that increases the risk of cancer?

- 1. Gender.
- 2. Nutrition.
- 3. Immunologic status.
- 4. Age.

**20.** A client at risk for lung cancer asks why he is scheduled for a computed tomography (CT) scan as part of his initial workup. The nurse's **best** response is which of the following?

- 1. "CT is far superior to magnetic resonance imaging for evaluating lymph node metastasis."
- 2. "CT is noninvasive and readily available."
- 3. "CT is useful for distinguishing small differences in tissue density and detecting nodal involvement."
- 4. "CT can distinguish a malignant from a non-malignant adenopathy."

**21.** Lifestyle influences that are considered risk factors for colorectal cancer include:

- 1. A diet low in vitamin C.
- 2. A high dietary intake of artificial sweeteners (Aspartame).
- 3. A high-fat, low-fiber diet.
- 4. Multiple sex partners.

**22.** The development of a culturally sensitive health education program for the socioeconomically disadvantaged requires the nurse to:

- 1. Locate the program at an existing government facility.
- 2. Integrate folk beliefs and traditions into the content.
- 3. Prepare materials in the primary language of the program sponsor.
- 4. Exclude community leaders from initial planning efforts.

### The Client with Pain

**23.** A client in a hospice program has increasing pain. The nurse and client collaborate to schedule analgesics to provide which of the following?

- 1. Doses of analgesic when pain is a "5" on a scale of 1–10.
- 2. Enough analgesia to keep the client semi-somnolent.
- 3. An analgesia-free period so that the client can carry out daily hygienic activities.
- 4. Around-the-clock routine administration of analgesics for continuous pain relief.

**24.** A client with pancreatic cancer is receiving morphine via a subcutaneous pump. The client is developing drug tolerance. The nurse understands that the client is:

- 1. Tolerating the medication well.
- 2. Showing addiction to morphine.
- 3. Requiring an increased dose.
- 4. Experiencing physical dependence.

**25.** A client with advanced ovarian cancer takes 150 mg of long-acting morphine orally every 12 hours for abdominal pain. When the client develops a small bowel obstruction, the physician discontinues the oral morphine and begins morphine 6 mg/hour I.V. After calculating the equianalgesic conversion from oral to intravenous morphine, the nurse should:

- 1. Continue the oral morphine for one more dose after the I.V. morphine is started.
- 2. Contact the physician to suggest a higher equianalgesic dose of I.V. morphine.
- 3. Administer the morphine I.V. as ordered.
- 4. Clarify the order to recommend the initial morphine dose of 4 mg/hour.

**26.** A client is transferred to his room from the intensive care unit after a craniotomy for treatment of a malignant brain tumor in the occipital region. The nurse should question which of these orders?

- 1. 400 mg of ibuprofen (Motrin).
- 2. 500 mg of naproxen (Naprosyn).
- 3. Morphine sulfate.
- 4. Acetaminophen (Tylenol).

**27.** A 62-year-old female is taking long-acting morphine 120 mg every 12 hours for pain from metastatic breast cancer. She can have 20 mg of immediate-release morphine every 3 to 4 hours as needed for breakthrough pain. The physician should be notified if the client uses **more** than how many breakthrough doses of morphine in 24 hours?

- 1. Seven.
- 2. Four.
- 3. Two.
- 4. One.

**28.** Assessment of a client taking a nonsteroidal anti-inflammatory drug (NSAID) for pain management should include specific questions regarding which of the following systems?

- 1. Gastrointestinal.
- 2. Renal.
- 3. Pulmonary.
- 4. Cardiac.

**29.** The nurse is assessing a client with chronic pain. Which of the following is an expected response?

- 1. Elevated vital signs, physical inactivity, facial grimacing, and periods of anxiety.
- 2. Normal vital signs, physical inactivity, and normal facial expressions.
- 3. Normal vital signs, normal facial expressions, and moaning.
- 4. Elevated vital signs, grimacing, and depression.

**30.** Which of the following terms describes the condition of a client who requires an **increase** in dosage to maintain adequate analgesia?

- 1. Pseudoaddiction.
- 2. Physical dependence.
- 3. Psychological dependence.
- 4. Drug tolerance.

**31.** A client with lung cancer is being cared for by his wife at home. His pain is increasing in severity. The nurse recognizes that teaching has been effective when the wife does which of the following? Select all that apply.

- 1. Administers long-acting or sustained-release oral pain formula (OxyContin) regularly around-the-clock.
- 2. Administers immediate-release medication (oxycodone) for breakthrough pain.
- 3. Avoids long-acting opioids due to her concern about addiction.
- 4. Uses music for distraction as well as heat or cold in combination with medications.
- 5. Substitutes acetaminophen (Tylenol) to avoid tolerance to the medications.
- 6. Has her husband use a pain rating scale to measure the effectiveness at reaching his individual pain goal.

**32.** A 52-year-old male was discharged from the hospital for cancer-related pain. His pain appeared to be well controlled on the I.V. morphine. He was switched to oral morphine when discharged 2 days ago. He now reports his pain as an 8 on a 10-point scale and wants the I.V. morphine. Which of the following represents the **most** likely explanation for the client's reports of inadequate pain control?

- 1. He is addicted to the I.V. morphine.
- 2. He is going through withdrawal from the I.V. opioid.
- 3. He is physically dependent on the I.V. morphine.
- 4. He is undermedicated on the oral opioid.

**33.** A nurse is assessing a client with bone cancer pain. Which of the following components of a thorough pain assessment is **most** significant for this client?

- 1. Intensity.
- 2. Cause.
- 3. Aggravating factors.
- 4. Location.

**34.** A 48-year-old client with cancer has been receiving 10 mg of I.V. morphine while hospitalized. In order to give an equivalent dose of oral morphine, the nurse should be sure the physician has ordered which of the following doses?

- 1. 25 mg.
- 2. 30 mg.
- 3. 40 mg.
- 4. 10 mg.

**35.** Which of the following reasons explains why meperidine (Demerol) is not recommended for chronic cancer-related pain?

- 1. It has a high potential for abuse.
- 2. It has agonist-antagonist properties.
- 3. It must be given intramuscularly to be effective.
- 4. It contains a metabolite that causes seizures.

**36.** A 60-year-old female with chronic cancer pain has been receiving opiates for 4 months. She rated her pain as an 8 on a 10-point scale before starting the opioid medication. She has just had a thorough examination with no new evidence of increased disease, yet her pain is close to 8 again. The **most** likely explanation for her increasing pain is:

- 1. Development of an addiction to the opioids.
- 2. Tolerance to the opioid.
- 3. Withdrawal from the opioid.
- 4. Placebo effect has decreased.

**37.** The nurse teaches the client with chronic cancer pain about optimal pain control. Which of the following recommendations is **most** effective for pain control?

- 1. Get used to some pain and use a little less medication than needed to keep from being addicted.
- 2. Take prescribed analgesics on an around-the-clock schedule to prevent recurrent pain.
- 3. Take analgesics only when pain returns.
- 4. Take enough analgesics around the clock so that you can sleep 12 to 16 hours a day to block the pain.

### The Client Who Is Receiving Chemotherapy

**38.** Doxorubicin (Adriamycin) is prescribed for a female client with breast cancer. The client is distressed about hair loss. The nurse should do which of the following?

- 1. Have the client wash and massage the scalp daily to stimulate hair growth.
- 2. Explain that hair loss is temporary and will quickly grow back to its original appearance.
- 3. Provide resources for a wig selection before hair loss begins.
- 4. Recommend that the client limit social contacts until hair regrows.

**39.** A client is receiving vincristine (Oncovin). Client teaching by the nurse should include instructions on:

- 1. Use of loperamide (Imodium).
- 2. Fluid restriction.
- 3. Low fiber, bland diet.
- 4. Bowel regimen.

**40.** The nurse is caring for a 78-year-old male with lung cancer who is receiving chemotherapy. The client states he is not eating well but otherwise feels healthy. Which meal suggestion would be **best** for this client?

- 1. Cereal with milk and strawberries.
- 2. Toast, gelatin dessert, and cookies.
- 3. Broiled chicken, green beans, and cottage cheese.
- 4. Steak and french fries.

**41.** A nurse is assessing a female who is receiving her second administration of chemotherapy for breast cancer. When obtaining this client's health history, what is the **most** important information the nurse should obtain?

- 1. "Has your hair been falling out in clumps?"
- 2. "Have you had nausea or vomiting?"
- 3. "Have you been sleeping at night?"
- 4. "Do you have your usual energy level?"

**42.** A 68-year-old male has been receiving monthly doses of chemotherapy for treatment of stage III colon cancer. He comes to the clinic for his fourth monthly dose. Which laboratory result(s) should be reported to the oncologist before the **next** dose of chemotherapy is administered? Select all that apply.

- 1. Hemoglobin of 14.5 g/dL.
- 2. Platelet count of 40,000/mm<sup>3</sup>.
- 3. Blood urea nitrogen (BUN) level of 12 mg/dL.
- 4. White blood cell count of 2,300/mm<sup>3</sup>.
- 5. Temperature of 101.2° F (38.4° C).
- 6. Urine specific gravity of 1.020.

**43.** A nurse is checking the laboratory results of a 52-year-old client with colon cancer admitted for further chemotherapy. The client has lost 30 lb (13.6 kg) since initiation of the treatment. Which laboratory result should be reported to the health care provider?

- 1. Blood glucose level of 95 mg/dL.
- 2. Total cholesterol level of 182 mg/dL.
- 3. Hemoglobin level of 12.3 mg/dL.
- 4. Albumin level of 2.8 g/dL.

**44.** The nurse is teaching a 17-year-old client and the client's family about what to expect with high-dose chemotherapy and the effects of neutropenia. What should the nurse teach as the **most** reliable early indicator of infection in a neutropenic client?

- 1. Fever.
- 2. Chills.
- 3. Tachycardia.
- 4. Dyspnea.

**45.** A nurse is caring for a client who is undergoing chemotherapy. Current laboratory values are noted on the chart. Which action would be **most** appropriate for the nurse to implement?

- 1. Wearing a protective gown and particulate respiratory mask when completing treatments.
- 2. Washing hands before and after entering the room.
- 3. Restricting visitors.
- 4. Contacting the physician for an order for hematopoietic factors such as erythropoietin (Epogen, Procrit).

#### Laboratory Results

Test	Result
Hemoglobin	12.0 mg/dL
Platelet count	108,000/mm <sup>3</sup>
White blood cell (WBC) count	1,600/mm <sup>3</sup>
Absolute neutrophil count (ANC)	less than 1,000/mm <sup>3</sup>

**46.** A client informs the nurse that she is using an herbal therapy while receiving chemotherapy. Which of the following actions should the nurse take?

- 1. Determine what substances the client is using and make sure that the physician is aware of all therapies the client is using.
- 2. Guide the client in the decision-making process to select either Western or alternative medicine.
- 3. Encourage the client to seek alternative modalities that do not require the ingestion of substances.
- 4. Recommend that the client stop using the alternative medicines immediately.

**47.** A 58-year-old male is going to have chemotherapy for lung cancer. He asks the nurse how the chemotherapeutic drugs will work. The **most** accurate explanation the nurse can give is which of the following?

- 1. "Chemotherapy affects all rapidly dividing cells."
- 2. "The molecular structure of the DNA is altered."
- 3. "Cancer cells are susceptible to drug toxins."
- 4. "Chemotherapy encourages cancer cells to divide."

**48.** A 56-year-old client is receiving chemotherapy that has the potential to cause pulmonary toxicity. Which of the following symptoms indicates a toxic response to the chemotherapy?

- 1. Decrease in appetite.
- 2. Drowsiness.
- 3. Spasms of the diaphragm.
- 4. Cough and shortness of breath.

### The Client Who Is Receiving Radiation Therapy

**49.** A client is beginning external beam radiation therapy to the right axilla after a lumpectomy for breast cancer. Which of the following should the nurse include in client teaching?

- 1. Use a heating pad under the right arm.
- 2. Immobilize the right arm.
- 3. Place ice on the area after each treatment.
- 4. Apply deodorant only under the left arm.

**50.** A female receiving radiation therapy for lung cancer complains to the nurse that she is having difficulty sleeping. The nurse should:

- 1. Suggest the client stop watching television before bed.
- 2. Assess the client's usual sleep patterns, amount of sleep, and bedtime rituals.
- 3. Tell the client sleeplessness is expected with radiation therapy.
- 4. Suggest that the client stop drinking coffee until the therapy is completed.

**51.** A 56-year-old female is currently receiving radiation therapy to the chest wall for recurrent breast cancer. She has pain while swallowing and burning and tightness in her chest. The nurse should further assess the client for indications of:

- 1. Hiatal hernia.
- 2. Stomatitis.
- 3. Radiation enteritis.
- 4. Esophagitis.

**52.** A 36-year-old female is scheduled to receive external radiation therapy and a cesium implant for cancer of the cervix. Which of the following statements would be **most** accurate to include in the teaching plan about the potential effects of radiation therapy on sexuality?

- 1. "You can have sexual intercourse while the implant is in place."
- 2. "You may notice some vaginal dryness after treatment is completed."
- 3. "You may notice some vaginal relaxation after treatment is completed."
- 4. "You will continue to have normal menstrual periods during treatment."

**53.** The nurse caring for a client who is receiving external beam radiation therapy for treatment of lung cancer should assess the client for which of the following?

- 1. Diarrhea.
- 2. Improved energy level.
- 3. Dysphagia.
- 4. Normal white blood cell count.

### The Client Who Requires Symptom Management

**54.** A client receiving radiation to the head and neck is experiencing stomatitis. The nurse should recommend:

- 1. Evaluation by a dentist.
- 2. Alcohol-based mouth wash rinses.
- 3. Artificial saliva.
- 4. Vigorous brushing of teeth after each meal.

**55.** A client undergoing chemotherapy has a white blood cell count of  $2300/\text{mm}^3$ ; hemoglobin of  $9.8 \text{ g/dL}$ ; platelet count of  $80,000/\text{mm}^3$  and potassium of 3.8. Which of the following should take **priority**?

- 1. Blood pressure 136/88.
- 2. Emesis of 90 mL.
- 3. Temperature  $101^\circ \text{ F}$  ( $38.3^\circ \text{ C}$ ).
- 4. Urine output 40 mL/hour.



**56.** A client with bladder cancer has lost an estimated 500 mL blood in the urine. The client's hemoglobin is 8.0 g/dL, and the physician orders a unit of packed blood cells. To administer the packed red blood cells, the nurse should:

- 1. Attach the packed cells to the existing 19G I.V. of normal saline solution using Y tubing.
- 2. Start an additional 22G I.V. site because the packed blood cells must be given in a separate line.
- 3. Attach the packed blood cells to the existing 22G I.V. of 5% dextrose using Y tubing.
- 4. Start an additional I.V. access device with a 22G Intracath.

**57.** A nurse is caring for a client 24 hours after he has undergone an abdominal-perineal resection for a bowel tumor. The client's wife asks if she can bring him some of his favorite home-cooked Italian minestrone soup. What would be an appropriate action by the nurse?

- 1. Auscultate for bowel sounds.
- 2. Ask the client if he feels hunger or gas pains.
- 3. Consult the dietician.
- 4. Encourage the wife to bring the soup.

**58.** A nurse is making follow-up phone calls to clients being treated for cancer. Place the options below in the order of **priority** that the nurse should return the calls.

1. The client receiving chemotherapy who complains of a loss of appetite.

2. The client who underwent a mastectomy 2 weeks ago who called for information on the Reach for Recovery program.

3. The client receiving spinal radiation for bone cancer metastases who complains of urinary incontinence.

4. The client with colon cancer who has questions about a high-fiber diet.





**59.** Which of the following nursing interventions would be **most** helpful in making the respiratory effort of a client with metastatic lung cancer more efficient?

- 1. Teaching the client diaphragmatic breathing techniques.
- 2. Administering cough suppressants as ordered.
- 3. Teaching and encouraging pursed-lip breathing.
- 4. Placing the client in a low semi-Fowler's position.

**60.** Which of the following should be included in the teaching plan for a cancer client who is experiencing thrombocytopenia? Select all that apply.

- 1. Use an electric razor.
- 2. Use a soft-bristle toothbrush.
- 3. Avoid frequent flossing for oral care.
- 4. Include an over-the-counter nonsteroidal anti-inflammatory (NSAID) daily for pain control.
- 5. Monitor temperature daily.
- 6. Report bleeding, such as nosebleed, petechiae, or melena, to a health care professional.

**61.** A 28-year-old client with cancer is afraid of experiencing a febrile reaction associated with blood transfusions. He asks the nurse if this will happen to him. The nurse's **best** response is which of the following?

- 1. "Febrile reactions are caused when antibodies on the surface of blood cells in the transfusion are directed against antigens of the recipient."
- 2. "Febrile reactions can usually be prevented by administering antipyretics and antihistamines before the start of the transfusion."
- 3. "Febrile reactions are rarely immune-mediated reactions and can be a sign of hemolytic transfusion."
- 4. "Febrile reactions primarily occur within 15 minutes after initiation of the transfusion and can occur during the blood transfusion."

**62.** A 56-year-old client who recently had a right pneumonectomy for lung cancer is admitted to the oncology unit with dyspnea and fever. The nurse should:

- 1. Place the client on the left side.
- 2. Position the client for postural drainage.
- 3. Provide education on deep breathing exercises.
- 4. Instruct the client to maintain bed rest with bathroom privileges.

**63.** A client undergoing chemotherapy tells the nurse, “I do not want to get out of bed in the morning because I am so tired.” The nursing plan of care should include:

- 1. Education on the use of Neupogen (filgrastim).
- 2. Individually tailored exercise program.
- 3. Weight lifting when not experiencing fatigue.
- 4. Bed rest until chemotherapy is completed.

**64.** The nurse is teaching the client and family how to manage possible nausea and vomiting at home. The nurse should include information about:

- 1. Eating frequent, small meals throughout the day.
- 2. Eating three normal meals a day.
- 3. Eating only cold foods with no odor.
- 4. Limiting the amount of fluid intake.

**65.** A terminally ill 82-year-old client in hospice care is experiencing nausea and vomiting because of a partial bowel obstruction. To respect the client’s wishes for conservative management of the nausea and vomiting, the nurse should recommend the use of:

- 1. A nasogastric (NG) suction tube.
- 2. I.V. antiemetics.
- 3. Osmotic laxatives.
- 4. A clear liquid diet.

**66.** A 62-year-old male is dying from metastatic lung cancer, and all treatments have been discontinued. The client’s breathing pattern is labored, with gurgling sounds. The client’s wife asks the nurse, “Can’t you do something to help with his breathing?” Which of the following is the nurse’s **best** response in this situation?

- 1. Direct the unlicensed personnel to assess the client’s vital signs and provide oral care.
- 2. Suction the client so that the client’s wife knows all interventions were performed.
- 3. Reposition the client, elevate the head of the bed, and provide a cool compress.
- 4. Explain to the wife that it is standard practice not to suction clients when treatments have been discontinued.

**67.** A 40-year-old female is losing most of her hair as a result of chemotherapy. Which of the following statements **best** explains chemotherapy-induced alopecia?

- 1. “The new growth of hair will be gray.”
- 2. “The hair loss is temporary.”
- 3. “New hair growth will always be the same texture and color as it was before chemotherapy.”
- 4. “The client should avoid use of wigs when possible.”

**68.** A 62-year-old male with a history of chronic obstructive pulmonary disease (COPD) and metastatic carcinoma of the lung has not responded to radiation therapy and is being admitted to the hospice program. The nurse should conduct a focused client assessment for:

- 1. Ascites.
- 2. Pleural friction rub.
- 3. Dyspnea.
- 4. Peripheral edema.

**69.** The nurse is working with a client who has cancer to improve the client’s independence in activities of daily living after radiation therapy. Which of the following is an appropriate nursing intervention?

- 1. Refer the client to a community support group after discharge from the rehabilitation unit.
- 2. Make certain that a family member is present for the rehabilitation sessions.
- 3. Provide positive reinforcement for skills achieved.
- 4. Inform the client of rehabilitation plans made by the rehabilitation team.

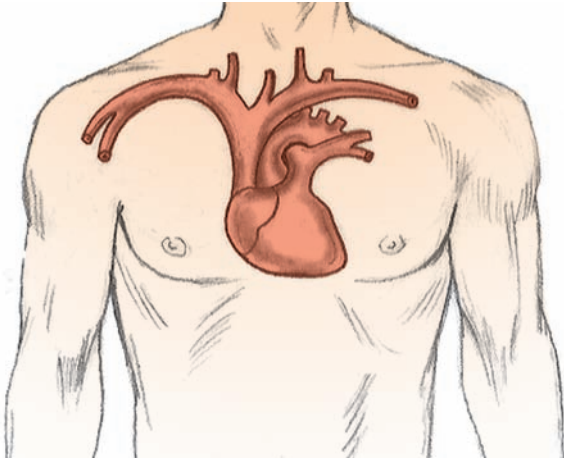
**70.** When teaching about prevention of infection to a client with a long-term venous catheter, the nurse can document that the client has understood discharge instructions when the client states which of the following?

- 1. “I will not remove the dressing until I return to the clinic next week.”
- 2. “My husband or I will do the dressing changes three times per week, exactly the way you showed us.”
- 3. “I will monitor my temperature once each weekday.”
- 4. “I know it is very important to wash my hands after irrigating the catheter.”

**71.** When caring for a client with a central venous line, which of the following nursing actions should be implemented in the plan of care for chemotherapy administration? Select all that apply.

- 1. Verify patency of the line by the presence of a blood return at regular intervals.
- 2. Inspect the insertion site for swelling, erythema, or drainage.
- 3. Administer a cytotoxic agent to keep the regimen on schedule even if blood return is not present.
- 4. If unable to aspirate blood, reposition the client and encourage the client to cough.
- 5. Contact the health care provider about verifying placement if the status is questionable.

**72.** Indicate on the illustration the area that correctly identifies the position of the distal tip of a central line that is inserted into the subclavian vessel.



**73.** A 58-year-old client with pancreatic cancer, who has been bed-bound for 3 weeks, has just returned from having a left subclavian, long-term, tunneled catheter inserted for administration of analgesics. The nurse has not yet received radiographic results for confirmation of placement. The client becomes restless and dyspneic and complains of chest pain radiating to the middle of his back. Physical assessment reveals tachycardia and absent breath sounds in the left lung. The nurse should further assess the client for:

- 1. An air embolus.
- 2. A pneumothorax.
- 3. A pulmonary embolus.
- 4. A myocardial infarction.

**74.** In setting goals for a client with advanced liver cancer who has poor nutrition, the nurse determines that which of the following is a realistic desired outcome for the client? The client will:

- 1. Have normalized albumin levels.
- 2. Return to ideal body weight.
- 3. Gain 1 lb every 2 weeks.
- 4. Maintain current weight.

**75.** The nurse administers a bolus tube feeding to a client with cancer. Which of the following nursing interventions is **most** appropriate to decrease the risk of aspiration?

- 1. Place the client on bed rest with the head of the bed elevated to 60 degrees for 2 hours.
- 2. Place the client on the left side with the head of the bed at 45 degrees for 15 minutes.
- 3. Assist the client out of bed to sit upright in a chair for 1 hour.
- 4. Ask the client to rest in bed with the head of the bed elevated to 30 degrees for 20 minutes.

**76.** A client with colon cancer had a left hemicolectomy 3 weeks previously. The client is still having difficulty maintaining an adequate oral intake to meet metabolic needs for optimal healing. Which of the following nutritional support methods would be **most** appropriate?

- 1. Total parenteral nutrition through a central catheter.
- 2. I.V. infusion of dextrose.
- 3. Nasogastric feeding tube with protein supplement.
- 4. Jejunostomy for high caloric feedings.

**77.** A client with colon cancer undergoes surgical removal of a segment of colon and creation of a sigmoid colostomy. What assessments by the nurse indicate the client is developing complications within the first 24 hours? Select all that apply.

- 1. Coarse breath sounds auscultated bilaterally at the bases.
- 2. Dusky appearance of the stoma.
- 3. No drainage in the ostomy appliance.
- 4. Temperature greater than 101.2° F (38.5° C).
- 5. Decreased bowel sounds.

**78.** A client receiving chemotherapy for metastatic colon cancer is admitted to the oncology unit due to several days of vomiting. Assessment findings include: irregular pulse of 120, blood pressure 88/48, respiratory rate of 14, serum potassium of 2.9 mEq/L, and arterial blood gas—pH 7.46, PCO<sub>2</sub> 45, PO<sub>2</sub> 95, bicarbonate level 29 mEq/L. Which of the following interventions is appropriate for the nurse to administer to the client?

- 1. Oxygen at 4L per nasal cannula.
- 2. Potassium 40 mEq PO now.
- 3. 5% Dextrose in 0.45% Normal Saline with KCl 40 mEq/L at 125 mL/hour.
- 4. NaHCO<sub>3</sub> 75 mEq IV.

**79.** A 32-year-old female meets with the nurse on her first office visit since undergoing a left mastectomy. When asked how she is doing, the woman says her appetite is still not good, she is not getting much sleep because she doesn't go to bed until her husband is asleep, and she is really anxious to get back to work. Which of the following nursing interventions should the nurse explore to support the client's current needs?

- 1. Call the physician to discuss allowing the client to return to work earlier.
- 2. Suggest that the client learn relaxation techniques for help with her insomnia.
- 3. Perform a nutritional assessment to assess for anorexia.
- 4. Ask open-ended questions about sexuality issues related to her mastectomy.

**80.** Which of the following client situations would require the **most** intensive nursing interventions for immobility?

- 1. A 38-year-old woman receiving internal radiation therapy for cervical cancer.
- 2. A 7-year-old boy with leukemia hospitalized for induction of high-dose chemotherapy.
- 3. A 75-year-old man with metastatic prostate cancer hospitalized for a pathologic fracture of the femur.
- 4. A 6-month-old undergoing surgery for placement of a central venous catheter.

**81.** A 52-year-old client with lung cancer tells the nurse that he has a low-grade fever (100.6° F [38.1° C]), nonproductive cough, and increasing fatigue. He completed the radiation therapy to the mass in his right lung and mediastinum 10 weeks ago and has a follow-up appointment to see the physician in 2 weeks. What is the **most** appropriate response by the telephone triage nurse?

- 1. Advise the client to take two acetaminophen tablets every 4 to 6 hours for 2 days and call back if his temperature increases to 101° F (38.3° C) or greater.
- 2. Advise the client that this is an expected side effect of the radiation therapy and to keep his appointment in 2 weeks.
- 3. Advise the client to come to the office to be examined today.
- 4. Advise the client to go to the nearest emergency department.

**82.** A client with malignant pleural effusions is complaining of dyspnea and chest pain. Place the following interventions that the nurse should perform in the correct order of priority.

1. Administer morphine sulfate 2 mg I.V.

2. Apply oxygen at 2 L via nasal cannula.

3. Educate the client in anticipation of a thoracentesis.

4. Coach the client on deep breathing exercise.

**83.** A client develops lymphedema after a left mastectomy with lymph node dissection. Which of the following should be included in the discharge teaching plan? Select all that apply.

- 1. Do not allow blood pressures or blood draws in the affected arm.
- 2. Avoid application of sunscreen on the left arm.
- 3. Use an electric razor for shaving.
- 4. Immobilize the left arm.
- 5. Elevate the left arm.
- 6. Perform hand pump exercises.

**84.** What instructions should the nurse provide to a client who develops cellulitis in the right arm after a right modified radical mastectomy?

- 1. Antibiotics will need to be taken for 1 to 2 weeks.
- 2. Arm exercises will get rid of the cellulitis.
- 3. Ice pack should be applied to the affected area for 20 minute periods to reduce swelling.
- 4. The right extremity should be lowered to improve blood flow to the forearm.

**85.** A 58-year-old male has just had a sclerosing agent instilled after chest tube drainage of a pleural effusion. The nurse should instruct the client to:

- 1. Lie still to prevent a pneumothorax.
- 2. Sit upright with arms on an overhead table to promote lung expansion.
- 3. Change position frequently to distribute the agent.
- 4. Lie on the side where the thoracentesis was done to hold pressure on the chest tube site.

**86.** After surgery for head and neck cancer, a client has a permanent tracheostomy. The nurse should teach the client and family about the importance of:

- 1. Providing tracheostomy site care.
- 2. Addressing the psychosocial issues related to tracheostomy.
- 3. Observing for early signs and symptoms of skin breakdown around the tracheostomy site.
- 4. Using humidifiers to prevent thick, tenacious secretions.

**87.** A client has malignant pleural effusions. The nurse should conduct a focused assessment to determine if the client has which of the following? Select all that apply.

- 1. Hiccups.
- 2. Weight gain.
- 3. Peripheral edema,
- 4. Chest pain.
- 5. Dyspnea.
- 6. Cough.

**88.** A 56-year-old female with lung cancer is undergoing a thoracentesis. Which of the following outcomes of the procedure are expected? Select all that apply.

- 1. Treatment of recurrent malignant effusion.
- 2. Diagnosis of underlying disease.
- 3. Palliation of symptoms.
- 4. Relief of acute respiratory distress.
- 5. Removal of the cancer cells.

**89.** The nurse is assessing a client with anemia. In order to plan nursing care, the nurse should focus the assessment on which of the following?

- 1. Decreased salivation.
- 2. Bradycardia.
- 3. Cold intolerance.
- 4. Nausea.

**90.** A nurse is assessing a 42-year-old client who has been receiving chemotherapy. The client has a platelet count of 22,000 cells/mm<sup>3</sup> and has petechiae on the lower extremities. The nurse should advise the client to:

- 1. Increase the amount of iron in the client's diet.
- 2. Apply lotion to the lower extremities.
- 3. Elevate the legs.
- 4. Consult the oncologist.

**91.** A nurse is teaching a 62-year-old female who has had a left modified radical mastectomy with axillary node dissection about lymphedema. The nurse should tell the client that lymphedema occurs:

- 1. If all cancer cells are not removed.
- 2. In older women.
- 3. At any time after surgery or not at all.
- 4. Only with radical mastectomy.

**92.** The client with lymphedema has an increased risk of cellulitis and lymphangitis because of:

- 1. Fragility of the capillaries.
- 2. Myelosuppression of the bone marrow.
- 3. Stagnation of accumulated fluid.
- 4. Increased use of the extremity.

**93.** A 38-year-old female client with a history of breast-conserving surgery, axillary node dissection, and radiation therapy reports that her arm is red, warm to touch, and slightly swollen. Which of the following actions should the nurse suggest?

- 1. Apply warm compresses to the affected arm.
- 2. Elevate the arm on two pillows.
- 3. See the physician immediately.
- 4. Schedule an appointment within 2 to 3 weeks.

**94.** The nurse is assessing a 42-year-old client with cancer. He has lost 1 lb in 4 weeks. He is taking ondansetron (Zofran) for nausea. He has a temperature of 101° F (38.3° C). The fever is indicative of:

- 1. Inadequate nutrition.
- 2. New resistance to current antiemetic therapy.
- 3. Expected response to chemotherapy treatment.
- 4. Infection.

**95.** A 36-year-old male with lymphoma is assessing a client who reports distress 9 days after chemotherapy. Because of the risk for septic shock, the nurse should assess the client for which cluster of symptoms?

- 1. Flushing, decreased oxygen saturation, mild hypotension.
- 2. Low-grade fever, chills, tachycardia.
- 3. Elevated temperature, oliguria, hypotension.
- 4. High-grade fever, normal blood pressure, increased respirations.

**96.** An appropriate nursing intervention for a client with fatigue related to cancer treatment includes teaching the client to:

- 1. Increase fluid intake.
- 2. Minimize naps or periods of rest during day.
- 3. Conserve energy by prioritizing activities.
- 4. Limit dietary intake of high-fiber foods.

**97.** The **most** common issue associated with sleep disturbances in the hospitalized client with cancer is:

- 1. Social.
- 2. Nutritional.
- 3. Cultural.
- 4. Psychological.

**98.** Which of the following represents the **most** appropriate nursing intervention for a client with pruritus caused by cancer or the treatments?

- 1. Administration of antihistamines.
- 2. Steroids.
- 3. Silk sheets.
- 4. Medicated cool baths.

**99.** A client receiving chemotherapy has experienced a flare-up of pruritus. In order to develop a care plan, the nurse should ask the client if she has been?

- 1. Wearing clothes made from 100% cotton.
- 2. Sleeping in a cool, humidified room.
- 3. Increasing fluid intake to at least 3,000 mL/day.
- 4. Taking daily baths with a deodorant soap.

**100.** Which of the following variables is **most** important to assess when determining the impact of the cancer diagnosis and treatment modalities on a long-term survivor's quality of life?

- 1. Occupation and employability.
- 2. Functional status.
- 3. Evidence of disease.
- 4. Individual values and beliefs.

**101.** A client with breast cancer has abdominal bloating and cramping with no bowel movement for 5 days. She says she usually has a bowel movement every day after her morning coffee. Bowel sounds are present in all four quadrants. She received 80 mg of doxorubicin hydrochloride (Adriamycin) 10 days ago. The nurse should contact the health care provider to request an order for which of the following?

- 1. A Fleet enema to stimulate peristalsis.
- 2. A soapsuds enema until clear.
- 3. An oral cathartic until the client has a bowel movement; then evaluate the need for daily stool softeners.
- 4. A daily stool softener for constipation and a mild opioid for abdominal discomfort.

**102.** A client with cancer has diarrhea and a nursing diagnosis of *Impaired skin integrity* related to the frequent diarrhea. Which of the following nursing interventions is appropriate for this diagnosis?

- 1. Discourage sitz baths because they promote bacterial growth.
- 2. Apply zinc oxide ointment to the rectal area after each bowel movement to protect the skin.
- 3. Apply a skin-barrier dressing daily to the rectal area to form a protective barrier.
- 4. Clean the rectal area with unscented soap and water after each bowel movement, rinse well, and pat dry.

**103.** Which of the following statements is **most** accurate regarding the long-term toxic effects of cancer treatments on the immune system?

- 1. Clients with persistent immunologic abnormalities after treatment are at a much greater risk for infection than clients with a history of splenectomy.
- 2. The use of radiation and combination chemotherapy can result in more frequent and more severe immune system impairment.
- 3. Long-term immunologic effects have been studied only in clients with breast and lung cancer.
- 4. The helper T cells recover more rapidly than the suppressor T cells, which results in positive helper cell balance that can last 5 years.

**104.** The nurse should expect single-donor platelets to be ordered for which of the following clients?

- 1. A client who is receiving multiple platelet transfusions.
- 2. A client who is deficient in coagulation factors.
- 3. A client whose platelet count is greater than 50,000/mm<sup>3</sup>.
- 4. A client who is refractory to random-donor platelets.

### The Client Who Is Coping with Loss, Grief, Bereavement, and Spiritual Distress

**105.** A client is newly diagnosed with cancer and is beginning a treatment plan. Which of the following nursing interventions will be **most** effective in helping the client cope?

- 1. Assume decision making for the client.
- 2. Encourage strict compliance with all treatment regimens.
- 3. Inform the client of all possible adverse treatment effects.
- 4. Identify available resources.

**106.** A daughter is concerned that her mother is in denial when discussing her diagnosis of breast cancer because she sometimes says that breast cancer isn't that serious and changes the subject. The nurse informs the daughter that denial can be a healthy defense mechanism if it is used:

- 1. To permit her mother to seek unconventional treatments.
- 2. When making decisions about her care.
- 3. Alone and not in combination with other defense mechanisms.
- 4. To allow her mother to continue in her role as a mother.

**107.** A 45-year-old single mother of three teen-aged boys has metastatic breast cancer. Her parents live 750 miles away and have only been able to visit twice since her initial diagnosis 14 months ago. The progression of her disease has forced the client to consider high-dose chemotherapy. She is concerned about her children's welfare during the treatment. When assessing the client's present support systems, the nurse will be **most** concerned about the potential problems with:

- 1. Denial as a primary coping mechanism.
- 2. Support systems and coping strategies.
- 3. Decision-making abilities.
- 4. Transportation and money for the boys.

**108.** Which of the following characteristics displayed by the wife of a 36-year-old man with pancreatic cancer suggests that she may be at risk for negative bereavement outcomes?

- 1. She is preparing for her husband's death.
- 2. Her high socioeconomic status.
- 3. Her strong family support.
- 4. She blames herself for her husband's cancer.

**109.** Which of the following factors assists a person to achieve positive bereavement outcomes?

- 1. Young age.
- 2. History of anxiety.
- 3. History of depression.
- 4. Higher socioeconomic status.

**110.** Which of the following nursing interventions will be **most** effective when caring for a client who is experiencing powerlessness?

- 1. Make certain that all staff members focus only on the client's capabilities.
- 2. Encourage family members to become more responsible for the client's care.
- 3. Request a referral to a psychologist.
- 4. Include the client in decision making whenever possible.

**111.** During the initial stage of adaptation to the diagnosis of cancer and its treatment, the nurse can facilitate the client's adaptation by:

- 1. Encouraging the client to maintain her usual role.
- 2. Facilitating family-related disagreements and conflicts.
- 3. Supporting the client in her use of denial as a coping strategy.
- 4. Arranging transportation and child care on treatment days.

**112.** The son of a 78-year-old client with metastatic prostate cancer is asking the nurse about the purpose of hospice care. Which of the following statements by the nurse **best** describes hospice care?

- 1. "Hospice care uses a team approach to direct hospice activity."
- 2. "Clients and their families are the focus of care."
- 3. "The client's physician coordinates all the care."
- 4. "All hospice clients will die at home."

**113.** A client's husband expresses concern that his dying wife keeps saying, "I have to go to the store." Which of the following statements by the nurse will be **most** effective in assisting the husband to understand the dying process?

- 1. "Many dying clients are restless and can be treated with sedatives."
- 2. "The client may be fighting death and you should leave her alone."
- 3. "Comments related to going somewhere or leaving on a trip are common in dying clients."
- 4. "Decreased circulation and lack of oxygen to the brain often causes delirium."

**114.** The wife of a terminally ill client asks the nurse, "Why is my husband having frequent bowel movements if he is not eating?" Which of the following responses by the nurse informs the wife about the client's condition?

- 1. "I know he is having frequent loose stools and it is distressing for you, but that's just the way it is."
- 2. "I don't know when the bowels will shut down, but they will eventually."
- 3. "The pain medication will eventually help to slow the process of bowel function."
- 4. "The intestines still produce some waste products even when a person is not eating."

**115.** The nurse formulates a nursing diagnosis of *Spiritual distress* related to advanced cancer disease. An appropriate goal for the client would be to:

- 1. Start attending church or chapel services once a week.
- 2. Call a chaplain and set up an appointment for spiritual guidance.
- 3. Reflect on past accomplishments.
- 4. Participate in spiritual activities of the client's choice.

**116.** A 72-year-old client with cancer needs assistance with paying hospital bills. The nurse should refer the client to a:

- 1. Bank representative.
- 2. Social worker.
- 3. Loan officer.
- 4. Representative of the hospital billing department.

**117.** The family members caring for a 72-year-old client who is near death from colon cancer are concerned about dehydration. What should the nurse tell them about dehydration at end of life?

- 1. The physician will make the decision regarding hydration therapy.
- 2. Dehydration may prolong the dying process.
- 3. Hydration is used only in extreme situations of dehydration.
- 4. Dehydration is expected during the dying process.

**118.** Which of the following actions should the nurse plan to do **first** when caring for a client who is experiencing spiritual distress?

- 1. Make a referral to a member of the clergy.
- 2. Explain the major beliefs of different religions.
- 3. Suggest reading material.
- 4. Help the client explore his or her own values and beliefs.

**119.** A nurse is caring for a client at home on hospice care for terminal renal cancer. People are calling the nurse to inquire about the client's condition. The nurse should tell the callers:

- 1. "Please call the oncologist."
- 2. "The client is in a coma now."
- 3. "Please call the client's sister"
- 4. "The client is not expected to live much longer."

**120.** A 42-year-old client with breast cancer is concerned that her husband is depressed by her diagnosis. Which of the following changes in her husband's behavior may confirm her fears?

- 1. Increased decisiveness.
- 2. Problem-focused coping style.
- 3. Increase in social interactions.
- 4. Disturbance in his sleep patterns.

**121.** The **most** appropriate suggestion for the hospice nurse to give a woman whose husband died 3 months ago and her three young children would be to:

- 1. Seek group counseling support for the three children.
- 2. Request individual counseling and medication to manage depression.
- 3. Remind her gently that bereavement care before death minimizes grieving.
- 4. Continue her bereavement support through hospice.

**122.** Which of the following interventions will be **most** effective in improving transcultural communications with oncology clients and their families?

- 1. Use touch to show concern and caring for the client.
- 2. Focus attention on verbal communication skills only.
- 3. Establish a rapport and listen to their concerns.
- 4. Maintain eye contact at all times.

**123.** A client with cancer verbalizes that he is afraid he won't be able to cope with all the issues that will arise. The nurse can **best** support the coping behaviors of a client with cancer by:

- 1. Helping the client identify available resources.
- 2. Encouraging compliance with treatment regimens.
- 3. Relieving the client of decision making as much as possible.
- 4. Assisting the client to prepare for adverse treatment effects.

**124.** The "I Can Cope," "CanSurmount," and "Reach to Recovery" programs are all designed to help cancer clients:

- 1. Choose treatment centers.
- 2. Find financial help.
- 3. Obtain home health care.
- 4. Cope with cancer.

**125.** A 56-year-old cancer survivor feels guilty at the "I Can Cope" meetings. The nurse can help him manage his feelings of guilt by pointing out that:

- 1. He is really angry at the terminally ill clients in the group.
- 2. He is experiencing very volatile emotions.
- 3. This is a spiritual response to his illness.
- 4. This is a normal reaction when surviving a life-threatening experience.

**126.** A 68-year-old client with colon cancer experiences an increase in his feelings of anxiety and depression and has suicidal ideation. He appears to be in great distress. The nurse realizes that he is at which stage in his disease?

- 1. Initiation of definitive treatment.
- 2. End of his first course of treatment.
- 3. End stage of his disease.
- 4. Recurrence of the disease.

**127.** A 57-year-old client has difficulty with mobility after cancer treatment therapies and states, "Why should I bother trying to get better? It doesn't seem to make any difference what I do." The nurse responds by helping the client establish reasonable activity goals, choose her own foods from the menu, and make choices about her daily activities. These interventions represent the nurse's attempt to address which of the following nursing diagnoses?

- 1. *Ineffective coping.*
- 2. *Powerlessness.*
- 3. *Risk prone health behavior.*
- 4. *Complicated grieving.*

**128.** The nurse is aware that a 65-year-old widower whose only son is 500 miles away is at higher risk for psychosocial distress because the client:

- 1. Has been successful in dealing with stress all his life.
- 2. Does not have to deal with other stressors right now.
- 3. Is able to use denial as a coping mechanism.
- 4. Perceives he has minimal social support.

**129.** A client with a diagnosis of cancer is frequently disruptive and challenges the nurse. This behavior is probably caused by:

- 1. Uncertainty and an underlying fear of recurrence.
- 2. The usual trajectory of a short-term illness.
- 3. A history of a behavioral illness.
- 4. The one-time crisis from learning of the diagnosis.



**130.** A 42-year-old husband and father of a 7-year-old girl and a 10-year-old boy is concerned about what he should tell his children regarding his wife's impending death from aggressive breast cancer. The nurse should:

- 1. Refer the family to pastoral care services.
- 2. Encourage the husband to come to terms with his own grief first.
- 3. Suggest that the children be told nothing until after death occurs.
- 4. Begin education about strategies for communication with his children.

**131.** While talking to her husband, who is caring for their children, a 52-year-old client slams the phone down. She begins to cry and states that she is feeling guilty for being hospitalized. Which of the following interventions will **best** support the client emotionally?

- 1. Call the physician and ask for a psychiatry consultation.
- 2. Call the physician and request an antidepressant medication.
- 3. Sit with the client and help her acknowledge and discuss her feelings.
- 4. Sit with the client and encourage her to see the good side of the situation.

**132.** A 56-year-old female who is receiving radiation therapy tells the nurse that she feels inadequate as a wife and mother because she can no longer carry out her usual duties with the same energy as before. What recommendations should the nurse make to help the client cope with this situation?

- 1. Suggest that she reassign all household chores to other members of the family.
- 2. Suggest that she prioritize her activities and ask for help from friends and family.
- 3. Suggest that she ignore the household chores during the crisis period.
- 4. Tell her not to worry so much because everyone gets a little tired at this phase of the therapy.

**133.** A 66-year-old female who is usually meticulous about her appearance and dress arrives today for her 23rd day of radiation therapy. She appears disheveled and emotionally labile, and her responses to the usual questions are a little inappropriate. Her heart rate is 124 bpm, her respirations are 32 breaths/minute, and her skin is cold and clammy. These findings would suggest that the nurse should further assess the client for which of the following conditions?

- 1. Schizophrenia.
- 2. Panic disorder.
- 3. Depression.
- 4. Delirium.

**134.** A client has undergone surgical resection for lung cancer. Which of the following nursing interventions will promote adaptation and rehabilitation?

- 1. Arranging a visit from a member of the American Cancer Society Lost Chord Club.
- 2. Planning a progressive activity regimen with the client.
- 3. Teaching tracheostomy care.
- 4. Planning a vigorous exercise program.

**135.** Which of the following activities indicates that the client with cancer is adapting well to body image changes?

- 1. The client names his brother as the person to call if he is experiencing suicidal ideation.
- 2. The client discusses changes in body structure and function.
- 3. The client discusses the date of his return to work.
- 4. The client serves as a volunteer in a client-to-client visitation program.

### The Client Who Is Experiencing Problems with Sexuality

**136.** A 36-year-old female is complaining of increased vaginal dryness during sexual intercourse. She has received chemotherapy in the past and has menopausal symptoms due to ovarian suppression. An appropriate nursing intervention would be to instruct the client on the use of:

- 1. Vaginal dilators.
- 2. Nightly douches.
- 3. Water-soluble vaginal lubricants.
- 4. Relaxation techniques.

**137.** A 49-year-old male with a tracheostomy tube confides to the nurse during a clinic visit that he is beginning to avoid sexual activity because of the increased tracheostomy secretions. Which of the following statements by the nurse will be **most** helpful to the client?

- 1. "Use a scopolamine patch to decrease secretions."
- 2. "Avoid fluid intake 2 hours before sexual activity."
- 3. "Place a thin piece of gauze over the tracheostomy."
- 4. "Wash the tracheostomy area with deodorizing antibacterial soap before sexual activity."

**138.** A 52-year-old client is scheduled for a total abdominal hysterectomy for cervical cancer. The nurse's discussion regarding the client's feelings and the potential impact of this procedure on her sexuality should include which of the following questions?

- 1. "All women experience sexual problems with this surgical procedure. Do you have any questions?"
- 2. "When can I schedule an appointment with you and your partner to discuss any issues either of you may have regarding sexuality?"
- 3. "Do you anticipate any problems with sex related to your scheduled hysterectomy?"
- 4. "Most women have concerns about their sexuality after this type of surgery. Do you have any concerns or questions?"

**139.** A young man with early-stage testicular cancer is scheduled for a unilateral orchiectomy. The client confides to the nurse that he is concerned about what effects the surgery will have on his sexual performance. Which of the following responses by the nurse provides accurate information about sexual performance after an orchiectomy?

- 1. "Most impotence resolves in a couple of months."
- 2. "You could have early ejaculation with this type of surgery."
- 3. "We will refer you to a sex therapist because you will probably notice erectile dysfunction."
- 4. "Because your surgery does not involve other organs or tissues, you'll likely not notice much change in your sexual performance."

**140.** A young female client is receiving chemotherapy and mentions to the nurse that she and her husband are using a diaphragm for birth control. Which of the following is **most** important for the nurse to discuss?

- 1. Inconvenience of the diaphragm.
- 2. Transmission of sexually transmitted diseases.
- 3. Body changes related to hormones.
- 4. Infection control.

**141.** To promote comfort and optimal respiratory expansion for a client with chronic obstructive pulmonary disease during sexual intimacy, the nurse can suggest that the couple:

- 1. Use a waterbed.
- 2. Use pillows to raise the affected partner's head and upper torso.
- 3. Have the affected partner assume a dependent position.
- 4. Limit the duration of the sexual activity.

## Ethical and Legal Issues Related to Clients with Cancer

**142.** A registered nurse is assigning care on the oncology unit and assigns the client with Kaposi's sarcoma and human immunodeficiency virus (HIV) infection to the licensed vocational nurse (LVN-LPN). The LVN-LPN states that she does not want to care for this client. How should the nurse respond?

- 1. "I will assign this client to another nurse."
- 2. "I will help you take care of this client so you are confident with his care."
- 3. "You seem worried about this assignment."
- 4. "I will review blood and body fluid precautions with you."

**143.** In an attempt to call public attention to the cancer survivor's needs, a bill of rights was put forth by the:

- 1. American Cancer Society.
- 2. National Coalition of Cancer Survivors.
- 3. National Cancer Institute.
- 4. National Hospice Organization.

**144.** A 32-year-old teacher is concerned that she will lose her job if she requests a leave of absence to care for her father who is getting daily treatment for colon cancer in a city 300 miles away. Which legislative measure will likely protect her job during an extended illness?

- 1. Family Leave Act of 1993.
- 2. Americans with Disabilities Act of 1990.
- 3. Medicare Coverage for Catastrophic Illness Act of 1988.
- 4. Rehabilitation Act of 1973.

**145.** A 62-year-old woman thinks her husband's rehabilitation needs have been unmet by his employer after his diagnosis and treatment of colon cancer. The nurse should give her information about:

- 1. The Americans With Disabilities Act of 1990.
- 2. Title V of the Rehabilitation Act of 1973.
- 3. The Civil Rights Act of 1964.
- 4. The Patient Self-Determination Act of 1991.

**146.** A client and nurse have established a goal for the client to be more autonomous. Which of the following situations indicates that the goal has been met?

- 1. The physician directs the client's care.
- 2. The nurse provides the client with the facts and then allows the client to reach an unassisted decision.
- 3. The nurse respects a client's choice not to know particular information.
- 4. The health care team makes health and treatment decisions.

## End-of-Life Care

**147.** The family of a hospitalized client demonstrates understanding of the teaching about advance directives when they make which of the following statements? Select all that apply.

- 1. "Advance directives give instructions about future medical care and treatment."
- 2. "If people are not capable of communicating their wishes, health care providers and family together can agree on measures or actions that will be taken."
- 3. "Ethics experts agree that the family is the sole deciding factor when the client is competent."
- 4. "Medical power-of-attorney gives primarily financial access to the designee."
- 5. "Medical power-of-attorney or durable power-of-attorney for health care is a document that lists who can make health care decisions should a person be unable to make an informed decision for himself or herself."
- 6. "Advance directives give details about the client's past medical history."

**148.** The nurse can be an important advocate for the client who is considering an alternative method of cancer treatment. Which of the following statements **best** demonstrates the nurse as client advocate?

- 1. The nurse will provide the information about standard therapies.
- 2. The nurse will monitor blood tests as indicated by the alternative therapy.
- 3. The nurse will document the client's desire to try an alternative therapy.
- 4. The nurse will allow the client to make health care choices on her own but will assist in ensuring the client is fully informed when making those decisions.

**149.** After completing the nursing assessment for a client and family entering the palliative care program, the nurse should develop a teaching plan that includes an understanding of which of the following outcomes? Select all that apply.

- 1. Alteration in the family's usual coping strategies.
- 2. Achievement of a dignified and respectful death.
- 3. Improvement in the client's quality of life.
- 4. Provision of comfort during the dying process.
- 5. Provision of support for client and family.
- 6. Advocacy for prolonging life while curing the disease.

**150.** When a 62-year-old client and his family receive the initial diagnosis of colon cancer, the nurse can act as an advocate by:

- 1. Helping them maintain a sense of optimism and hopefulness.
- 2. Determining their understanding of the results of the diagnostic testing.
- 3. Listening carefully to their perceptions of what their needs are.
- 4. Providing them with written materials about the cancer site and its treatment.

**151.** A client who is dying of acquired immunodeficiency syndrome (AIDS) is admitted to the inpatient psychiatric unit because he attempted suicide. His close friend recently died of AIDS. The client begins to talk about his feelings related to his illness and the loss of his friend. He begins to cry. Which of the following responses by the nurse would be **most** appropriate?

- 1. Give the client some tissues and tell him it is okay to cry.
- 2. Tell the client to stop crying and that everything will be okay.
- 3. Sort the client's mail to distract the client.
- 4. Change the subject.

**152.** A 79-year-old male client is admitted again for heart failure and kidney failure. After completing his admission, the nurse is talking with the client's wife, who expresses several concerns. She says, "I know he doesn't want to die in a hospital, but it is so hard for me to take care of him at home. He said he doesn't want any more treatment, but I'm not ready to let him go. We have so many arrangements to decide before he dies." Which of the following statements by the nurse to the client's wife would be **most** appropriate? Select all that apply.

- 1. "He's not going to die that soon judging by his current symptoms."
- 2. "What are your fears about your husband dying?"
- 3. "I can imagine that it is hard for you to care for him at home."
- 4. "What do you and your husband know about advance directives?"
- 5. "We can discuss types of hospice and home care available."
- 6. "What kind of arrangements do you think need to be made before he dies?"

**153.** A terminally ill client's husband tells the nurse, "I wish we had taken that trip to Europe last year. We just kept putting it off, and now I'm furious that we didn't go." The nurse interprets the husband's statement as indicating which of the following stages of adaptation to dying?

- 1. Anger.
- 2. Denial.
- 3. Bargaining.
- 4. Depression.

**154.** Which of the following philosophies should the nurse **most** likely integrate into the plan of care for a client and family to help them best cope during the final stages of the client's illness?

- 1. Living each day as it comes as fully as possible.
- 2. Reliving the pleasant memories of days gone by.
- 3. Expecting the worst and being grateful when it does not happen.
- 4. Planning ahead for the remaining good times that will be spent together.

**155.** A client admitted to the hospital for the third time is diagnosed as having acute lymphatic leukemia. The liaison psychiatric nurse is asked by the team leader to help the nursing staff work more effectively with this terminally ill child and his family. One of the nurses says to the liaison nurse, "Whenever I go to the client's room, I feel that I have to smile and act happy even though I want to cry when I see him." Which of the following responses by the liaison nurse would be **most** appropriate?

- 1. "Call me when you feel that way. We can talk it over at the time."
- 2. "Try not to show emotion, such as crying. You'll upset the client."
- 3. "Keep smiling. The client and family need all the support they can get."
- 4. "Tell the client you feel bad because he is ill and cry, too, if it seems appropriate."

**156.** A client who is in the end-stages of cancer is increasingly prone to outbursts concerning chemotherapy treatments. Which of the following approaches by the nurse would likely be **most** helpful in gaining the client's cooperation?

- 1. Telling the client how the treatment can be expected to help.
- 2. Describing the probable effect on that missing a treatment would have.
- 3. Saying "be a good client" and not make the treatment any harder for yourself.
- 4. Promising to give a backrub when the treatment is completed.

**157.** A client suspects that he will not live. However, others talk about only pleasant matters with him and maintain a persistently cheerful facade around him. The nurse anticipates that the client will **most** likely feel which of the following as a result of such behavior?

- 1. Relief.
- 2. Isolation.
- 3. Hopefulness.
- 4. Independence.

**158.** The young sister of a client with leukemia asks, "Can you check my blood? When my sister got the measles, so did I. And I think I have this, too." Which of the following by the nurse would be inappropriate?

- 1. Asking the client's physician to take a sample of the sister's blood.
- 2. Explaining to the sister that leukemia is not a communicable disease.
- 3. Discussing the sister's concern with her parents.
- 4. Telling the sister's parents about a group for siblings of clients with terminal illness.

**159.** When talking with the nurse, the brother of a client with leukemia says, "We used to play pretty rough games together. Maybe some of the bruises he got when I tackled him caused this." Which of the following would be the nurse's **best** response?

- 1. "Don't feel guilty. You didn't cause your brother's illness."
- 2. "I can see you're worried. Let's talk about how people get leukemia."
- 3. "Here is some information about leukemia for you to read."
- 4. "Lots of people worry about things like this. It isn't your fault."

**160.** During the nursing shift report, the team leader lists tasks and routines completed for a terminally ill client. Which of the following kinds of behavior is the nurse **most** likely demonstrating when emphasizing the technical aspects of caring for a dying client?

- 1. Tactful behavior.
- 2. Efficient behavior.
- 3. Objective behavior.
- 4. Defensive behavior.

## Managing Care Quality and Safety

**161.** The nurse is caring for a client with end stage cancer whose health status is declining. An order is written by the attending physician to withhold all fluid, but the health care team cannot locate a family member or guardian. The nurse requests an ethics consultation. Which of the following is true of an ethics consultation? Select all that apply.

- 1. Persons requesting an ethics consultation may do so without intimidation or fear of reprisal.
- 2. Ethics consultations may prevent poor outcomes in cases involving ethical problems.
- 3. The recommendations of ethics consultants are advisory only.
- 4. Requests for ethics consultations may only be made by the physician or nurse.
- 5. Ethics consultation is intended to provide legal advice on client care.

**162.** The nurse-manager on the oncology unit wants to address the issue of correct documentation of the effectiveness of analgesia medication within 30 minutes after administration. What should the nurse-manager do **first**?

- 1. Change the policy of documentation to 45 minutes.
- 2. Consult the pharmacist.
- 3. Consult the nurses on the evening shift where documentation of analgesia is the greatest problem.
- 4. Complete a brief quality improvement study and chart audit to document the rate of adherence to the policy and the pattern of documentation over shifts.

**163.** A registered nurse (RN) instructs the unlicensed assistive personnel (UAP) to check the urine intake and output (I&O) on clients on the oncology unit at the end of the 8-hour shift. It is important for the nurse to instruct the UAP to do what?

- 1. Ask the clients if they are thirsty when calculating the I&O.
- 2. Report back to the nurse immediately if any client has an output less than 240 mL.
- 3. Document the I&O results on the medical records.
- 4. Write the I&O results down for the nurse to give report to the next shift.

**164.** An 82-year-old elderly, alert, and oriented female with metastatic lung cancer is admitted to the medical-surgical unit for treatment of heart failure. She was given 80 mg of furosemide (Lasix) in the emergency department. Although the client is ambulatory, the unlicensed assistive personnel are concerned about urinary incontinence because the client is frail and in a strange environment. The nurse should instruct the unlicensed personnel to assist with implementing the nursing plan of care by:

- 1. Ordering adult diapers for the client so she will not have to worry about incontinence.
- 2. Requesting an indwelling urinary catheter to avoid incontinence.
- 3. Padding the bed with extra absorbent linens.
- 4. Placing a commode at the bedside and instructing the client in its use.

**165.** The nursing team on an oncology unit consists of a registered nurse (RN), a licensed vocational nurse (LVN-LPN), and unlicensed assistive personnel (UAP). Which client should be assigned to the registered nurse?

- 1. A 52-year-old client with lung cancer admitted for acute dyspnea.
- 2. A 45-year-old client receiving tube feedings.
- 3. A 28-year-old client being evaluated for a bone marrow transplant.
- 4. A 65-year-old client diagnosed with endometrial cancer who underwent an abdominal hysterectomy 3 days ago.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client at Risk for Cancer

**1. 3.** The nurse needs to consider the beliefs and concerns for all socioeconomic levels of African American women when providing education on breast cancer. Access to screening and care may differ. African American women are more likely to develop breast cancer and be diagnosed later in the disease process than Caucasian women. Not all African American women believe that breast cancer is inevitable.

🔑 CN: Health promotion and maintenance;  
CL: Synthesize

**2. 3.** Clients over age 50 who have a history of inflammatory bowel disease are at risk for colon cancer. The client who smokes is at high risk for lung cancer. While the exact cause is not always known, other risk factors for colon cancer are a diet high in animal fats, including a large amount of red meat and fatty foods with low fiber, and the presence of colon cancer in a first-generation relative.

🔑 CN: Reduction of risk potential;  
CL: Analyze

**3. 1, 3, 5.** Acetaminophen (Tylenol) is a safer analgesic than aspirin in order to avoid bleeding. Contact sports or trauma to the site should be avoided. Cool compresses should limit swelling and bruising. The puncture site should be inspected every 2 hours for bleeding or bruising during the first 24 hours.


🔑 CN: Reduction of risk potential;  
CL: Evaluate

**4. 4.** Basal cell carcinoma occurs most commonly in sun-exposed areas of the body. The incidence of skin cancer is highest in older people who live in the mountains or spend outdoor leisure time at higher altitudes.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**5. 1.** Because of the high risk of infertility with chemotherapy, pelvic irradiation, and

retroperitoneal lymph node dissection that may follow an orchiectomy, cryopreservation of sperm is completed before treatment is started and should be discussed with the client.

 CN: Physiological adaptation;  
CL: Apply

**6. 1.** Progression is the change in a tumor from the preneoplastic state or low degree of malignancy to a rapidly growing tumor; it cannot be reversed. Promotion is reversible. Initiation is at first reversible (through repair of damaged DNA) and later irreversible. Regression is not a recognized stage of carcinogenesis.

 CN: Health promotion and maintenance;  
CL: Apply

**7. 2.** The word *prevalence* in a statistical setting is defined as the number of cases of a disease present in a specified population at a given time.

 CN: Health promotion and maintenance;  
CL: Apply

**8. 3.** Sun damage is a cumulative process. Parents should be taught to apply sunscreen and teach their children to use sunscreen at an early age. Although preventive education is always valuable, serious sunburns in childhood are associated with an increased risk of melanoma. Adults and senior citizens have already been exposed to the harmful effects of the sun and, although they, too, should use sunscreen, they are not the group that will most benefit from intervention. Exposure to chemicals is not a risk factor for melanoma.

 CN: Health promotion and maintenance;  
CL: Analyze

**9. 4.** A sunscreen with an SPF of 15 or higher should be worn on all sun-exposed skin surfaces. It should be applied before sun exposure and reapplied after being in the water. Peak sun exposure usually occurs from 10 a.m. to 2 p.m. Tightly woven clothing, protective hats, and sunglasses are recommended to decrease sun exposure. Suntanning parlors should be avoided.

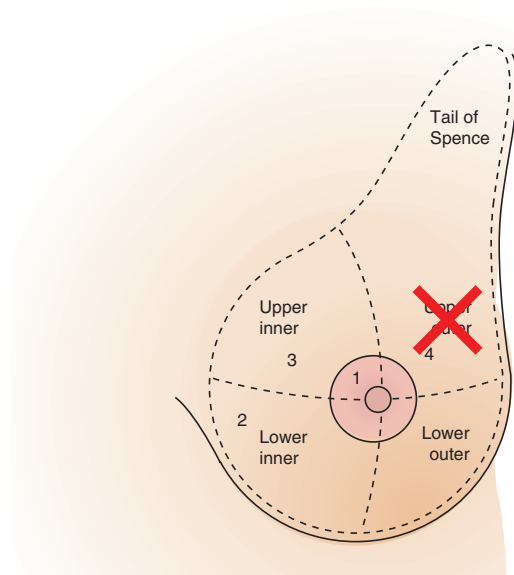
 CN: Health promotion and maintenance;  
CL: Synthesize

**10. 1.** Malignant melanoma may have a familial basis, especially in families with dysplastic nevi syndrome. First-degree relatives should be monitored closely. Malignant melanoma occurs most often in the 20- to 45-year-old age-group. Severe sunburn as a child does increase the risk; however, this client is at increased risk because of her family history.


 CN: Health promotion and maintenance;  
CL: Apply

**11. 1.** The upper outer quadrant is the area of the breast in which most breast tumors are found. This area should be palpated thoroughly. Although breast tumors can be found in any area of the breast, including the nipple, the tumors are most often in the upper outer quadrant.

 CN: Health promotion and maintenance;  
CL: Apply



**12. 3.** The American Cancer Society guidelines (2004) state that a Pap smear and pelvic examination should be done 3 years after a woman first has vaginal intercourse, but no later than 21 years of age. Annual Pap smears are recommended only for clients at risk and not for the general female population. After three or more consecutive annual examinations with normal findings, the Pap smear may be performed less frequently at the discretion of the physician. Colposcopy is indicated for an abnormal Pap smear, not a negative Pap smear.

 CN: Health promotion and maintenance;  
CL: Apply

**13. 3.** Because more than 50% of the cancers occur in people who are older than age 65, the single most important factor in determining risk would be age.

 CN: Health promotion and maintenance;  
CL: Apply

**14. 3.** Evidence suggests that a high-fat diet increases the risk of several cancers, including breast, colon, and prostate cancers. Ovarian, lung, and liver cancers have not been linked to a high-fat diet.

 CN: Health promotion and maintenance;  
CL: Apply


**15. 4.** The client is at increased risk for development of lung, skin, or breast cancer. Consequently, the most urgent changes in behavior should include smoking cessation, protection from the sun, and weight loss. Decreasing alcohol consumption is certainly desirable, as is improving overall nutritional intake (e.g., eating low-fat foods, increasing fiber) but is not the most urgent behavior change for this client.

 CN: Health promotion and maintenance;  
CL: Synthesize


**16. 1.** Asbestos and alcohol, when combined with smoking, produce a synergistic effect and result in increased cancer risk and incidence. Ultra-violet radiation exposure is associated with skin cancer. HPV exposure is associated with cervical cancer. However, the risks of contracting these types of cancer are not markedly increased when combined with smoking.

 CN: Health promotion and maintenance;  
CL: Apply


**17. 4.** Although exposure to the sun increases the risk of skin cancers and family history is significant in the development of some types of cancer, heavy tobacco use and alcohol intake have a synergistic effect and increase the risk and incidence of head and neck cancers. Patterns of medication use, exposure to wood dust, and a high-fat diet are not associated with an increased risk and incidence of head and neck cancers.

 CN: Health promotion and maintenance;  
CL: Analyze

**18. 2.** High-fiber, low-fat diets are recommended to reduce the risk of colon cancer. Stir-frying, poaching, steaming, and broiling are all low-fat methods to prepare foods. Croissants are made of refined flour. They are also high in fat, as are peanut butter squares and whole milk, granola, cream cheese, and sour cream.


 CN: Health promotion and maintenance;  
CL: Apply

**19. 2.** Environmental factors include place of residence, nutrition, occupation, personal habits, iatrogenic factors, and physical environment. Gender, immunologic status, and age are individual factors.

 CN: Health promotion and maintenance;  
CL: Apply

**20. 3.** CT scanning is the standard noninvasive method used in a workup for lung cancer because it can distinguish small differences in tissue density and can detect nodal involvement. CT is comparable to magnetic resonance imaging in evaluating lymph

node metastasis. CT is noninvasive and usually available, but these are not the main reasons for its use. CT can distinguish malignancy in some situations only.

 CN: Physiological adaptation;  
CL: Synthesize

**21. 3.** A high-fat, low-fiber diet is a risk factor for colorectal cancer. A diet low in vitamin C, use of artificial sweeteners, and multiple sex partners are not considered risk factors for colorectal cancer.


 CN: Health promotion and maintenance;  
CL: Analyze

**22. 2.** Strategies to reach the socioeconomically disadvantaged should include incorporating the folk beliefs and traditions of the target population into the program. Identification of a centrally located building with available access by the target population, use of materials in the native or primary language of the target population, and involvement by the community leaders will also help the program succeed.


 CN: Health promotion and maintenance;  
CL: Synthesize

## The Client with Pain


**23. 4.** The desired outcome for management of pain is that the client's or family's subjective report of pain is acceptable and documented using a pain scale; the goal is that behavioral and physiologic indicators of pain are absent around the clock. The nurse and client/family should develop a systematic approach to pain management using information gathered from history and a hierarchy of pain measurement. Pain should be assessed at frequent intervals. The client should not wait to receive medication until the pain is midpoint on the pain scale, nor should the client receive so much pain medication that he or she is not alert. Continuous pain relief is the goal, not just during particular periods during the day.

 CN: Basic care and comfort;  
CL: Synthesize


**24. 3.** Tolerance develops from taking opioids over an extended period. It is characterized by the need for an increased dose to achieve the same degree of analgesia. Addiction is characterized by a drive to take the medication for the psychic effect rather than the therapeutic effect. Physical dependence is a response to ongoing exposure to a medication manifested by withdrawal symptoms when discontinued abruptly.

 CN: Pharmacological and parenteral therapies;  
CL: Analyze


**25. 4.** The conversion ratio for morphine is 10 mg I.V. equals 30 mg oral, or 1:3. The client is receiving 300 mg orally per 24 hours, which is equivalent to 100 mg of I.V. morphine. Morphine 100 mg I.V./24 hours = approximately 4 mg/hour I.V. The effect of the I.V. morphine is quick and the oral morphine should be discontinued prior to starting the I.V. morphine. Morphine at 6 mg or higher are above the initial conversion dose from oral to I.V. and can cause untoward side effects.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**26. 3.** Administration of morphine sulfate is contraindicated because morphine causes respiratory depression. It may also increase intracranial pressure if the client is not ventilating properly, which could result in an accumulation of CO<sub>2</sub>, a potent vasodilator. Ibuprofen, naproxen, and acetaminophen are not likely to mask symptoms of increased intracranial pressure or impact respiratory status.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**27. 1.** If the maximum dose specified by the physician's order is required every 3 to 4 hours for break-through pain, the physician should be notified to increase the long-acting medication or rotate to another type of opioid. Around-the-clock dosing is mandatory to achieve a steady state of analgesia. The rescue dose for breakthrough pain is administered over and above the regularly scheduled medication. If three to four analgesic doses are required every 24 hours, the sustained-release around-the-clock dose should be increased to include the amount used for previous breakthrough pain while maintaining a dose for future breakthrough pain.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**28. 1.** The most common toxicities from NSAIDs are gastrointestinal disorders (nausea, epigastric pain, ulcers, bleeding, diarrhea, and constipation). Renal dysfunction, pulmonary complications, and cardiovascular complications from NSAIDs are much less common.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**29. 2.** In the client with chronic pain, physiologic adaptation results in minimal changes in behavior and vital signs. Elevated vital signs, grimacing, and moaning are characteristic responses to acute pain.

 CN: Basic care and comfort; CL: Analyze

**30. 4.** *Tolerance* is a reduced responsiveness to the effect of any drug, which necessitates larger


doses to achieve an equivalent effect of the initial dose. *Pseudoaddiction* is a term used to describe the iatrogenic syndrome of drug-seeking behavior that develops as a direct consequence of inadequate pain management. *Physical dependence* refers to the state in which an individual must take the substance to feel physically normal; not taking the drug results in withdrawal symptoms. *Psychological dependence* refers to an individual's need to derive an alteration in mood from a substance.

 CN: Basic care and comfort; CL: Apply

**31. 1, 2, 4, 6.** Guidelines (Agency for Healthcare Research and Quality and The Joint Commission) recommend use of scheduled long-acting opioids (MS Contin, OxyContin). Around-the-clock dosing is necessary to achieve a steady level of analgesia. Whatever the route or frequency, an order should be available for "breakthrough" pain medication to be administered in addition to the regularly scheduled medication. Oral drug administration is the route of choice for economy, safety, and ease of use. Even severe pain requiring high doses of opioids can be managed orally as long as the client can swallow medication and has a functioning gastrointestinal system. Tolerance occurs due to the need for increasing doses to achieve the same pain relief and will not be avoided with the use of Tylenol. Addiction is a complex condition in which the drug is used for psychological effect and not analgesia. Nurses need to educate families about the appropriate use of opioids and assure them that addiction is not a concern when managing cancer pain. Nonpharmacologic methods are useful as an adjunct to assist in pain control. Self-report is the best assessment of pain and is an individual response.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**32. 4.** Most cancer clients with inadequate pain control while taking an oral opioid after being switched from I.V. administration have been undermedicated. Equianalgesic conversions should be made to provide estimates of the equivalent dose needed for the same level of relief as provided by the I.V. dose. There is research to suggest that cancer clients do not become addicted to opioids when dosed adequately. There is no evidence to suggest that the client is physically addicted or is having withdrawal symptoms.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**33. 1.** Intensity is indicative of the severity of pain and is important for evaluating the efficacy of pain management. The cause and location of the pain cannot be managed but the intensity of the




pain can be controlled. The nurse and client can collaborate to reduce aggravating factors; however, the goal will ultimately be to reduce the intensity of the pain.

 CN: Basic care and comfort;  
CL: Analyze


**34. 2.** There is a 1:3 ratio with equianalgesic dosing of I.V. to oral morphine; therefore, the physician should order three times the I.V. dose.

 CN: Pharmacological and parenteral therapies; CL: Apply


**35. 4.** Normeperidine is a potent long-acting metabolite, which can cause central nervous system (CNS) stimulation and seizures. Meperidine is a short-acting drug and must be given in more frequent intervals and may require increased dosages for effectiveness. Mixed agonist-antagonists act competitively at different pain receptor sites. It is generally accepted by cancer pain experts that opioid agonist-antagonist drugs have very limited usefulness in cancer pain management because of their tendency to induce opioid withdrawal and cause severe CNS adverse effects. Meperidine does not have a higher potential for abuse than other opioids. There are other routes of meperidine administration, so the route of administration is not the limiting factor.

 CN: Pharmacological and parenteral therapies; CL: Apply

**36. 2.** Tolerance to an opioid occurs when a larger dose of the analgesic is needed to provide the same level of pain control. The risk of addiction is low with opioids to treat cancer pain. There are no data to support that this client is experiencing withdrawal. Although the client may have experienced a placebo effect at one time, placebo effects tend to diminish over time, especially in regard to chronic cancer pain.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**37. 2.** The regular administration of analgesics provides a consistent serum level of medication, which can help prevent breakthrough pain. Therefore, taking the prescribed analgesics on a regular schedule is the best way to manage chronic cancer-related pain. There is little risk for the client with cancer-related pain to become addicted. Sleeping 12 to 16 hours a day would not allow the client to participate in usual daily activities or preferred activities.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

## The Client Who Is Receiving Chemotherapy

**38. 3.** Resources should be provided for acquiring a wig since it is easier to match hair style and color before hair loss begins. The client has expressed negative feelings of self image with hair loss. Excessive shampooing and manipulation of hair will increase hair loss. Hair usually grows back in 3 to 4 weeks after the chemotherapy is finished, however new hair may have a new color or texture. A wig, hairpiece, hat, scarf, or turban can be used to conceal hair loss. Social isolation should be avoided and the client should be encouraged to socialize with others.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**39. 4.** A side effect of vincristine is constipation and a bowel protocol should be considered. Imodium is used to treat diarrhea. Fluids should be encouraged, along with high fiber foods to prevent constipation.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**40. 3.** Carbohydrates are the first substance used by the body for energy. Proteins are needed to maintain muscle mass, repair tissue, and maintain osmotic pressure in the vascular system. Fats, in a small amount, are needed for energy production. Chicken, green beans, and cottage cheese are the best selection to provide a nutritionally well-balanced diet of carbohydrate, protein, and a small amount of fat. Cereal with milk and strawberries as well as toast, gelatin dessert, and cookies have a large amount of carbohydrates and not enough protein. Steak and french fries provide some carbohydrates and a good deal of protein; however, they also provide a large amount of fat.

 CN: Health promotion and maintenance; CL: Synthesize

**41. 2.** Chemotherapy agents typically cause nausea and vomiting when not controlled by antiemetic drugs. Antineoplastic drugs attack rapidly growing normal cells, such as in the gastrointestinal tract. These drugs also stimulate the vomiting center in the brain. Hair loss, loss of energy, and sleep are important aspects of the health history, but not as critical as the potential for dehydration and electrolyte imbalance caused by nausea and vomiting.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**42. 2, 4, 5.** Chemotherapy causes bone marrow suppression and risk of infection. A platelet count of 40,000/mm<sup>3</sup> and a white blood cell count of

2,300/mm<sup>3</sup> are low. A temperature of 101.2° F (38.4° C) is high and could indicate an infection. Further assessment and examination should be performed to rule out infection. The BUN, hemoglobin, and specific gravity values are normal.

 CN: Reduction of risk potential;  
CL: Analyze


**43. 4.** The nurse must recognize that an albumin level of 2.8 g/dL indicates catabolism and potential for malnutrition. Normal albumin is 3.5 to 5.0 g/dL; less than 3.5 indicates malnutrition. The other laboratory results are normal.

 CN: Reduction of risk potential;  
CL: Analyze

**44. 1.** Fever is an early sign requiring clinical intervention to identify potential causes. Chills and dyspnea may or may not be observed. Tachycardia can be an indicator in a variety of clinical situations when associated with infection; it usually occurs in response to an elevated temperature or change in cardiac function.

 CN: Reduction of risk potential;  
CL: Analyze

**45. 2.** Chemotherapy causes myelosuppression with a decrease in red blood cells (RBCs), WBCs, and platelets. This client's data demonstrate neutropenia, placing the client at risk for infection. An ANC of 500 to 1,000/mm<sup>3</sup> indicates a moderate risk of infection; an ANC of less than 500/mm<sup>3</sup> indicates severe neutropenia and a high risk of infection. When the WBC count is low and immature WBCs are present, normal phagocytosis is impaired. Precautions are implemented to protect the client from life-threatening infections. These may be instituted when ANC is less than 1,000/mm<sup>3</sup>. Hand washing is the single best way to avoid the spread of infection. It is not necessary to wear a gown and mask to take care of this client. It is also not necessary to restrict visitors; however, the client's visitors should be screened to avoid exposing the client to possible infections. Epogen or Procrit are used for stimulating RBCs, not WBCs. Granulocyte colony-stimulating factors or granulocyte macrophage colony-stimulating factors are useful for treating neutropenia.


 CN: Safety and infection control;  
CL: Synthesize

**46. 1.** The role of the nurse is to assess what substances or medications the client is using and to document and inform other members of the health care team. It is very important to encourage the client to keep the physician informed of all therapeutic agents, medications, and supplements she is using, to avoid adverse interactions. It is not appropriate for the nurse to suggest that the client choose either Western or alternative therapies or to discourage


the client's use of alternative therapies. The nurse should remain objective about the client's treatment choices and respect her autonomy.

 CN: Reduction of risk potential;  
CL: Synthesize

**47. 1.** There are many mechanisms of action for chemotherapeutic agents, but most affect the rapidly dividing cells—both cancerous and noncancerous. Cancer cells are characterized by rapid cell division. Chemotherapy slows cell division. Not all chemotherapeutic agents affect molecular structure. All cells are susceptible to drug toxins, but not all chemotherapeutic agents are toxins.

 CN: Pharmacological and parenteral therapies; CL: Apply

**48. 4.** Cough and shortness of breath are significant symptoms because they may indicate decreasing pulmonary function secondary to drug toxicity. Decrease in appetite, difficulty in thinking clearly, and spasms of the diaphragm may occur as a result of chemotherapy; however, they are not indicative of pulmonary toxicity.


 CN: Physiological adaptation;  
CL: Evaluate

### The Client Who Is Receiving Radiation Therapy

**49. 4.** Hot, cold, and chemical applications to the area treated should be avoided. The client should be encouraged to use the extremity to prevent muscle atrophy and contractures.


 CN: Health promotion and maintenance;  
CL: Synthesize

**50. 2.** The nurse should first assess the client's usual sleep patterns, hours of sleep required before treatment, and usual bedtime routine. Refraining from watching television before bedtime and avoiding caffeine intake are reasonable suggestions and sleeplessness is an adverse effect of radiation therapy. However, assessment is required before any of these options should be suggested.

 CN: Health promotion and maintenance;  
CL: Synthesize

**51. 4.** Difficulty in swallowing, pain, and tightness in the chest are signs of esophagitis, which is a common complication of radiation therapy of the chest wall. Hiatal hernia is a herniation of a portion of the stomach into the esophagus. The client could experience burning and tightness in the chest secondary to a hiatal hernia, but not pain when swallowing. Also, hiatal hernia is not a complication of radiation therapy. Stomatitis is an inflammation of

the oral cavity characterized by pain, burning, and ulcerations. The client with stomatitis may experience pain with swallowing, but not burning and tightness in the chest. Radiation enteritis is a disorder of the large and small bowel that occurs during or after radiation therapy to the abdomen, pelvis, or rectum. Nausea, vomiting, abdominal cramping, the frequent urge to have a bowel movement, and watery diarrhea are the signs and symptoms.

 CN: Physiological adaptation;  
CL: Analyze

**52. 2.** Radiation fields that include the ovaries usually result in premature menopause. Vaginal dryness will occur without estrogen replacement. There should be no sexual intercourse while the implant is in place. Cesium is a radioactive isotope used for therapeutic irradiation of cancerous tissue. There is no documentation to support vaginal relaxation after treatment. Because the client will have premature menopause, she will not have normal menstrual periods.


 CN: Physiological adaptation;  
CL: Synthesize

**53. 3.** Radiation-induced esophagitis with dysphagia is particularly common in clients who receive radiation to the chest. The anatomic location of the esophagus is posterior to the mediastinum and is within the field of primary treatment. Diarrhea may occur with radiation to the abdomen. Decreased energy level and decreased white blood cell count are potential complications of radiation therapy.

 CN: Reduction of risk potential;  
CL: Analyze


### The Client Who Requires Symptom Management

**54. 3.** Head and neck radiation can cause the complication of stomatitis and decreased salivary flow. A saliva substitute will assist with dryness, moistening food, and swallowing. Meticulous mouth care is needed; however, alcohol and vigorous brushing will increase irritation. Evaluation by a dentist to perform necessary dental work is done prior to initiation of therapy.


 CN: Physiological adaptation;  
CL: Synthesize

**55. 3.** The client has a low white blood cell count from the chemotherapy and has a temperature. Signs and symptoms of infection may be diminished in a client receiving chemotherapy; therefore, the temperature elevation is significant. Early detection of the source of infection facilitates early intervention.

Surveillance for bleeding is important with the low hemoglobin and platelet count, however, the high blood pressure does not indicate bleeding. Vomiting is a side effect of chemotherapy and should be treated. The urine output and potassium are within normal limits.

 CN: Physiological adaptation;  
CL: Synthesize

**56. 1.** The packed cells should be administered using a central catheter or 19G needle. Y tubing is used and the normal saline solution is used to keep the vein open when the blood transfusion is complete. Blood is not compatible with dextrose because dextrose may cause blood coagulation. Blood products should be given with normal saline solution. A blood filter must be used for all blood products to filter out sediment from stored blood products. It is not necessary to add another I.V. access.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**57. 1.** The nurse should perform a thorough assessment of the abdomen and auscultate for bowel sounds in all four quadrants. Clients who have gastrointestinal surgery may have decreased peristalsis for several days after surgery. The nurse should check the abdomen for distention and check with the client and the medical record regarding the passage of flatus or stool. Consulting a dietician would be inappropriate because the client must be kept on nothing-by-mouth status until bowel sounds are present. The nurse should explain to the wife that it is too soon after surgery for her husband to eat.

 CN: Reduction of risk potential;  
CL: Synthesize

**58.**

**3.** The client receiving spinal radiation for bone cancer metastases who complains of urinary incontinence.

**1.** The client receiving chemotherapy who complains of a loss of appetite.

**4.** The client with colon cancer who has questions about a high-fiber diet.


**2.** The client who underwent a mastectomy 2 weeks ago who called for information on the Reach for Recovery program.

Using Maslow's hierarchy of needs to set priorities, the nurse should first call the client with bone cancer metastases to the spine because this client is at risk for compression, damage, or severing of the spinal cord. The nurse should evaluate the client

immediately for urinary incontinence, paralysis, difficulty ambulating, and possible weakness or loss of motor function. The nurse should next call the client with loss of appetite to assess weight loss and suggest ways to increase the appetite. The client with colon cancer requires assistance with diet planning, also a physiologic need, but this client is not at high risk for weight loss. Lastly, the nurse should obtain information on Reach to Recovery and return the call to the client with a mastectomy. The needs of this client are the least urgent.

 CN: Reduction of risk potential;  
CL: Synthesize


**59. 3.** For clients with obstructive versus restrictive disorders, extending exhalation through pursed-lip breathing will make the respiratory effort more efficient. The usual position of choice for this client is the upright position, leaning slightly forward to allow greater lung expansion. Teaching diaphragmatic breathing techniques will be more helpful to the client with a restrictive disorder. Administering cough suppressants will not help respiratory effort. A low semi-Fowler's position does not encourage lung expansion. Lung expansion is enhanced in the upright position.

 CN: Basic care and comfort;  
CL: Synthesize


**60. 1, 2, 3, 6.** Thrombocytopenia places the client at risk for bleeding. Therefore, electric razors will reduce the potential for skin nicks and bleeding. Oral hygiene should be provided with a soft toothbrush and with minimal friction to gently clean without trauma. Clients should be instructed to read labels on all over-the-counter medications and avoid medication such as aspirin or NSAIDs due to their effect on platelet adhesiveness. Clients should evaluate mucous membranes, skin, stools, or other sources of potential bleeding. Monitoring temperature may be an important part of assessment but is focused on neutropenia instead of the problem of thrombocytopenia.

 CN: Reduction of risk potential;  
CL: Create

**61. 2.** The administration of antipyretics and antihistamines before initiation of the transfusion in the frequently transfused client can decrease the incidence of febrile reactions. Febrile reactions are immune-mediated and are caused by antibodies in the recipient that are directed against antigens present on the granulocytes, platelets, and lymphocytes in the transfused component. They are the most common transfusion reactions and may occur with onset, during transfusion, or hours after transfusion is completed.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**62. 3.** The fever and dyspnea suggest a respiratory infection. Education on deep breathing exercises or incentive spirometry, elevating the head of the bed, and getting out of bed to a chair is necessary to promote lung expansion. When in bed, positioning the client with good lung down should be avoided, since this impedes expansion of the only lung. Postural drainage positioning will lower the head of bed and increase dyspnea.

 CN: Physiological adaptation;  
CL: Synthesize


**63. 2.** An individualized exercise program will increase stamina and endurance. Weight lifting may be too vigorous. Neupogen is used to increase white blood cells and is not applicable in this situation. Decreased hemoglobin and hematocrit predisposes the client to fatigue due to decreased oxygen availability. Bed rest causes muscle atrophy, adding to fatigue, and promotes DVT formation.

 CN: Health promotion and maintenance;  
CL: Synthesize


**64. 1.** Dietary suggestions to reduce adverse effects of cancer and cancer therapies include a soft, bland diet low in fat and sugar. Frequent, small meals are usually better tolerated. It is not necessary to restrict the diet to cold foods. Fluid intake should be encouraged to avoid dehydration.

 CN: Basic care and comfort;  
CL: Synthesize

**65. 4.** The use of diet modification is a conservative approach to treat the terminally ill or hospice clients who have nausea and vomiting related to bowel obstruction. Osmotic laxatives would be harder for the client to tolerate. An NG tube is more aggressive and invasive. I.V. antiemetics are also invasive. The hospice philosophy involves comfort and palliative care for the terminally ill.


 CN: Basic care and comfort;  
CL: Synthesize

**66. 3.** Repositioning the client, elevating the head of the bed, and providing a cool compress are comfort interventions consistent with the concept of palliative care of the dying. Directing the unlicensed personnel to assess vital signs focuses on the dying process, not the client. Suctioning may not benefit the client and is considered invasive and uncomfortable. Telling the wife an intervention is not needed discounts her judgment and concerns.


 CN: Basic care and comfort;  
CL: Synthesize

**67. 2.** Alopecia from chemotherapy is temporary. The new hair will not be necessarily gray, but the texture and color of new hair growth may be different. Clients who will be receiving chemotherapy

should be encouraged to purchase a wig while they still have hair so that they can match the color and texture of their hair. Loss of hair, or alopecia, is a serious threat to self-esteem and should be addressed quickly before treatment.

 CN: Pharmacological and parenteral therapies; CL: Apply

**68. 3.** Dyspnea is a distressing symptom in clients with advanced cancer including metastatic carcinoma of the lung, previous radiation therapy, and coexisting COPD. Ascites does occur in clients with metastatic carcinoma; however, in the client with COPD and lung cancer, dyspnea is a more common finding. A pleural friction rub is usually associated with pneumonia, pleurisy, or pulmonary infarct.

 CN: Physiological adaptation; CL: Analyze

**69. 3.** The positive reinforcement builds confidence and facilitates achievement of rehabilitation goals. Community support may or may not be applicable after discharge. Although family support is an important component of rehabilitation, reinforcing the skills the client has acquired is of greater importance when regaining independence. Rehabilitation plans should include the client, family, or both.

 CN: Psychosocial adaptation; CL: Synthesize

**70. 2.** The most important intervention for infection control is to continue meticulous catheter site care. Dressings are to be changed two to three times per week depending on institutional policies. Temperature should be monitored at least once a day in someone with a vascular access device. Hand washing before and after irrigation or any manipulation of the site is a must for infection prevention.

 CN: Safety and infection control; CL: Evaluate

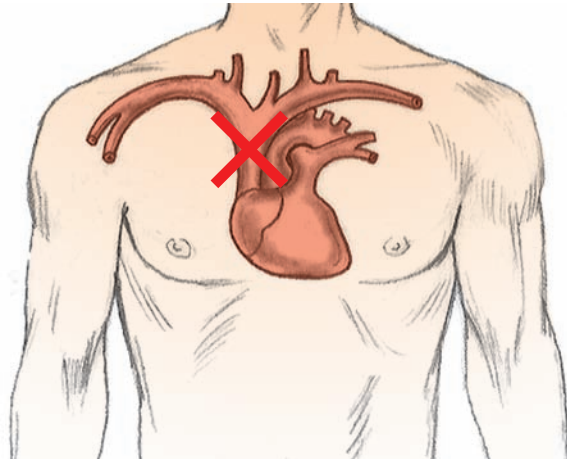
**71. 1, 2, 4, 5.** A major concern with I.V. administration of cytotoxic agents is vessel irritation or extravasation. The Oncology Nursing Society and hospital guidelines require frequent reevaluation of blood return when administering vesicant or nonvesicant chemotherapy due to the risk of extravasation. These guidelines apply to peripheral and central venous lines. The nurse should also assess the insertion site for signs of infiltration, such as swelling and redness. In addition, central venous lines may be long-term venous access devices. Thus, difficulty drawing or aspirating blood may indicate the line is against the vessel wall or may indicate the line has occlusion. Having the client cough or move position may change the status of the line if it is temporarily against a vessel wall. Occlusion warrants more thorough evaluation via X-ray study to verify placement if the status is questionable and may require a

declotting regimen (Abbokinase). The nurse should not administer any drug if the I.V. line is not open or does not have an adequate blood return.


 CN: Pharmacological and parenteral therapies; CL: Create

**72.** The distal tip of a central line lies in the superior vena cava or right atrium.


 CN: Pharmacological and parenteral therapies; CL: Apply




**73. 2.** The client is exhibiting signs and symptoms of a pneumothorax from the insertion of the subclavian venous catheter. Although it is possible that the client suffered an air embolus during the procedure, and the client is at risk for pulmonary emboli because of his immobility, absent breath sounds immediately after insertion of a subclavian line are strongly suggestive of a pneumothorax. Unilateral absent breath sounds are not associated with a myocardial infarction.

 CN: Physiological adaptation; CL: Analyze


**74. 4.** An appropriate and realistic outcome would be for the client to maintain current weight or not lose weight. It is unrealistic to expect that the client with advanced liver cancer will have normal albumin levels or will be able to gain weight.

 CN: Basic care and comfort; CL: Synthesize

**75. 3.** As long as the client is able to get out of bed, the preferred position and time frame for preventing aspiration after a bolus tube feeding is sitting upright out of bed in a chair for 30 to 60 minutes. Placing the client on the right, not the left, side may facilitate gastric emptying, but this is not the preferred position. Elevating the bed 30 degrees decreases the risk of aspiration, but this elevation must be maintained for at least 45 to 60 minutes.

 CN: Basic care and comfort; CL: Synthesize


**76. 1.** Total parenteral nutrition solutions supply the body with sufficient amounts of dextrose, amino acids, fats, vitamins, and minerals to meet metabolic needs. Clients who are unable to tolerate adequate quantities of foods and fluids and those who have had extensive bowel surgery may not be candidates for enteral feedings. The nurse would anticipate total parenteral nutrition via central catheter to promote wound healing. I.V. dextrose does not supply all the nutrients required to promote wound healing.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**77. 1, 2, 4.** Elevated temperature in the first 24 hours along with coarse breath sounds may indicate a respiratory complication or the result of general anesthesia. Use of incentive spirometry and increasing activity would be key interventions. A healthy stoma will be beefy red. A dusky appearance of the stoma indicates decreased blood supply and is of concern. It is not uncommon to have decreased bowel sounds initially after gastrointestinal surgery. In addition, it usually will take time for the ostomy to function.

 CN: Reduction of risk potential; CL: Analyze

**78. 3.** The vital signs suggest that the client is dehydrated from the vomiting. I.V. fluids should be initiated with the addition of potassium. Oral potassium should be avoided since the client is vomiting and potassium is irritating to the stomach. Oxygen is not indicated at this time since the  $PO_2$  is 95. The client with a metabolic alkalosis should not receive sodium bicarbonate; this will increase the alkalosis.


 CN: Physiological adaptation; CL: Synthesize

**79. 4.** The content of the client's comments suggests that she is avoiding intimacy with her husband by waiting until he is asleep before going to bed. Addressing sexuality issues is appropriate for a client who has undergone a mastectomy. Rushing her return to work may debilitate her and add to her exhaustion. Suggesting that she learn relaxation techniques for help with her insomnia is appropriate; however, the nurse must first address the psychosocial and sexual issues that are contributing to her sleeping difficulties. A nutritional assessment may be useful, but there is no indication that she has anorexia.

 CN: Psychosocial adaptation; CL: Synthesize

**80. 3.** Although each client listed is at some risk of complication secondary to immobility, the

75-year-old man is in need of intensive interventions. Contributing factors include his age, pain management, extended bed rest, and the potential for preexisting nutritional deficits.

 CN: Management of care; CL: Synthesize

**81. 3.** The client is exhibiting early symptoms of pulmonary toxicity as a result of the radiation therapy. These are not expected adverse effects of radiation. He needs to be examined to differentiate between an infection and radiation pneumonitis. Suggesting that the client take acetaminophen and call back in 2 days is inappropriate. These signs and symptoms are not indicative of a true emergency, but the client should be seen before his next scheduled office visit.

 CN: Reduction of risk potential; CL: Synthesize

**82.**

2. Apply oxygen at 2 L via nasal cannula.

1. Administer morphine sulfate 2 mg I.V.

4. Coach the client on deep breathing exercise.

3. Educate the client in anticipation of a thoracentesis.

The client is short of breath. The head of the bed should be elevated to enable breathing and oxygen should be applied. Morphine should be administered for pain prior to initiating deep breathing exercises. Deep breathing exercises improve lung expansion and decrease dyspnea. Education can be provided on the thoracentesis that is anticipated once the symptoms are managed.

 CN: Physiological adaptation; CL: Synthesize

**83. 1, 3, 5, 6.** Blood pressures or blood draws in the affected arm, sun exposure, trauma with a sharp razor, and immobilization increase the risk of lymphedema. Elevation of the arm and hand pump exercises promote lymph flow and reduce edema.

 CN: Health promotion and maintenance; CL: Create

**84. 1.** Treatment for cellulitis includes oral or intravenous antibiotics for 1 to 2 weeks, elevation of the affected extremity, and application of warm, moist packs to the site. Arm exercises help to reduce swelling, but do not treat the infection.

 CN: Physiological adaptation; CL: Synthesize

**85. 3.** Changing positions frequently aids in distributing the agent to the pleura for sealing. The majority of the pleural fluid is drained, and the lung should already be reexpanded before instillation of the sclerosing agent. A pressure dressing is applied to the chest tube exit site, and it is not necessary to lie on that side to hold pressure on the area.

 CN: Reduction of risk potential;  
CL: Synthesize

**86. 4.** Providing adequate humidification for the client with a tracheostomy is essential. The client no longer has the functions of the nose for warming, moistening, or filtering the air when breathing through the tracheostomy site. Providing tracheostomy site care, addressing the psychosocial issues, and observing for early signs and symptoms of skin breakdown around the tracheostomy site are also important; however, using humidifiers to prevent thick, tenacious secretions is the most important recommendation for long-term management and the prevention of pulmonary infection.

 CN: Reduction of risk potential;  
CL: Synthesize


**87. 4, 5.** A malignant pleural effusion is an accumulation of excessive fluid within the pleural space that occurs when cancer cells irritate the pleural membrane. Dyspnea can result from the increased pressure that may contribute to increased anxiety and fear of suffocation. Pain is a consequence of the pleural irritation. Cough is related to the atelectasis of the bronchi and inability to clear the airways. Hiccups are usually associated with pericardial effusions. Weight gain and peripheral edema may occur with peritoneal effusion.

 CN: Physiological adaptation;  
CL: Analyze


**88. 2, 3, 4.** Thoracentesis is usually successful for diagnosis of underlying disease, palliation of symptoms, and treating the acute respiratory distress; alleviation of the symptoms and distress is usually short-term. The thoracentesis is not used as a treatment for recurrent pleural effusion because the fluid accumulates rapidly. Thoracentesis does not remove cancer cells.

 CN: Reduction of risk potential;  
CL: Evaluate

**89. 3.** Cold intolerance may be associated with anemia because of the diminished oxygen supply to the peripheral circulation. Decreased salivation is not necessarily associated with anemia. Tachycardia may be expected in severe anemia. Clients with anemia are usually not nauseated.

 CN: Physiological adaptation;  
CL: Analyze

**90. 4.** Petechiae are tiny purplish, hemorrhagic spots visible under the skin. Petechiae usually appear when platelets are depleted. Bleeding gums or oozing of blood may accompany the petechiae, and the client should seek medical assistance immediately. Increasing iron in the diet will not improve the platelet count. Lotion will not treat the petechiae. Elevating the legs will not cause the petechiae to disappear.

 CN: Physiological adaptation;  
CL: Synthesize

**91. 3.** Lymphedema after breast cancer surgery is the accumulation of lymph tissue in the tissues of the upper extremity extending down from the upper arm. It may occur at any time after surgery in women of any age. It is caused by the interruption or removal of lymph channels and nodes after axillary node dissection. Removal results in less efficient filtration of lymph fluid and a pooling of lymph fluid in the tissues on the affected side. Treatments or interventions should be instituted as soon as lymphedema is noted to prevent or reduce further progression. Range-of-motion exercises, elevation, and avoidance of injury in the affected arm are important when completing client teaching. Lymphoma is not caused by failure to remove all cancer cells. Lymphedema can occur after any surgery that disrupts lymph flow, not just radical mastectomy.

 CN: Reduction of risk potential;  
CL: Synthesize

**92. 3.** Infection may occur in a client with lymphedema because of the stagnant accumulated fluid, which becomes an excellent medium for bacteria growth. Capillary permeability, not fragility, increases fluid in lymphedema. Myelosuppression is not related to lymphedema, only to a neoplastic disease or sequela to treatment of neoplastic disease. Increased use of the extremity may also cause increased accumulation of fluid, but it is not a direct cause of cellulitis and lymphangitis.


 CN: Reduction of risk potential;  
CL: Apply

**93. 3.** Redness, warmth, and swelling are all signs of infection. Treatment with antibiotics is usually indicated. Infection usually increases fluid accumulation and could worsen the lymphedema. Warm compresses could also increase fluid accumulation. Elevation will not treat the infection. It is critical that the client not delay treatment.


 CN: Reduction of risk potential;  
CL: Synthesize

**94. 4.** Fever is most commonly related to infection. In a neutropenic client, fever frequently occurs in the absence of the usual clinical signs


and symptoms of infection. Inadequate nutrition or antiemetic therapy resistance would not result in fever. Fever is not usually expected with most chemotherapy drugs.

 CN: Physiological adaptation;  
CL: Analyze


**95. 2.** Nine days after chemotherapy, one would expect the client to be immunocompromised. The clinical signs and symptoms of shock reflect changes in cardiac function, vascular resistance, cellular metabolism, and capillary permeability. Low-grade fever, tachycardia, and chills may be early signs of shock. The client with signs and symptoms of impending septic shock may not have decreased oxygen saturation levels. Oliguria and hypotension are late signs of shock. Urine output can be initially normal or increased.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**96. 3.** Prioritizing physical activities helps to conserve energy, which promotes adaptation to fatigue. The client should learn to take short naps or short rest periods during the day for additional energy conservation. Increased fluid intake is important but may interrupt rest periods by causing frequent urination. Limiting intake of high-fiber foods can add to constipation, which may be a problem because of inactivity in fatigued clients.

 CN: Basic care and comfort;  
CL: Synthesize

**97. 4.** Most hospitalized persons are at risk for sleep disturbances. Psychological issues (such as anxiety and depression) and pain are related to sleep deprivation. Social, nutritional, and cultural issues are not necessarily associated with sleep disturbances.

 CN: Psychosocial adaptation;  
CL: Apply

**98. 4.** Nursing interventions to decrease the discomfort of pruritus include those that prevent vasodilation, decrease anxiety, and maintain skin integrity and hydration. Medicated baths with salicylic acid or colloidal oatmeal can be soothing as a temporary relief. The use of antihistamines or topical steroids depends on the cause of the pruritus, and these agents should be used with caution. Using silk sheets is not a practical intervention for the hospitalized client with pruritus.


 CN: Basic care and comfort;  
CL: Apply

**99. 4.** Use of deodorant or fragrant soaps is drying to the skin. Cotton clothing gives the least irritation to skin. A cool, humidified environment adds to the client's comfort as well as providing


hydration for skin comfort. Fluid intake of 3,000 mL day is recommended for adequate hydration.

 CN: Basic care and comfort; CL: Analyze


**100. 4.** Individuals with cancer have various cultural values and beliefs that help them cope with the cancer experience. Quality of life cannot be evaluated solely by quantifiable factors such as employability, functional status, or evidence of disease. It must be evaluated by the survivors within the context of their subjective and individual values and beliefs.

 CN: Psychosocial adaptation;  
CL: Analyze


**101. 3.** Constipation lasting 3 days or longer is unusual in this client and warrants immediate action. However, because the client had chemotherapy with doxorubicin (Adriamycin) 10 days ago, she is susceptible to infection and should avoid rectal medications and treatments. Abdominal discomfort secondary to constipation will be relieved after the client has a bowel movement; an opioid would contribute to the constipation.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**102. 4.** The rectal area needs to be cleaned and gently dried after each bowel movement to prevent skin breakdown and inhibit growth of bacteria. Sitz baths are appropriate because they promote comfort. Zinc oxide ointment does form a protective skin barrier, but it makes it difficult to thoroughly clean the perirectal area of feces and increases the risk of infection, as do skin-barrier dressings.

 CN: Safety and infection control;  
CL: Synthesize


**103. 2.** Studies of long-term immunologic effects in clients treated for leukemia, Hodgkin's disease, and breast cancer reveal that combination treatments of chemotherapy and radiation can cause overall bone marrow suppression, decreased leukocyte counts, and profound immunosuppression. Persistent and severe immunologic impairment may follow radiation and chemotherapy (especially multiagent therapy). There is no evidence of greater risk of infection in clients with persistent immunologic abnormalities. Suppressor T cells recover more rapidly than the helper T cells.

 CN: Pharmacological and parenteral therapies; CL: Apply

**104. 1.** Clients who receive multiple platelet transfusions may form antibodies against many foreign antigens, thereby decreasing platelet response. Single-donor platelets are drawn from a single donor, decreasing the number of possible foreign antigens and increasing platelet response




for long-term therapy. Platelets do not contain coagulation factors in clinically significant amounts. Clients with a platelet count greater than 50,000/mm<sup>3</sup> are not at risk for bleeding. Human leukocyte antigen–matched platelets are used when clients become refractory to single-donor and random-donor platelets.


 CN: Pharmacological and parenteral therapies; CL: Analyze

### The Client Who Is Coping with Loss, Grief, Bereavement, and Spiritual Distress


**105. 4.** Identifying available resources for the client and family represents a respectful effort to make options available and encourages the client to become involved in treatment decisions. Assuming decision making for the client may foster dependence. Encouraging strict compliance with all treatment regimens may increase anxiety and limit the client's options and treatment choices. Informing the client of all possible adverse treatment effects may increase anxiety and fear by focusing on adverse outcomes too soon.

 CN: Psychosocial adaptation; CL: Synthesize


**106. 4.** Denial is a defense mechanism used to shut out a situation that is too frightening or threatening to tolerate. In this case, denial allows the client to vacillate between acceptance of the illness and its treatment and denial of the actual or potential seriousness of the disease. This may allow the client more psychological freedom to maintain her current roles in the family and elsewhere. Denial can be harmful if the client ignores standard medical therapies in favor of unconventional treatments. Denial is not helpful when it interferes with a client's willingness to seek treatment or make decisions about care. Using any one defense mechanism exclusively usually reflects maladaptive coping. Other defense mechanisms that may be used include regression, humor, and sublimation.

 CN: Psychosocial adaptation; CL: Apply


**107. 2.** The client's resources for coping with the emotional and practical needs of herself and her family need to be assessed because usual coping strategies and support systems are often inadequate in especially stressful situations. The nurse may be concerned with the client's use of denial, decision-making abilities, and ability to pay for transportation; however, the client's support systems will be of more importance in this situation.

 CN: Psychosocial adaptation; CL: Analyze


**108. 4.** Variables that are most predictive of negative bereavement outcomes include anger and self-reproach, low socioeconomic status, lack of preparation for death, and lack of family support. Making preparations suggests that she is coping with her husband's approaching death.

 CN: Psychosocial adaptation; CL: Analyze


**109. 4.** Having a higher socioeconomic status helps a person achieve healthy bereavement. Younger people are at higher risk for negative bereavement outcomes. Having a history of depressive illness or anxiety is a risk factor for negative bereavement outcomes.

 CN: Psychosocial adaptation; CL: Analyze


**110. 4.** Focusing on the client's physical capabilities is important, but powerlessness reflects a perceived lack of control over the current situation and the belief that one's actions will not affect the outcome. Participation in decision making is key to getting the client involved and feeling more in control of his own care. Apathy and dependence on others are characteristics of powerlessness. Encouraging others to take responsibility for the client's care will increase his feelings of powerlessness. A referral to a psychologist is not necessarily indicated. The nurse should implement strategies to involve the client in decisions about his care and evaluate the response to this intervention before suggesting a referral.

 CN: Psychosocial adaptation; CL: Synthesize


**111. 1.** Maintaining role function has been found to be a supportive source of normalcy and positive self-esteem for the client and family during the cancer experience. Facilitating family-related disagreements and conflicts is not the nurse's role. Supporting the client in her use of denial as a coping strategy will not help facilitate the client's adaptation to the diagnosis. Arranging transportation and child care on treatment days may be helpful but does not necessarily facilitate adaptation to the diagnosis.

 CN: Psychosocial adaptation; CL: Synthesize


**112. 2.** The most important central component of hospice care is focus of care on the client as well as the family or significant other. The team approach and the physician's coordination of the hospice team are important, but they are not the focus. Not all hospice clients want to die at home.

 CN: Basic care and comfort; CL: Apply


**113. 3.** Mental changes and decreased level of consciousness are common in the dying process. Comments that allude to travel, trips, or going somewhere are also common. Suggesting that the client be sedated ignores the husband's question about what his wife is experiencing. Suggesting that the client is fighting death and that the husband should leave her alone is inappropriate and denies the husband time to spend with his wife. Although decreased circulation and lack of oxygen may cause delirium, delirium is not the norm in the dying process.

 CN: Psychosocial adaptation;  
CL: Synthesize


**114. 4.** It is important to give factual information to answer a loved one's questions and concerns. Stating, "That's just the way it is," is unprofessional and uncaring. Saying, "I don't know when the bowels will shut down, but they will eventually," projects an uncaring attitude and does not address the wife's concern for her husband or her need for information. Although it may be true that the pain medication will slow bowel function, this does not provide the wife with the information she is seeking.

 CN: Psychosocial adaptation;  
CL: Apply


**115. 4.** It is important to allow the client to choose his or her own form of spiritual support. The dying client who is weakened by disease may not be able to attend services. The client must be consulted before referral to a chaplain is made. Reflection on past accomplishments may be comforting to the client, but it does not directly address spiritual concerns.

 CN: Psychosocial adaptation;  
CL: Synthesize


**116. 2.** A social worker can provide information for supportive services and can help the client with financial concerns. A bank representative, loan officer, or someone from the hospital billing department may be needed; however, it is most appropriate for the social worker to first assess the client's needs.

 CN: Psychosocial adaptation;  
CL: Synthesize

**117. 4.** Dehydration is an expected event within the dying process. Hydration may be used in any situation of dehydration as long as it is within the client and family's wishes. Rehydrating the client may actually prolong the dying process. Decisions about treatment are made with the family.

 CN: Basic care and comfort;  
CL: Apply


**118. 4.** The nurse must first allow the client to explore his or her own beliefs and values before making referrals, explaining various religious beliefs, or suggesting appropriate reading material.

 CN: Psychosocial adaptation;  
CL: Synthesize


**119. 3.** The family is in the best position to give the information they elect to disclose to friends and community members. The hospice nurse and the oncologist must maintain client confidentiality and follow HIPPA guidelines for release of confidential information. Therefore, disclosing any information about the client's condition would be inappropriate.

 CN: Management of care; CL: Synthesize


**120. 4.** Depression can be a mixture of affective responses (feelings of worthlessness, hopelessness, sadness), behavioral responses (appetite changes, withdrawal, sleep disturbances, lethargy), and cognitive responses (decreased ability to concentrate, indecisiveness, suicidal ideation). Increased decisiveness, problem-solving ability, and increased social interactions are reflective of adaptive coping.

 CN: Psychosocial adaptation;  
CL: Analyze

**121. 4.** Bereavement support after death usually continues for about 1 year or as needed at little or no cost to the remaining family. Mutual support groups by nonprofessionals are usually free or inexpensive but are not necessarily appropriate for young children. Professional individual counseling and medication are expensive, and medication may not be appropriate for young children. To remind someone of what she should have done before the death is not helpful at this time.

 CN: Psychosocial adaptation;  
CL: Synthesize

**122. 3.** It is important to establish rapport with the client and family by listening to verbal and nonverbal concern and showing respect for cultural differences. The use of touch or eye contact is culture-specific and cannot be generalized as an intervention for all individuals with cancer. Miscommunication between individuals of different cultures is often caused by language differences, rules of communication, age, and gender.

 CN: Psychosocial adaptation;  
CL: Synthesize

**123. 1.** Helping the client to identify available resources allows the client respect and time to make informed decisions and encourages him to become actively involved with treatment options. Encouraging compliance with treatment regimens

discourages the client from becoming actively involved in his treatment and diminishes coping ability. Relieving the client of decision making as much as possible is not appropriate and encourages feelings of helplessness and powerlessness. Assisting the client to prepare for adverse treatment effects may foster hopelessness and increase anxiety by focusing on adverse outcomes too soon.

 CN: Psychosocial adaptation;  
CL: Synthesize


**124. 4.** These American Cancer Society–sponsored groups are designed to educate clients and their families experiencing cancer about the disease and methods of coping positively with it. These are self-help and support groups monitored by professionals and cancer survivors who have undergone a training course that helps them to facilitate small groups.

 CN: Psychosocial adaptation; CL: Apply

**125. 4.** Many cancer survivors question why they are doing so well and others are not. Often they express feeling guilty when they hear that others are not doing well. Suggesting that the client does not know how to describe his own emotions is inappropriate and may discourage him from expressing his feelings. Although the client may be experiencing volatile emotions, this is not the likely source of his feelings of guilt. Guilt about doing well after cancer treatment is not a spiritual response to illness.


 CN: Psychosocial adaptation;  
CL: Synthesize

**126. 4.** The recurrence of the disease is found to be the most distressing time, and clients may experience anxiety, depression, and suicidal ideation. Clients may feel a decrease in their anxiety and depression with the initiation of definitive treatment or at the end of their first course of treatment. Clients in the end stage of the disease may feel all of these emotions; however, when clients have been free from cancer for some time and learn that there is a recurrence, they often experience a sharp increase in their feelings of distress.


 CN: Psychosocial adaptation;  
CL: Analyze

**127. 2.** Powerlessness is a subjective experience of helplessness and apathy that can be threatening to one's competency and result in increased dependence on others. Effective nursing interventions will provide opportunities for the client to be involved in decision making and to regain a sense of control. Ineffective coping may also be a response to altered mobility, but the nursing interventions would be directed toward enhancing coping skills. Impaired adjustment is characterized by statements or actions suggesting that the client has not accepted the


change in her health status. Complicated grieving is characterized by sadness, reliving past experiences, and expressions of distress about the loss.

 CN: Psychosocial adaptation;  
CL: Analyze


**128. 4.** The person who has minimal social support, has not been successful in dealing with stressors, and has multiple other stressors is at greater risk for psychosocial distress. Being successful in dealing with stress all his life would decrease the client's risk for psychosocial distress. Not having to deal with other stressors would be helpful in managing the current stressful situation. The denial coping mechanism, if used for short periods, can decrease the risk for psychosocial distress.

 CN: Psychosocial adaptation;  
CL: Analyze

**129. 1.** Cancer clients report that the lifelong fear of recurrence is one of the most disruptive aspects of the disease. The trajectory of the disease is unpredictable and can be intertwined with many short- and long-term illnesses related to cancer and the treatment modalities. A diagnosis of cancer challenges the individual and the family with a series of crises rather than a time-limited episode. There are no data to indicate that the client has an underlying behavioral disorder.


 CN: Psychosocial adaptation;  
CL: Analyze

**130. 4.** Without clear, consistent communication, the parent-child relationship may become strained during the illness and subsequent death of a parent. A great number of parents do not know how to communicate with their children, especially about difficult emotional topics at a time when they are also under great emotional stress. The nurse should begin by providing information and developmentally appropriate books about the grieving process for children. Referral to pastoral care services may be appropriate; however, the nurse's direct intervention of beginning education about strategies for communication will be of immediate and long-term benefit. The grieving process cannot be rushed for the husband, nor should an opportunity for the father and children to communicate and grieve together be delayed. Excluding children from participating in the grieving ritual is not shielding them from the sorrow and sadness.


 CN: Psychosocial adaptation;  
CL: Synthesize

**131. 3.** Acknowledgment and discussion of the client's feelings begin the establishment of a therapeutic relationship between nurse and client. It also acknowledges the seriousness of the current situation and validates the client's feelings. Psychiatric


help and antidepressant medication may be options if the depression is severe and prolonged. Encouraging a client to see the good or positive side of a situation minimizes the client's feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**132. 2.** Individuals who are experiencing fatigue need to prioritize their activities and ask for assistance from others. It is best not to take away all of the client's activities because her role as wife and mother is obviously important to her and to her sense of self-worth. Suggesting that she ignore the household chores or telling her not to worry because everyone gets tired disregards the client's feelings and is not appropriate.

 CN: Basic care and comfort;  
CL: Synthesize


**133. 4.** Tachycardia, tachypnea, moist or clammy skin, and disorientation are classic symptoms of delirium. Clients with panic disorder do not exhibit disorientation. Clients with depression exhibit a flat affect, apathy, and sleep disturbances. Clients with schizophrenia have thought disorders such as hallucinations or delusions.

 CN: Physiological adaptation;  
CL: Analyze

**134. 2.** A progressive activity regimen may be prescribed to increase pulmonary function after surgical lung resection. Rehabilitation should include walking and some stair climbing as tolerated. Vigorous exercise is usually not recommended initially. Joining the Lost Chord Club and learning tracheostomy care are appropriate for the client who has undergone a laryngectomy.

 CN: Psychosocial adaptation;  
CL: Synthesize


**135. 4.** Serving as a volunteer in a client-to-client program represents reintegration with constructive channeling of energies, which indicates a higher level of adaptation than attention to safety, knowledge, or planned activity.

 CN: Psychosocial adaptation;  
CL: Evaluate

### The Client Who Is Experiencing Problems with Sexuality

**136. 3.** Water-soluble lubricants used during sexual intercourse can augment reduced natural vaginal lubrication caused by ovarian dysfunction and decreased circulating estrogen related to chemotherapy. The use of vaginal dilators, relaxation techniques, or nightly douches would not increase


vaginal lubrication. Frequent douching can disrupt the normal vaginal environment.

 CN: Health promotion and maintenance;  
CL: Synthesize


**137. 3.** Placing a thin piece of gauze over the tracheostomy during sexual activity will help to contain the secretions and yet allow ventilation. Although a scopolamine patch may depress the salivary and bronchial secretions, it is not recommended for long-term use and would not be indicated in this situation. Avoiding fluids before sexual activity is not recommended to decrease secretions. Washing the tracheostomy area with any deodorizing soap may cause skin irritation and place the client at risk for infection.

 CN: Health promotion and maintenance;  
CL: Synthesize


**138. 4.** This question introduces some basic information and allows for support for the client who may be experiencing some sexuality concerns. Not all women experience sexual problems after undergoing a hysterectomy. Assuming that the client will want to schedule an appointment with her partner is inappropriate and may embarrass her. Simply asking the client whether she expects to have problems with sex is too abrupt and does not provide any information.

 CN: Psychosocial adaptation;  
CL: Synthesize

**139. 4.** Although there may not be a big change in sexual function with a unilateral orchiectomy, the loss of a gonad and testosterone may result in decreased libido and sterility. Sperm banking may be an option worth exploring if the number and motility of the sperm are adequate. Remember, the population most affected by testicular cancer is generally young men ages 15 to 34, and in this crucial stage of life, sexual anxieties may be a large concern.

 CN: Psychosocial adaptation;  
CL: Synthesize

**140. 4.** The risk of becoming neutropenic during chemotherapy is very high. Therefore, an inserted foreign object such as a diaphragm may be a nidus for infection. Although the nurse may wish to inform the client about the ease with which various contraceptive modalities may be used, the focus of this discussion should be on preventing an infection, which can be fatal for the neutropenic client. There are no data to suggest the client is at risk for acquiring a sexually transmitted disease. The client will not be experiencing body changes directly related to hormonal changes.

 CN: Safety and infection control;  
CL: Synthesize

**141. 2.** Raising the upper torso for the affected partner facilitates respiratory function. The use of a waterbed may be helpful for the sensation of movement but it does not promote respiratory expansion. A dependent position may compromise respiratory expansion, even though energy may be conserved. Duration of sexual activity is not necessarily related to exertion.

 CN: Health promotion and maintenance; CL: Synthesize

### Ethical and Legal Issues Related to Clients with Cancer

**142. 3.** The registered nurse assigning care should first give the LVN-LPN the opportunity to explore his concerns and fears about caring for a client with HIV infection. Reassigning care for this client, assisting with care, and reviewing precautions do not address the present concern or create an environment that will generate useful knowledge regarding future assignments for client care.

 CN: Management of care; CL: Synthesize

**143. 1.** The American Cancer Society wrote *The Cancer Survivors' Bill of Rights*. These rights address medical care, personal life adjustment, job opportunities, and insurance coverage.

 CN: Management of care; CL: Apply

**144. 1.** The Family Leave Act of 1993 ensures that family caregivers who must take a leave of absence or decrease their hours during the treatment or recovery phase of an illness will not lose their jobs. The Americans with Disabilities Act of 1990 prohibits employment discrimination against persons with disabilities or those who are perceived to have disabilities; it has an indirect economic impact for cancer victims and their families. The Medicare Coverage for Catastrophic Illness Act of 1988 provides increased coverage for clients with a catastrophic illness. The Rehabilitation Act of 1973 prohibits discrimination on the basis of handicap under any program or activity receiving federal financial assistance.

 CN: Management of care; CL: Apply

**145. 1.** The Americans with Disabilities Act of 1990 requires equal opportunity in selection, testing, and hiring of qualified applicants with disabilities. Under this act, anyone who has had cancer is considered disabled. This law prohibits discrimination against workers with disabilities and is similar to the Civil Rights Act of 1964 and Title V of the Rehabilitation Act of 1973. The Patient Self-Determination Act addresses the rights of clients in

regard to making health care decisions and the use of advance directives.

 CN: Management of care; CL: Apply

**146. 3.** The goal of client autonomy is to respect the client's choice not to know particular information. The client's best interests should be determined by the client after he or she receives all the necessary information and in conjunction with other people of the client's choice, including family, physicians, and other health care personnel. The client's best interests are not totally directed by the physician or the health care team.

 CN: Management of care; CL: Evaluate

### End-of-Life Care

**147. 1, 2, 5.** In 1991, the Omnibus Reconciliation Act became effective. This Patient Self-Determination Act requires all institutions that participate in Medicare to provide information about and the right to initiate advance directives. Advance directives are written statements of person's wishes related to health care if they are unable to decide for themselves. These documents relate to current or future health care and not past medical history. Competent adults are responsible for their own health care decisions and their own right to accept or refuse treatment. Advance directives are used when the person cannot make the decision. Medical power-of-attorney is a term used to describe the person who makes health care decisions should someone be unable to make informed decisions for himself or herself. The focus is not primarily financial access.

 CN: Management of care; CL: Evaluate

**148. 4.** The advocacy role of the nurse implies that the nurse will ensure that the client's wishes are being respected and that she is making informed decisions. Therefore, the nurse will assist in ensuring that the client is fully informed. The other interventions are appropriate for the nurse but are not related to client advocacy. The client may not understand or have all the necessary information for standard therapy. A client who is taking an alternative therapy should be monitored for adverse effects. If a client is taking an alternative therapy, it is essential for the physician to know so that the therapy can be incorporated into the client's treatment plan and to ensure that there are no incompatibilities with other therapies or medications.


 CN: Management of care; CL: Evaluate

**149. 2, 3, 4, 5.** End-of-life care is the term currently used for issues related to death and dying. End-of-life care focuses on physical and psychosocial needs at the end of life for the client and client's family.


Palliative care is health care aimed at symptom management rather than curative treatment for diseases. Goals would include providing comfort and support for the client and family and improving the client's quality of life. Grief counseling is a component and efforts would be to enhance the coping of all involved and not to alter usual coping methods.

 CN: Management of care; CL: Create


**150. 3.** The best nursing advocacy intervention is listening carefully to the client's and family's perceptions of their needs. Studies have demonstrated that these needs are not necessarily what the nurse thinks they are. Intervening without listening carefully may result in a lack of responsiveness to the real needs. Helping the client and family maintain a sense of optimism and hopefulness is appropriate but is not necessarily advocacy. Determining the client's and family's understanding of the results of the diagnostic testing and providing written materials about the cancer site and its treatment are examples of the nurse's role as educator.

 CN: Psychosocial adaptation;  
CL: Synthesize


**151. 1.** The nurse would give the client a tissue and tell him it's okay to cry to convey acceptance and empathy. He needs to know that it is natural to have tremendous feelings of loss and sadness. Telling the client to stop crying, busying oneself in the client's room, and changing the subject are not helpful to the client because they ignore his needs and inhibit the expression of emotion.

 CN: Psychosocial adaptation;  
CL: Synthesize

**152. 2, 3, 4, 5, 6.** With serious, chronic, and terminal illnesses, it is important to help clients and families address fears, difficulties with home care, advance directives, hospice and home care options, and final arrangements. Predicting the length of life for this client is not appropriate at admission.


 CN: Psychosocial adaptation;  
CL: Synthesize

**153. 1.** The client's husband is experiencing anger, much of which stems from feelings of guilt about not taking the trip. During the stage of denial, the husband is more likely to deny the client's diagnosis and prognosis. During the stage of bargaining, the husband would offer to do certain things in exchange for more time before the client dies. In the stage of depression, the husband is likely to make few or no comments and to act dejected.


 CN: Psychosocial adaptation;  
CL: Analyze

**154. 1.** When supporting the friends or family of a terminally ill client, it is best to focus on the


present. This can be accomplished by living each day to its fullest. Friends and families also want to know what to expect and want someone to listen to them as they express grief over the approaching death. Focusing on the past can interfere with enjoying the present. Expecting the worst interferes with focusing on day-to-day positive experiences. Planning ahead is inappropriate because of uncertainty when the length of life is unknown.

 CN: Psychosocial adaptation;  
CL: Synthesize

**155. 4.** Clients often sense a nurse's feelings. Therefore, when the nurse becomes emotionally upset it is appropriate to share her emotions with the client; it is also acceptable to cry. It is of little help to the client or the nurse who is upset if the nurse waits until a later time to speak to someone about the situation. Trying to smile or not to show emotion is inappropriate; clients are very aware of someone's incongruent mood and behavior.

 CN: Psychosocial adaptation;  
CL: Synthesize


**156. 1.** The best course of action when the client has outbursts concerning treatments is to explain how the treatment is expected to help. Describing the effect if the client misses a treatment is a negative approach and may be threatening to the client. The client is likely to feel angry if told to be a "good client" during treatments. Offering to give the client a backrub does not give information to the client and may negatively reinforce the behavior.

 CN: Psychosocial adaptation;  
CL: Synthesize

**157. 2.** Children are aware of and show anxieties about death at an earlier age than was once thought, and they recognize false cheerfulness. They tend to experience isolation and loneliness when those around them are trying to hide or mask the truth. They are then left to face the realities of death alone. Children do not experience relief or hopefulness when others are falsely cheerful. Independence is promoted by offering the child realistic choices about care at the end of life.

 CN: Health promotion and maintenance;  
CL: Analyze


**158. 1.** Taking a blood sample is an unnecessary, invasive procedure that would not directly address the sister's fear. Leukemia is not considered a communicable disease. Providing an explanation and alerting the parents to the sibling's concern and the resources available to assist siblings to deal with the terminal illness are all appropriate interventions.

 CN: Psychosocial adaptation;  
CL: Synthesize

**159. 2.** A response that acknowledges the brother's concern and provides him with information is most helpful. Therefore, telling the brother that the nurse sees that he is worried and then following this up with a discussion about leukemia is most appropriate. Providing reassurance or information without acknowledging the expressed concern is not as helpful as acknowledging the concern and providing the information. Although acknowledging his worry is appropriate, more importantly, the brother needs factual information about the disease.

 CN: Psychosocial adaptation;  
CL: Synthesize

**160. 4.** The nurse caring for a terminally ill client who reports only tasks and routines completed for the client is probably behaving defensively. This behavior does not convey compassion and caring for the client. It is likely that this nurse has not come to grips with death and dying. Tactful behavior respects the client's needs. Efficient care will prevent unnecessary disturbance for the client. When caring for a terminally ill client, the nurse can remain objective while providing comprehensive nursing care to this client.

 CN: Psychosocial adaptation;  
CL: Analyze

### Managing Care Quality and Safety

**161. 1, 2, 3.** Ethics consultation seeks to facilitate communication and shared decision-making in client care. Ethics consultations also tend to increase knowledge of clinical ethics, to improve client care, and to prevent poor outcomes in cases involving ethical problems. Requests for ethics consultations can be made by any member of the health care team and by clients, family members, guardians, students, or others with a legitimate interest in the client. The recommendations of ethics consultants are advisory only; the ethics consultation process is intended to supplement and support existing departmental and institutional mechanisms for making decisions and resolving conflict in clinical practice. Clinicians are encouraged to seek an ethics consultation when the client is incapacitated when no family member/s or guardian/s exist or can be found, or when the client's family members disagree about the ethically appropriate action to be taken. Ethics consultation is not intended or authorized to provide legal advice on client care. Persons requesting an ethics consultation may do so without intimidation or fear of reprisal.


 CN: Management of care; CL: Synthesize

**162. 4.** To determine the cause of this problem, a quality improvement study should be conducted.


Before implementing solutions to a problem, the precise issues in the hospital system must be observed and documented. The Joint Commission requirements mandate documentation of the effectiveness of analgesia within 30 minutes after administration. It is not the pharmacist's role to provide consultation about documentation of drugs administered by nurses. Consulting the evening nurses may be helpful, but this is a systems issue of the entire unit and involves every registered nurse administering analgesia.

 CN: Management of care; CL: Create


**163. 2.** The RN is responsible for describing to the UAP when to report to the RN a result that indicates a potential client problem with dehydration. The RN must assess and interpret results, but must give concrete feedback to the UAP on what is an expected situation or a specific result to report back to the RN. Urine output should be at least 30 mL/hour, or 240 mL over the 8-hour shift. Dehydrated clients may be thirsty and the UAP can ask if the client is thirsty and offer water if permitted. However, because urine output is the critical indicator of dehydration, the UAP should document I&O and give results outside the normal range to the nurse. The nurse is specifically assessing dehydration and should request to receive this information.

 CN: Management of care;  
CL: Synthesize

**164. 4.** A bedside commode should be near the client for easy, safe access. Measurement of urine output is also important in a client with heart failure. Putting diapers on an alert and oriented individual would be demeaning and inappropriate. Indwelling catheters are associated with increased risk of infection and are not a solution to possible incontinence. There is no reason to think that the client would not be able to use the bedside commode.

 CN: Safety and infection control;  
CL: Synthesize

**165. 1.** Ongoing assessment by the RN is required to evaluate the client with dyspnea to monitor for potential deterioration of the respiratory status. If the RN is the care provider, she will have greater interaction with the individual client. The RN is responsible for assessment of all the clients. The other clients would not be considered unstable, and maintaining a patent airway is always the priority in providing care. Care for the other clients could be assigned safely, according to the abilities of the LVN-LPN and UAP.

 CN: Management of care;  
CL: Synthesize

# TEST 14

## The Client Having Surgery

- The Client Who Is Preparing for Surgery
- The Client Who Is Receiving or Recovering from Anesthesia
- The Client Who Has Had Surgery
- Legal and Ethical Issues Associated with Surgery
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

### The Client Who Is Preparing for Surgery

**1.** A client tells the nurse on admission that she is uneasy about having to leave her children with a relative while being in the hospital for surgery. The **most** appropriate action by the nurse is to do which of the following?

- 1. Reassure the client that her children will be fine and she should stop worrying.
- 2. Contact the relative to determine their capacity to be an adequate care provider.
- 3. Encourage the client to call the children to make sure they are doing well.
- 4. Gather more information about the client's feelings about the childcare arrangements.

**2.** The client has a latex allergy. What should the nurse teach the client to do before having surgery at a free-standing surgery center? Select all that apply.

- 1. Determine that there will be a latex-safe environment for surgery.
- 2. Report symptoms experienced with the latex allergy (e.g., rhinitis, conjunctivitis, flushing).
- 3. Notify the health care providers at the surgery center.
- 4. Wear a stainless steel medical alert bracelet into the surgical suite.
- 5. Ask to have the surgery at a hospital.

**3.** During preadmission testing for same-day surgery, a client states that she has added two cloves of garlic each day to her diet to help control her blood pressure. The nurse should further inquire about which of the following?

- 1. The type of surgery the client is having.
- 2. What her blood pressure has been running.
- 3. The amount of garlic she is eating.
- 4. Her preference for the type of anesthesia.

**4.** What action should this nurse take to avoid spreading nosocomial infections?

- 1. Remove the face mask.
- 2. Remove the hair covering.
- 3. Wash her hands before tying the strings on the mask.
- 4. Tie the dangling strings of the mask around her neck.



**5.** The client is to have surgery on his fourth metatarsal. Identify the place on the illustration below where the client should mark the operative site.





**6.** The nurse is reviewing the chart of a 55-year-old male client who is scheduled for a lumbar laminectomy. The nurse should report which of the following to the surgeon?

- 1. Pimple on the lower back.
- 2. Abnormal electrocardiogram (ECG).
- 3. Hearing aid.
- 4. Allergy to iodine.

**7.** The client tells the preoperative nurse that she cannot hear without her hearing aid and asks to wear it to surgery and recovery. What is the nurse's **best** response?

- 1. Explain to the client that it is policy not to take personal items to surgery because they may be lost or broken.
- 2. Tell the client that she will bring the hearing aid to the postanesthesia care unit so that she can have it as soon as she wakes up.
- 3. Explain to the client that she will have a premedication that will make her sleepy before she goes to surgery and she won't need to hear.
- 4. Call the surgery unit to explain the client's concern and ask if she can wear her hearing aid to surgery.

**8.** The client is to take nothing by mouth after 4 a.m. The nurse recognizes that the client has deficient knowledge when he states that he:

- 1. Ate a gelatin dessert at 3:30 a.m.
- 2. Brushed his teeth at 4:00 a.m. but did not swallow.
- 3. Held a cold washcloth against his lips.
- 4. Smoked a cigarette at 6:00 a.m.

**9.** The client tells the nurse that he is allergic to shellfish. The nurse should ask the client if he is also allergic to:

- 1. All other seafood.
- 2. Iodine skin preparations.
- 3. Caffeine.
- 4. Alcohol-based skin preparations.

**10.** The surgeon orders cefazolin (Ancef) 1 g to be given I.V. at 7:30 a.m. when the client's surgery is scheduled at 8:00 a.m. What is the **primary** reason to start the antibiotic exactly at 7:30 a.m.?

- 1. Legally the medication has to be given at the ordered time.
- 2. The antibiotic is most effective in preventing infection if it is given 30 to 60 minutes before the operative incision is made.
- 3. The postoperative dose of Ancef needs to be started exactly 8 hours after the preoperative dose of Ancef.
- 4. The peak and titer levels are needed for antibiotic therapy.

**11.** Which of the following is the **best** way for the nurse to begin the preoperative interview?

- 1. Walk in the client's room and ask, "Are you Mrs. Smith?"
- 2. Walk in the client's room, sit down, and take the client's blood pressure.
- 3. Walk in the client's room, sit down, maintain eye contact, and introduce yourself.
- 4. Walk in the client's room, and ask the client her name.

**12.** A client who is to receive general anesthesia has a serum potassium level of 5.8 mEq/L. What should be the nurse's **first** response?

- 1. Call the surgeon.
- 2. Send the client to surgery.
- 3. Make a note on the front of the chart.
- 4. Notify the anesthesiologist.

**13.** Prior to being transported to the surgery suite, the nurse asks the client whether he has any allergies. The client responds, "Doesn't anyone communicate with anyone? I have been asked that question over and over!" What is the nurse's **best** response?

- 1. "I'm sorry! I just have to ask that question for the record."
- 2. "It's an important question and we just have to check."
- 3. "You will hear it again and again as you go through surgery."
- 4. "This question is asked for verification and safety with each new phase of treatment."

**14.** For which of the following preoperative clients should the nurse assess the glucose level? **Select all that apply.**

- 1. A client with diabetes mellitus controlled by diet.
- 2. A client with a high stress response to surgery.
- 3. A client receiving corticosteroids for the past 3 months.
- 4. A client with a family history of diabetes receiving dextrose 5% in lactated Ringer's solution (D<sub>5</sub>LR) I.V. fluids.
- 5. A client who consumes a high carbohydrate diet.

**15.** On the day of surgery, a client with diabetes who takes insulin on a sliding scale is ordered to have nothing by mouth and all medications withheld. The client's 6 a.m. glucose level is 300 mg/dL. The nurse should:

- 1. Withhold all medications as ordered.
- 2. Administer the insulin dose dictated by the sliding scale.
- 3. Call the physician for specific orders based on the glucose level.
- 4. Notify the surgery department.

**16.** The nurse is preparing a preoperative teaching plan for a client who is undergoing a bilateral breast reduction. Which aspect of the plan is the priority?

- 1. Reduction of risk potential.
- 2. Physiologic adaptation.
- 3. Psychosocial integrity.
- 4. Health promotion and maintenance.

**17.** A client is scheduled to have an elective mandibular osteotomy to correct a mandibular fracture sustained in an accident 6 months earlier. Which statement by the client indicates to the nurse maladaptive coping?

- 1. "I will be glad to have my jaw fixed because my wife thinks I do not look like myself."
- 2. "I am somewhat afraid to have the surgery but feel OK about it."
- 3. "My wife will help me, but I don't think I will need that much help."
- 4. "I am ready to get this over with."

**18.** The nurse is assessing a client's nutritional status preoperatively. Which of the following observations would indicate poor nutrition in a 5-foot 7-inch female client who is 21 years of age?

- 1. Poor posture.
- 2. Brittle nails.
- 3. Dull expression.
- 4. Weight of 128 lb (58.1 kg).

**19.** A 92-year-old male client who is independent and lives alone has an inguinal hernia repair. Which teaching method is the **best** approach to use for his postoperative and discharge teaching plans?

- 1. Explaining all the instructions to him.
- 2. Demonstrating the instructions to him.
- 3. Explaining all the instructions to a family member.
- 4. Writing the instructions down for him.

**20.** A client is admitted for an arthroscopy of the right shoulder through same-day surgery. Which nurse is responsible for starting the client's discharge planning?

- 1. Preadmission nurse.
- 2. Preoperative nurse.
- 3. Intraoperative nurse.
- 4. Postoperative nurse.

**21.** The nurse is preparing to administer a preoperative medication. Which of the following actions should the nurse take **first**?

- 1. Have the family present.
- 2. Ensure that the preoperative shave is completed.
- 3. Have the client empty his bladder.
- 4. Make sure the client is covered with a warm blanket.

**22.** Before surgery a client states that she is afraid of surgery because her cousin died in surgery when having her tonsils removed. What is the nurse's **best** response?

- 1. Reassure the client that technology has changed over the last 10 years.
- 2. Encourage the client to further express her concerns.
- 3. Explain to the client that it is normal to be afraid.
- 4. Ask the client if anyone else in her family has had trouble when they had surgery.

**23.** Which of the following clients is **higher** at risk for latex allergies?

- 1. A woman who is admitted for her seventh surgery.
- 2. A man who works as a sales clerk.
- 3. A man with well-controlled type 2 diabetes.
- 4. A woman who is having laser surgery.

**24.** The nurse is preparing to start an intravenous infusion and has raised the head of the client's bed. After the nurse applies gloves to insert an I.V. catheter, the client begins to rub her eyes and wipe away nasal drainage. Which of the following should the nurse complete **first**?

- 1. Distract the client's attention.
- 2. Assess the client for pain.
- 3. Remove the catheter and assess the client's vital signs.
- 4. Lower the head of the client's bed.

**25.** When evaluating a client's preoperative cognitive-perceptual pattern, which of the following questions should the nurse ask the client?

- 1. "Do you have difficulty swallowing?"
- 2. "Do you need special equipment to walk?"
- 3. "Do you smoke?"
- 4. "Do you wear glasses?"

**26.** When attempting to check the pupils of a client scheduled to receive general anesthesia, the nurse notices that the client has trouble tilting his head back. Which of the following does the nurse recognize as the **primary** concern related to this finding?

- 1. The client has limited movement of his neck.
- 2. The client is at risk for postoperative neck pain.
- 3. The client is at risk for difficult intubation.
- 4. The ability to assess the client's pupils is limited.

**27.** The nurse is developing a plan to teach a client deep-breathing exercises to expand collapsed alveoli and prevent postoperative atelectasis and pneumonia. Which of the following steps should be included? Select all that apply.

- 1. Splint or support the incision to promote maximal comfort.
- 2. Inhale slowly through the nostrils; exhale through pursed lips.
- 3. Hold the breath for about 5 seconds to expand the alveoli.
- 4. Repeat this breathing method 5 to 10 times hourly.
- 5. Close one nostril while inhaling.

**28.** The nurse receives the preoperative blood work report for a client who is scheduled to undergo surgery. Which of the following laboratory findings should be reported to the surgeon?

- 1. Red blood cells, 4.5 million/mm<sup>3</sup>.
- 2. Creatinine, 2.6 mg/dL.
- 3. Hemoglobin, 12.2 g/dL.
- 4. Blood urea nitrogen, 15 mg/dL.

**29.** A client will receive I.V. midazolam hydrochloride (Versed) during surgery. Which of the following should the nurse determine as a therapeutic effect?

- 1. Amnesia.
- 2. Nausea.
- 3. Mild agitation.
- 4. Blurred vision.

**30.** When administering I.V. midazolam hydrochloride (Versed) the nurse should?

- 1. Assess the blood pressure.
- 2. Monitor the pulse oximeter.
- 3. Encourage slow, deep breaths.
- 4. Explain relaxation techniques.

**31.** When the nurse administers I.V. midazolam hydrochloride (Versed), the client demonstrates signs of an overdose. The nurse should **next** collaborate with the surgical team to:

- 1. Ventilate with an oxygenated Ambu bag.
- 2. Shock the client with ECG paddles.
- 3. Administer 0.5 mL 1:1000 epinephrine.
- 4. Titrate flumazenil (Romazicon).

**32.** Metoclopramide (Reglan) is ordered as a premedication for a client about to undergo a gastroduodenoscopy. The nurse expects which of the following as the **primary** therapeutic effect?

- 1. Increased gastric pH.
- 2. Increased gastric emptying.
- 3. Reduced anxiety.
- 4. Inhibited respiratory secretions.

**33.** What therapeutic outcome does the nurse expect for a client who has received a premedication of glycopyrrolate (Robinul)?

- 1. Increased heart rate.

- 2. Increased respiratory rate.
- 3. Decreased secretions.
- 4. Decreased amnesia.

**34.** Atropine sulfate (Atropine) is contraindicated in all but which one of the following clients?

- 1. A client with diabetes.
- 2. A client with glaucoma.
- 3. A client with urine retention.
- 4. A client with bowel obstruction.

**35.** After the nurse has administered droperidol (Inapsine), care is taken to move the client slowly based on the knowledge of droperidol's effect on the:

- 1. Central nervous system.
- 2. Respiratory system.
- 3. Cardiovascular system.
- 4. Psychoneurologic system.

**36.** A client is receive enoxaparin (Lovenox) 6 hours before the scheduled time of her laparoscopic vaginal assisted hysterectomy. Which of the following effects does the nurse recognize as an intended therapeutic action of the enoxaparin?

- 1. Increase in red blood cell production.
- 2. Reduction of postoperative thrombi.
- 3. Decrease in postoperative bleeding.
- 4. Promotion of tissue healing.

**37.** During the preoperative interview, the nurse obtains information about the client's medication history. Which of the following is not necessary to record about the client?

- 1. Current use of medications, herbs, and vitamins.
- 2. Over-the-counter medication use in the last 6 weeks.
- 3. Steroid use in the last year.
- 4. Use of all drugs taken in the last 18 months.

**38.** When the nurse is conducting a preoperative interview with a client who is having a vaginal hysterectomy, the client states that she forgot to tell her doctor that she had a total hip replacement 3 years ago. The nurse communicates this information to the perioperative nurse because:

- 1. The prosthesis may cause a problem with the electrosurgical unit used to control bleeding.
- 2. The client should not have her hip externally rotated when she is positioned for the procedure.
- 3. The perioperative nurse can inform the rest of the team about the total hip replacement.
- 4. There is not enough time to notify the surgeon and note this finding on the history and physical information before the procedure.

**39.** The nurse learns that a client who is scheduled for a tonsillectomy has been taking 40 mg of oral prednisone daily for the last week for poison ivy on his leg. What is the nurse's **best** action?

- 1. Document the prednisone with current medications.
- 2. Notify the surgeon of the poison ivy.
- 3. Notify the anesthesiologist of the prednisone administration.
- 4. Send the client to surgery.

**40.** A client who is scheduled for an open cholecystectomy has a 20-pack-year history of smoking. For which postoperative complication is the client **most** at risk?

- 1. Deep vein thrombosis.
- 2. Atelectasis and pneumonia.
- 3. Delayed wound healing.
- 4. Prolonged immobility.

**41.** The family cannot go with the surgical client past the doors that separate the public from the restricted area of the operating room suite. These traffic control measures are designed to:

- 1. Protect the privacy of clients.
- 2. Prevent electrical sparks that could ignite the anesthetic gases.
- 3. Separate the family from the surgical team while they are working on the client.
- 4. Provide for an aseptic environment to prevent infection.

**42.** Which of the following clients is **most** at risk for potential hazards from the surgical experience?

- 1. A 68-year-old client.
- 2. A 50-year-old client.
- 3. A 30-year-old client.
- 4. A 13-year-old client.

**43.** Which pediatric surgery client should not play with a balloon?

- 1. A child having her 15th laser surgery for a hemangioma.
- 2. A child having a tonsillectomy.
- 3. A child having an inguinal hernia repair.
- 4. A child having an orchiopexy.

**44.** In which of the following clients is an auto-transfusion possible?

- 1. The client who has cancer.
- 2. The client who is in danger of cardiac arrest.
- 3. The client with a contaminated wound.
- 4. The client with a ruptured bowel.

**45.** The nurse teaches a client who had cystoscopy about the urge to void when the procedure is over. What other teaching should be included?

- 1. Ignore the urge to void.
- 2. Force fluids.
- 3. Ask for the bedpan.
- 4. Ring for assistance to the bathroom.

**46.** Which of the following nursing interventions is **most** important in preventing postoperative complications?

- 1. Progressive diet planning.
- 2. Pain management.
- 3. Bowel and elimination monitoring.
- 4. Early ambulation.

### The Client Who Is Receiving or Recovering from Anesthesia

**47.** A client who had a gastrectomy has been in the postanesthesia recovery room for 30 minutes when his vital signs suddenly change. The nurse checks the recovery room record (see chart). In addition to notifying the physician, what other action should the nurse take immediately?

- 1. Administer dantrolene.
- 2. Elevate the head of the bed 30 degrees.
- 3. Administer a bolus of I.V. fluids.
- 4. Insert an indwelling urinary catheter.

#### Vital Signs

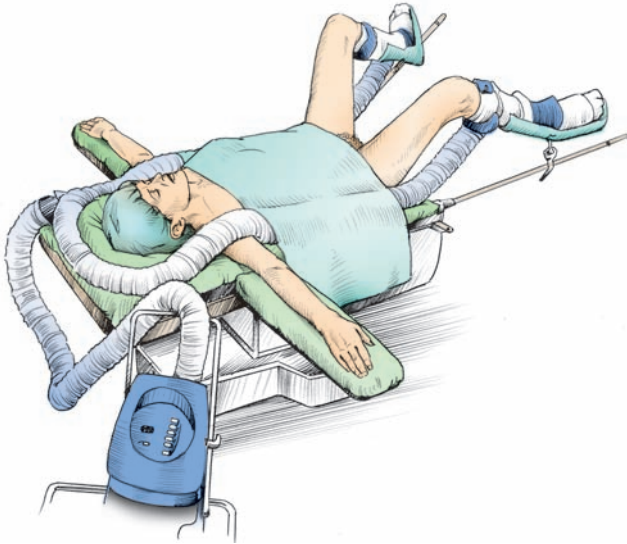
	06/30/07	06/30/07	06/30/07
Date	06/30/07	06/30/07	06/30/07
Time	1:45 p.m.	2:00 p.m.	2:15 p.m.
Pulse	70	82	90
Respiration	12	14	20
Blood pressure	100/60	110/70	140/90
Temperature	98°F (36.7°C)	99°F (37.2°C)	102°F (38.9°C)

**48.** The nurse should do which of the following to decrease a female client's anxiety about being placed in the lithotomy position for surgery?

- 1. Explain in detail what will occur in the operating room.
- 2. Determine what the client is concerned about.
- 3. Pad the stirrups for comfort.
- 4. Reassure the client that an all-female surgical team will be present.

**49.** A client has been in the position shown in the figure for surgery. The nurse should document that the client has been in which of the following positions?

- 1. Reverse Trendelenburg.
- 2. Low Fowler's.
- 3. High lithotomy.
- 4. Prone.



**50.** A client arrives from surgery to the postanesthesia care unit. Which of the following respiratory assessments should the nurse complete **first**?

- 1. Oxygen saturation.
- 2. Respiratory rate.
- 3. Breath sounds.
- 4. Airway flow.

**51.** The nurse assesses vital signs on a client who has had epidural anesthesia. For which of the following should the nurse assess **next**?

- 1. Bladder distention.
- 2. Headache.
- 3. Postoperative pain.
- 4. Ability to move the legs.

**52.** When assessing a client who has had spinal anesthesia, which of the following would the nurse expect to find?

- 1. The client feels pain before moving the legs.
- 2. The blood pressure is significantly increased.
- 3. Sensation returns to the toes first, then progresses to the perineal area.
- 4. The client complains of a headache while in the lying position.

**53.** The nurse in the postanesthesia care unit notes that one of the client's pupils is larger than the other. The nurse should:

- 1. Rate the client on the Glasgow Coma Scale.
- 2. Administer oxygen.
- 3. Check the client's baseline data.
- 4. Call the surgeon.

**54.** The surgical floor receives a new postoperative client from the postanesthesia care unit. Assessment reveals that the client has a patent airway and stable vital signs. The nurse should **next**:

- 1. Check the dressing for signs of bleeding.
- 2. Empty any peri-incisional drains.
- 3. Assess the client's pain level.
- 4. Assess the client's bladder.

**55.** When preparing a teaching plan for an adult client about general anesthesia induction, which explanation would be **most** appropriate?

- 1. "Your premedication will put you to sleep."
- 2. "You will breathe in an inhalant anesthetic mixed with oxygen through a facial mask and receive intravenous medication to make you sleepy."
- 3. "You will receive intravenous medication to make you sleepy."
- 4. "You will breathe in medication through a facial mask to make you sleepy."

**56.** Which explanation would be **most** appropriate for a child when teaching him about general anesthesia induction?

- 1. "You will be given an injection before you go to surgery to make you sleepy."
- 2. "You will breathe in oxygen through a facial mask and receive intravenous medication to make you sleepy."
- 3. "You will receive intravenous medication to make you sleepy."
- 4. "You will breathe in medication through a facial mask to make you sleepy."

**57.** A client with impaired cardiac functioning is at risk during anesthesia induction with thiopental sodium (Sodium Pentothal) because this drug causes:

- 1. Bradycardia.
- 2. Complete muscle relaxation.
- 3. Hypotension.
- 4. Tachypnea.

**58.** The nurse anticipates that a client who has received propofol (Diprivan) as the induction and maintenance agent for general anesthesia will **most** likely experience:

- 1. Minimal nausea and vomiting.
- 2. Hypotension.
- 3. Slow induction of anesthesia.
- 4. Small tremors of the skeletal muscles.

**59.** What is the main reason desflurane (Suprane) and sevoflurane (Ultane), volatile liquid anesthesia agents, are used for surgical clients who go home the day of surgery?

- 1. These agents are better tolerated.
- 2. These agents are predictable in their cardiovascular effects.
- 3. These agents are nonirritating to the respiratory tract.
- 4. These agents are rapidly eliminated.

**60.** A 250-lb male client recovering from general anesthesia has the following assessment findings: pulse, 150 bpm; blood pressure, 90/50 mm Hg; respiratory rate, 28 breaths/minute; tympanic temperature, 99.8° F (37.7° C); and rigid muscles. The nurse determines that the client is:

- 1. Recovering as expected from the anesthesia and continues monitoring him.
- 2. Exhibiting the effects of excessive blood loss experienced in the operating room and increases the rate of his I.V. infusion.
- 3. In the early stages of malignant hyperthermia and obtains emergency medications and notifies the anesthesiologist.
- 4. In pain and offers him pain medication.

**61.** The nurse is assessing a client recovering from anesthesia. Which of the following is an early indicator of hypoxemia?

- 1. Somnolence.
- 2. Restlessness.
- 3. Chills.
- 4. Urgency.

**62.** The nurse is to administer flumazenil (Mazicon) I.V. for reversal of sedation. Which of the following interventions should be included in the care plan? Select all that apply.

- 1. Administer the medication as a 2-mg bolus.
- 2. Give the medication undiluted in incremental doses.
- 3. Be alert for shivering and hypotension.
- 4. Use only a free-flowing I.V. line in a large vein.
- 5. Monitor the client's level of consciousness.

**63.** An 80-year-old client had spinal anesthesia for a transurethral resection of the prostate and received 4,000 mL of room temperature isotonic bladder irrigation. He now has continuous irrigation through a three-way indwelling urinary catheter. Which postoperative nursing intervention is **most** important to include in his plan of care?

- 1. Empty the catheter drainage bag.
- 2. Cover the client with warm blankets.
- 3. Hang new bags of irrigation.
- 4. Turn the client.

**64.** Which of the following clients is expected to retain anesthetic agents longest?

- 1. A client who is 6 feet 2 inches tall and weighs 250 lb.
- 2. A client who is 5 feet 4 inches tall and weighs 110 lb.
- 3. A client who is 5 feet 1 inch tall and weighs 200 lb.
- 4. A client who is 5 feet 7 inches tall and weighs 145 lb.

**65.** An awake postoperative client received an intravenous regional nerve block (Bier block) in the arm that is now casted and elevated on a pillow. What action should the nurse encourage the client to avoid until sensation returns?

- 1. Holding the operated arm close to the face.
- 2. Holding the operated arm with the unoperated arm.
- 3. Using the unoperated arm.
- 4. Using pain medication.

**66.** The physician ordered I.V. naloxone (Narcan) to reverse the respiratory depression from morphine administration. After administration of the naloxone the nurse should:

- 1. Check respirations in 5 minutes because naloxone is immediately effective in relieving respiratory depression.
- 2. Check respirations in 30 minutes because the effects of morphine will have worn off by then.
- 3. Monitor respirations frequently for 4 to 6 hours because the client may need repeated doses of naloxone.
- 4. Monitor respirations each time the client receives morphine sulfate 10 mg I.M.

**67.** The nurse should monitor the surgical client closely for which clinical manifestation with the administration of naloxone (Narcan)?

- 1. Dizziness.
- 2. Biliary colic.
- 3. Bleeding.
- 4. Urine retention.

**68.** The nurse anticipates that the client who has received epidural anesthesia is at decreased risk for a spinal headache because:

- 1. A 17G needle is used.
- 2. A subarachnoid injection is made.
- 3. A noncutting needle is used.
- 4. A faster onset occurs.

**69.** Which of the following systems is not blocked by spinal anesthesia?

- 1. The sympathetic nervous system.
- 2. The sensory system.
- 3. The parasympathetic nervous system.
- 4. The motor system.

**70.** The nurse is to administer midazolam (Versed) 2.5 mg. The medication is available in a 5 mg/mL vial. The nurse should administer

\_\_\_\_\_ mL.

**71.** A client in the postanesthesia care unit is being actively rewarmed with an external warming device. How often should the nurse monitor the client's body temperature?

- 1. Every 5 minutes.
- 2. Every 10 minutes.
- 3. Every 15 minutes.
- 4. Every 20 minutes.

### The Client Who Has Had Surgery

**72.** A client requests a narcotic analgesic shortly after the oncoming nurse receives change-of-shift report. The nurse who is leaving reported that the client had received morphine 10 mg (IM) within the past hour. In what order from first to last should the oncoming RN do the following actions?

- 1. Validate with the outgoing RN that morphine 10 mg (IM) had been administered.
- 2. Assess the client for manifestations of pain.
- 3. Check the medication documentation as to when morphine 10 mg (IM) was dispensed and to whom.
- 4. Check to ascertain if any discrepancy had been documented with accompanying reason/s.

**73.** Following abdominal surgery, a client refuses to deep breathe and cough every 2 hours as ordered. The nurse should do which of the following first?

- 1. Ask the client's wife to insist that the client take the deep breaths every 2 hours.
- 2. Respect the client's wishes and turn the client from side-to-side more frequently.
- 3. Suggest that the client increase the daily fluid intake to at least 2,500 mL.
- 4. Explain the risks of not expanding the lungs and why the exercise is important.

**74.** Eight hours after surgery, a client has a distended bladder and is unable to void. Which of the following interventions is contraindicated?

- 1. Facilitate voiding by normal position.
- 2. Pour running water over perineum.
- 3. Insert an indwelling urinary catheter.
- 4. Insert a straight catheter every 4 hours.

**75.** A client who had open heart surgery is being transported to the intensive care unit (ICU) for postoperative recovery from anesthesia. The nurse in the ICU is assessing the client's level of consciousness. When asked, the client can give his name but is not sure about where he is or the time of day. What should the nurse do?

- 1. Notify the surgeon.
- 2. Rub the client's sternum to arouse the client.
- 3. Encourage the client's wife to orient the client.
- 4. Tell the client where he is and the time of day.

**76.** Following surgery, a client is receiving 1,000 mL normal saline (I.V.) with 40 mEq KCl which has been ordered to be infused at 125 mL/hour. The client states, "My I.V. hurts." What should the nurse do first?

- 1. Contact the client's physician for a different IV order.
- 2. Slow down the infusion to a keep-open rate (20–50 mL/hour).
- 3. Assess the I.V. site for signs of phlebitis, extravasation, or I.V.-related infection.
- 4. Check the hanging parenteral fluid and administration set for documentation as to when they were last changed.

**77.** A nurse is assessing a client when she returns from same-day surgery for a dilatation and curettage. The nurse checks preoperative vital signs at 8:30 a.m. to compare them with the current vital signs at 10:30 p.m. (see chart). What should the nurse do first?

- 1. Call the physician for pain medication.
- 2. Cover the client with warmed blankets.
- 3. Administer oxygen at 4 L/minute.
- 4. Increase the I.V. fluid rate.

#### Vital Signs

	8:30 AM	10:30 PM
Pulse	80	90
Respirations	16	20
Blood pressure	90/60	100/80
Temperature	99.5	97

**78.** A client returns to the medical-surgical floor from the postanesthesia recovery room after a colon resection for adenocarcinoma. The client has comorbidities of stage 2 hypertension and a previous myocardial infarction. The first set of postoperative vital signs recorded are pulse rate of 110 bpm, respiration rate of 20/minute, blood pressure of 130/86 mm Hg, and temperature of 98° F (36.7° C). The surgeon calls to ask if the client needs a unit of packed red blood cells. The nurse's response should be based on which data? Select all that apply.

- 1. Cyanotic mucous membrane.
- 2. Warm, dry skin.
- 3. Vital sign changes.
- 4. Oxygen saturation.
- 5. Intake and output.

**79.** A client had a colectomy 8½ hours ago. She has received 1,500 mL of dextrose 5% in water with normal saline solution. The client has just used a patient-controlled analgesia pump to administer morphine for pain, has been repositioned for comfort, and has stable pulse rate, respirations, and blood pressure. What should the nurse do **next**?

- 1. Check that the family is comfortable.
- 2. Assess vital signs following the use of morphine.
- 3. Dim the lights in the room.
- 4. Increase nasal oxygen from 2 to 3 L.

**80.** A client who had an esophageal hernia repair 4 hours ago has a pulse rate of 90 bpm, respiration rate of 16/minute, blood pressure of 130/80 mm Hg, pulse oximeter of 91, and a temperature of 100.4° F (38° C). What should the nurse do **first**?

- 1. Obtain a culture of the incision.
- 2. Notify the surgeon to obtain an antibiotic order.
- 3. Offer pain medication.
- 4. Assist the client to a sitting position to take deep breaths.

**81.** A client had a total abdominal hysterectomy and bilateral oophorectomy for ovarian carcinoma yesterday. She received 2 mg of morphine sulfate I.V. by patient-controlled analgesia (PCA) 10 minutes ago. The nurse was assisting her from the bed to a chair when the client felt dizzy and fell into the chair. The nurse should:

- 1. Discontinue the PCA pump.
- 2. Administer oxygen.
- 3. Take the client's blood pressure.
- 4. Assist the client back to bed.

**82.** A nurse is instructing a client who had abdominal surgery that day to do deep-breathing exercises. In which order should the nurse teach the client to perform diaphragmatic breathing and coughing?

1. Inhale through the nose.

2. Cough deeply from the lungs.

3. Exhale through pursed lips.

4. Splint the incisional site.





**83.** The postoperative nursing assessment of a client's ability to swallow fluids before providing oral fluids is based on the type of anesthesia given. Which of the following clients would not have delayed fluid restrictions?

- 1. The client who has undergone a bronchoscopy under local anesthesia.
- 2. The client who has undergone a transurethral resection of a bladder tumor under general anesthesia.
- 3. The client who has undergone a repair of carpal tunnel syndrome under local anesthesia.
- 4. The client who has undergone an inguinal herniorrhaphy with spinal and intravenous conscious sedation.

**84.** A client is admitted to the surgical floor after having bowel surgery. The nurse observes that the client's urine output has decreased from 50 to 20 mL/hour. Which of the following is the **most** likely cause?

- 1. Bowel obstruction.
- 2. Adverse effect of opioid analgesics.
- 3. Hemorrhage.
- 4. Hypertension.

**85.** A client who had a left thoracoscopy sustained an injury secondary to the surgery position. The nurse should assess the client for:

- 1. Footdrop.
- 2. Knee swelling and pain.
- 3. Tingling in the arm.
- 4. Absence of the Achilles reflex.

**86.** Which of the following is **most** likely to cause the client to experience postoperative nausea and vomiting?

- 1. Total hip replacement.
- 2. Mitral valve repair.
- 3. Abdominal hysterectomy.
- 4. Mastectomy of the left breast.

**87.** The nurse is planning to teach incisional care to a client before discharge. Which of the following instructions should be included?

- 1. Do not touch your incision before your next appointment.
- 2. Clean your incision three times a day with hydrogen peroxide and water.
- 3. Do not be concerned about uneven lumps under the suture lines.
- 4. If the staples don't come out by themselves before your next appointment, the surgeon will remove them.



**88.** The nurse is removing the client's staples from an abdominal incision when the client sneezes and the incision splits open, exposing the intestines. Which of the following actions should the nurse take **next**?

- 1. Press the emergency alarm to call the resuscitation team.
- 2. Cover the abdominal organs with sterile dressings moistened with sterile normal saline.
- 3. Have all visitors and family leave the room.
- 4. Call the surgeon to come to the client's room immediately.

**89.** On the fourth day after surgery, a client has a postoperative wound infection. Which of the following should the nurse assess? Select all that apply.

- 1. Total white blood count (WBC) 10,000/mm<sup>3</sup>.
- 2. Redness and swelling beyond the incision line.
- 3. Temperature of 102° F (38.9° C).
- 4. 89% segmented neutrophils.
- 5. Incisional pain greater than on day 2.

**90.** Which of the following should be included in the plan of care for a client with a surgical wound that requires a wet-to-dry dressing?

- 1. Place a dry dressing in the wound.
- 2. Use Burrow's solution to wet the dressing.
- 3. Pack the wet dressing tightly into the wound.
- 4. Cover the wet packing with a dry sterile dressing.

**91.** The nurse empties a Jackson-Pratt drainage bulb. Which of the following nursing interventions ensures correct functioning of the drain?

- 1. Irrigating it with normal saline.
- 2. Connecting it to low intermittent suction.
- 3. Compressing it and then plugging it to establish suction.
- 4. Connecting it to a drainage bag and clamping it off.

**92.** Which of the following interventions should the nurse implement for pulmonary emboli prophylaxis?

- 1. Have the client perform leg exercises every hour while awake.
- 2. Encourage the client to cough and deep-breathe.
- 3. Massage the calves of the client's legs.
- 4. Have the client wear antiembolism stockings when out of bed.

**93.** The nurse assesses a client who has just received morphine sulfate. The client's blood pressure is 90/50 mm Hg; pulse rate, 58 bpm; respiration rate, 4 breaths/minute. The nurse should check the client's chart for an order to administer?

- 1. Flumazenil (Romazicon).
- 2. Naloxone hydrochloride (Narcan).
- 3. Doxacurium (Nuromax).
- 4. Remifentanyl (Ultiva).

**94.** A client is being discharged from same-day surgery. Which of the following statements indicates that the client has deficient knowledge?

- 1. "My husband is taking the day off from work to drive me home."
- 2. "I can drive myself home after surgery."
- 3. "I am taking a taxi home and my daughter will meet me at home."
- 4. "My son will be here at noon to take me home."

**95.** The nurse is teaching a client who has had a laparoscopic cholecystectomy about postoperative pain management. Which of the following statements indicates that the client has deficient knowledge?

- 1. "My pain is related to the gas used to distend my abdominal cavity."
- 2. "My diet should include eating bland foods until the gas clears up."
- 3. "My pain is related to the large incision and manipulation."
- 4. "My pain should be relieved by walking to eliminate the gas."

**96.** The initial postoperative assessment is completed on a client who had an arthroscopy of the knee. Assessment of which of the following parameters is not necessary every 15 minutes during the first postoperative hour?

- 1. Vital signs including pulse oximeter.
- 2. Pain rating of the operative site.
- 3. Urine output.
- 4. Neurovascular check distal to the operative site.

**97.** After surgery, a client was treated for postoperative nausea and vomiting and now is experiencing hypotension and tachycardia. Which of the following medications would be **most** likely associated with these findings?

- 1. Ondansetron hydrochloride (Zofran).
- 2. Droperidol (Inapsine).
- 3. Prochlorperazine (Compazine).
- 4. Promethazine (Phenergan).

**98.** When an epidural catheter is used for postoperative pain management, the nurse should:

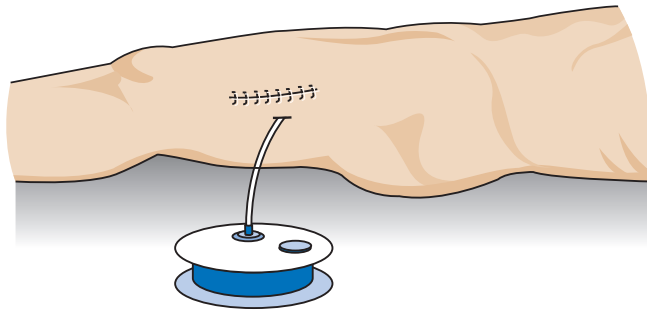
- 1. Assess but not disturb the epidural dressing.
- 2. Change the epidural dressing daily.
- 3. Change the epidural dressing daily only if it is wet.
- 4. Use strict aseptic technique when handling the epidural catheter.

**99.** The nurse understands that the client who has epidural pain management postoperatively can ambulate because:

- 1. The analgesia is periodically administered through the epidural catheter.
- 2. A low concentration of analgesia is used with the catheter.
- 3. The analgesia from the epidural catheter bathes the spinal fluid.
- 4. The epidural medication affects the sympathetic and motor function.

**100.** The nurse is caring for a client who is using a portable wound suction unit (see figure). Six hours following surgery, the drainage unit is full. The nurse should do which of the following?

- 1. Remove the drain from the incision.
- 2. Notify the surgeon.
- 3. Empty drainage.
- 4. Record the amount in the unit as output on the client's chart.



**101.** Two days after surgery, a client continues to take hydrocodone 7.5 mg and acetaminophen 500 mg (Lortab 7.5/500). What should the nurse ask the client before administering the pain medication?

- 1. "Where is your pain located?"
- 2. "Have you emptied your bladder?"
- 3. "How long has it been since your last dose?"
- 4. "Is your pain better than before you had surgery?"

**102.** A client wakes up in the postanesthesia care unit and sees a drain with bright red fluid in it exiting from her total hip incision. She asks the nurse, "Is this the way it is supposed to be?" Which of the following represents the nurse's **best** response?

- 1. "The drainage is blood and fluid that must be drained out for healing."
- 2. "Don't worry about it. I will explain it when you are more awake."
- 3. "This blood is being kept sterile and will be given back to you."
- 4. "I will give you something to make you sleep so you will not worry."

**103.** A client has a Jackson-Pratt drainage tube in place the first day after surgical repair of a ruptured diverticulum. The client asks the nurse the purpose of the drain. What is the nurse's **best** response?

- 1. "The drainage tube is used to prevent infection in the peritoneal cavity."
- 2. "The drainage tube is used to prevent bleeding into the peritoneal cavity."
- 3. "The drainage tube is used to prevent pressure on the bladder."
- 4. "The drainage tube is used to prevent pressure on the gallbladder."

**104.** A client who had a cholecystectomy with a biliary drainage tube in place. Which of the following colors of the drainage is expected?

- 1. Pinkish red.
- 2. Dark yellow-orange.
- 3. Clear.
- 4. Green.

**105.** A client is to be discharged from same-day surgery 7 hours after his inguinal hernia repair. Which of the following indicates this client is ready to be discharged?

- 1. The client voids 500 mL of urine.
- 2. The client tolerates eating a hamburger.
- 3. The client is pain-free.
- 4. The client walks in the hallway unassisted.

**106.** A client is eligible for patient-controlled analgesia (PCA) when:

- 1. A family member is able to assist with self-dosing.
- 2. There is a court-appointed advocate to assist with self-dosing.
- 3. The client has the ability to self-dose.
- 4. There is a nurse to assist with self-dosing.

**107.** How often should the postoperative client's temperature be assessed during the first 24 hours after surgery?

- 1. Every 2 hours.
- 2. Every 4 hours.
- 3. Every 6 hours.
- 4. Every 8 hours.

**108.** A nurse is assessing a surgical client's blood pressure 8 hours after surgery. The client's blood pressure before surgery was 120/80 mm Hg and on admission to the postsurgical nursing unit, it was 110/80 mm Hg. The client's blood pressure is now 90/70 mm Hg. What should the nurse do **first**?

- 1. Notify the health care provider.
- 2. Elevate the head of the bed.
- 3. Administer pain medication.
- 4. Check the intake and output record.

**109.** A client has been positioned in the lithotomy position under general anesthesia for a pelvic procedure. In which anatomic area may the client expect to experience postoperative discomfort?

- 1. Shoulders.
- 2. Thighs.
- 3. Legs.
- 4. Feet.

**110.** Which of the following nursing interventions does not aid in meeting the goal of clear breath sounds?

- 1. Offering pain relief before having the client cough.
- 2. Providing a minimum of 1,500 mL of fluid per day.
- 3. Monitoring breath sounds.
- 4. Assisting with early ambulation.

**111.** The nurse is teaching the client about deep-breathing techniques. Which of the following client statements indicates the need for additional education?

- 1. "I will use my incentive spirometer every hour while I'm awake."
- 2. "I should place my hands lightly over my lower ribs and upper abdomen."
- 3. "I should get into a comfortable position before doing my breathing exercises."
- 4. "I should take four deep breaths and then cough deeply from the lungs."

**112.** A client has had a nasogastric tube connected to low intermittent suction. The client is at risk for which of the following complications?

- 1. Confusion.
- 2. Muscle cramping.
- 3. Edema.
- 4. Tremors.

### Legal and Ethical Issues Associated with Surgery

**113.** On admission to same-day surgery, the nurse reviews the chart to verify the client's identification documentation. Which of the following is **most** important?

- 1. Admitting record.
- 2. Addressograph labels.
- 3. Identification bracelet.
- 4. Location of family.

**114.** Which of the following items of documentation is not required for the nurse to have on the chart before the client is transported to the operating suite?

- 1. Operative consent.
- 2. History and physical information.
- 3. Laboratory test results.
- 4. Anesthesia note.

**115.** A 15-year-old client needs life-saving emergency surgery, but his relatives live an hour away from the hospital and cannot sign the consent form. What is the nurse's **best** response?

- 1. Send the client to surgery without the consent.
- 2. Call the family for a consent over the telephone and have another nurse listen as a witness.
- 3. No action is necessary in this case because consent is not needed.
- 4. Have the family sign the consent form as soon as they arrive.

**116.** A client is being prepared to have a craniotomy for a brain tumor. As a client advocate, the nurse is evaluating the client's understanding of the informed consent before witnessing the client's signature on the operative consent form. Which of the following indicates that the nurse needs to contact the surgeon for further communication with the client?

- 1. "We talked about the effect of my diabetes on healing."
- 2. "The surgeon explained how the craniotomy was done."
- 3. "There are no major risks from this surgery."
- 4. "I will die if the tumor is not removed from my brain."

**117.** The nurse should ask all clients age 65 or older who are having surgery which question?

- 1. "Do you have Medicare Part A to help pay for the hospital reimbursement?"
- 2. "Do you have an advance directive such as a health care proxy or living will?"
- 3. "Do you have extra coverage to help pay for medications?"
- 4. "Do you have Medicare Part B to help pay for your expenses?"

**118.** When a client cannot read or write but is of sound mind, the nurse should read the consent to the client in the presence of two witnesses and:

- 1. Have the client's next-of-kin sign the consent.
- 2. Have the client put an "X" on the signature line.
- 3. Have a court appoint a guardian for the client.
- 4. Have a hospital quality management coordinator sign for the client.

### Managing Care Quality and Safety

**119.** A client is admitted on the day of surgery for an arthroscopy of the left knee. Which nursing activities should be completed to avoid wrong-site surgery? Select all that apply.

- 1. Ask the surgeon preoperatively to mark with a permanent marker the correct knee for the surgical site.
- 2. Verbally ask the client to state his name, surgical site, and procedure.
- 3. Verify the correct client with the correct operative site by medical records and radiographic diagnostic reports.
- 4. Call a "time-out" in the operating room to have the surgeon verify the correct knee before making the incision.
- 5. Show the client an anatomic model of the surgery site.

**120.** The nurse is planning care for a client with severe postoperative pain. There is an order for 10 mg MSO<sub>4</sub>. Which of the following should the nurse do **first**?

- 1. Obtain an intravenous infusion system.
- 2. Prepare the medication for administration.
- 3. Contact the Pharmacy Department.
- 4. Contact the physician that ordered the medication.

**121.** The client has returned to the surgery unit from the Post Anesthesia Care Unit (PACU). The client's respirations are rapid and shallow, the pulse is 120, and the blood pressure is 88/52. The client's level of consciousness is deteriorating. The nurse should do which of the following **first**?

- 1. Call the Post Anesthesia Care Unit (PACU).
- 2. Call the primary care physician.
- 3. Call the respiratory therapist.
- 4. Call the Rapid Response Team.

**122.** When completing the Preoperative Checklist on the nursing unit, the nurse discovers an allergy that the client has not reported. What should the nurse do **first**?

- 1. Administer the prescribed pre-anesthetic medication.
- 2. Note this new allergy prominently at the front of the chart.
- 3. Contact the scrub nurse in the operating room.
- 4. Inform the nurse anesthetist.

**123.** Which of the following activities should the nurse encourage the unlicensed assistive personnel to assist with in the care of postoperative clients? Select all that apply.

- 1. Empty and measure indwelling urinary catheter collection bags.
- 2. Reposition clients for pain relief.
- 3. Teach clients the proper use of the incentive spirometer.
- 4. Tell the nurse if clients report they are having pain.
- 5. Assess I.V. insertion site for redness.

**124.** A very elderly, drowsy client with fragile skin is being transferred from the surgery cart to the bed. How should the nurse plan to direct the transfer to prevent skin shearing?

- 1. With two people at each side using a drawsheet.
- 2. With two people, one at each side using a drawsheet, and one person at the head.
- 3. With two people using a roller and a drawsheet.
- 4. With two people, one at each side using a drawsheet, one person at the head, and one person at the feet.

**125.** The client's identification armband was removed to start an I.V. line as a part of the preoperative preparation. The transport team has arrived to transport the client to the operating room. The nurse notices that the client's identification band is not on his wrist. What is the nurse's best response?

- 1. Send the removed armband with the chart and the client to the operating room.
- 2. Place a new identification armband on the client's wrist before transport.
- 3. Tape the cut armband back onto the client's wrist.
- 4. Send the client without an armband because she can verbally identify herself.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.


### The Client Who Is Preparing for Surgery

**1. 4.** The health history is conducted to ascertain a client's state of wellness or illness. A personal dialogue between a client and a nurse is conducted to obtain information. To achieve a relationship of mutual trust and respect, the nurse must have the ability to communicate a sincere interest in the client. The therapeutic communication must be adapted to the responses, problems, and needs of the client. Reassurance and the remaining options do not demonstrate that the nurse is genuinely interested in the client's needs.


🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**2. 1, 2, 3.** Treatment and diagnostic evaluation must be done in a latex-safe environment. Signs/symptoms may be mild to anaphylaxis. Clients with latex allergy are advised to notify their health care providers and to wear a medical ID; however, all metal and jewelry must be removed prior to surgery as they could conduct an electrical current.


The surgery can be safely performed at a free-standing surgery center as long as latex precautions are observed.

 CN: Safety and infection control;  
CL: Create

**3. 3.** Garlic has anticoagulant properties and may pose a problem with bleeding if enough has been taken too close to surgery. Therefore, the nurse must obtain more quantifiable details about the client's statement. The nurse should check the surgical procedure, anesthesia preference, and blood pressure status with the client. However, the part of the client's statement that needs further investigation concerns intake of an herb with anticoagulant properties before a surgical procedure.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**4. 1.** The nurse should remove the face mask. The face mask contains nasal and oral droplets, which are easily transmitted to the hands as the mask dangles when left hanging around the neck. When a face mask is not worn over the mouth and nose, it should be completely removed.

 CN: Safety and infection control;  
CL: Synthesize


**5.** This is the correct surgical site.




 CN: Physiological adaptation; CL: Apply

**6. 1.** A pimple close to the incision site may be reason for the surgeon to cancel the surgical procedure because it increases the risk of infection. If the client had an abnormal ECG, the nurse would notify the anesthesiologist who will be administering the anesthesia. The anesthesiologist is the decision maker regarding the implications of the anesthesia on the cardiac system. The surgical team should be notified of the client's hearing disability, but the surgeon, who has already met the client, does not

need to be notified. The surgical team should be notified of the client's allergy to iodine and it should be documented in all the appropriate places, but the surgeon would not need to be notified in advance of the surgical procedure.

 CN: Safety and infection control;  
CL: Synthesize

**7. 4.** When a client has a concern, it is important to decrease her stress as much as possible. The nurse should call the operating room and inform the intraoperative nurse. A special container with correct identification can be prepared so that when the client is anesthetized and her hearing aid is removed, it will not be lost or broken. It is usual policy not to send personal belongings to surgery because they are easily broken or lost in the transfer of an anesthetized client with higher priority needs, but special needs do exist. In some instances the nurse does bring a client's personal belongings to the postanesthesia care unit, but in this case the item involves the client's ability to communicate. Because the trend is to use little premedication, clients are more alert and may want to talk with their surgical team before going to sleep. Decreasing the client's anxieties preoperatively affects the amount of medication used to induce the client and her overall psychological and physiologic status. Telling the client that she won't need to hear is insensitive.

 CN: Basic care and comfort;  
CL: Synthesize

**8. 4.** The client has deficient knowledge if he smoked a cigarette after 4 a.m. because, even though he did not have anything to eat or drink, smoking has increased the production of gastric hydrochloric acid, which can increase the risk of aspiration in an anesthetized client. A gelatin dessert is a clear liquid and is acceptable. Comfort measures, such as brushing the teeth without swallowing or holding a cold washcloth against the lips, are acceptable for a client who is to have nothing by mouth.

 CN: Reduction of risk potential;  
CL: Evaluate

**9. 2.** Clients who are allergic to shellfish are allergic to iodine skin preparations (Iodophor and Betadine) or any other products containing iodine, such as dyes. Clients who are allergic to shellfish do not necessarily have an allergy to any other substances or seafood.

 CN: Reduction of risk potential;  
CL: Analyze

**10. 2.** The antibiotic is most effective in preventing infection, according to research, if it is given 30 to 60 minutes before the operative incision is made. When the surgeon orders the antibiotic to be given

at a specific time related to the scheduled time of the surgical procedure, it is imperative that the antibiotic is given on time. Legally, the nurse considers 30 minutes on either side of the scheduled time to be acceptable for administering medications; however, in this situation, giving the antibiotic 30 minutes too soon can make the prophylactic antibiotic ineffective. The postoperative dose of antibiotic is not timed according to the preoperative dose. Peak and titer levels are measured for some antibiotics, but in this case the primary reason is to have the antibiotic infused before the time of the incision.

 CN: Reduction of risk potential;  
CL: Apply

**11. 3.** Nurses should provide the preoperative client individual and sincere attention by meeting the client at eye level and introducing themselves by name and role. The nurse should ask the client to tell her full name rather than asking if she is Mrs. Smith because there might be another client by that name on the schedule. Nurses should not start the physical assessment or ask the client's name without first identifying themselves and their role out of courtesy and to relieve the client's anxiety in the new environment of the surgical experience.

 CN: Psychosocial adaptation; CL: Apply

**12. 4.** The nurse should notify the anesthesiologist because a serum potassium level of 5.8 mEq/L places the client at risk for arrhythmias when under general anesthesia. The surgeon may be notified; however, the anesthesiologist will make the decision about whether to proceed with surgery. The nurse should not automatically send a client with abnormal laboratory findings to surgery because the procedure may be canceled. Once the client is inside the operating room and sterile supplies have opened up for the procedure, the client is usually charged. The nurse should call ahead of time to communicate the abnormal laboratory result instead of placing a note on the front of the chart. A note would not be seen until after the client has been transported to the operating room and the supplies have been opened.

 CN: Reduction of risk potential;  
CL: Synthesize

**13. 4.** Clients should be made aware that some questions are asked for verification and safety with each new phase of treatment.


 CN: Psychosocial adaptation;  
CL: Synthesize

**14. 1, 2, 3.** Clients who have diabetes mellitus controlled by diet, those with a high stress response to surgery, or those who have been on steroid treatment for the last 3 months should have their serum glucose level assessed. A client with a family history


of diabetes receiving D<sub>5</sub>LR I.V. fluids does not need to have the serum glucose level checked unless other clinical manifestations are present. The client who has a high carbohydrate diet should be able to metabolize the glucose unless there are other health problems.

 CN: Reduction of risk potential;  
CL: Analyze


**15. 3.** The nurse should notify the physician directly for specific orders based on the client's glucose level. The nurse cannot ignore the elevated glucose level. The surgical experience is stressful and the client needs specific insulin coverage during the perioperative period. The nurse should not administer the insulin without checking with the surgeon because there are specific orders to withhold all medications. It is not necessary to notify the surgery department unless the physician cancels the surgery.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**16. 3.** Psychosocial integrity issues, including coping mechanisms, situational role changes, and body image changes, are more common in a client who undergoes elective cosmetic surgical procedures. Reduction of risk potential, physiologic adaptation, and health promotion and maintenance are greater needs for clients who are undergoing surgical correction of functional, anatomic, or physiologic defects in nonelective surgical procedures.

 CN: Psychosocial adaptation;  
CL: Analyze

**17. 1.** A client should not elect surgery to meet someone else's needs. The nurse should encourage the client to share his feelings and his perception of the deformity and to clarify his reasons for electing to have the surgery. It is normal to be somewhat afraid, and it is good if a client says he feels "OK" about the surgery. The fact that a client believes that his wife will help him after surgery and that he will also be relatively independent reflects appropriate adaptation. It is a common feeling among preoperative clients that they are ready to "get this over with," indicating that the waiting period is stressful.

 CN: Psychosocial adaptation;  
CL: Evaluate

**18. 2.** Brittle nails indicate poor nutrition. Poor posture indicates that the client does not stand up straight and use her muscles to support herself. A dull expression reflects the client's affect and emotional status. The client's weight of 128 lb is within normal range.

 CN: Health promotion and maintenance;  
CL: Analyze


**19. 4.** The Joint Commission requires that discharge instructions be written for the postoperative client. The nurse will review all instructions orally and will demonstrate any skill. Clients need to be given discharge instructions orally and in written form because of stress, medications, and the volume of material to be learned. Explaining all the instructions to a family member is important but does not replace the need for written instructions.

 CN: Health promotion and maintenance;  
CL: Synthesize

**20. 1.** The preadmission nurse, the first person in contact with the client, starts the discharge planning for the client undergoing surgery. All nurses involved with the client, from preadmission through postoperative recovery, should continue to reinforce the discharge plan.

 CN: Health promotion and maintenance;  
CL: Apply

**21. 3.** The nurse should have the client empty his bladder before the premedication is administered. This will be more comfortable and safe for the client. The purpose of the premedication is to decrease anxiety and promote a relaxed state. The client must have an empty bladder before being transferred to the operating room, where he will be immobilized and receive I.V. fluids. The family does not have to be present, but it is usually desired. Shaving the operative area is not generally recommended because it can cause small nicks that harbor bacteria. If the client must be shaved, it is usually done in the operating room holding area. The client should be comfortable at all times and offered a warm blanket whenever he is cool, before or after the premedication.

 CN: Basic care and comfort;  
CL: Synthesize


**22. 4.** The nurse should immediately think of the congenital metabolic tendency for malignant hyperthermia, which occurs in the presence of certain kinds of anesthetics. Whenever a preoperative client states that a family member has had problems with anesthesia or surgery, the nurse should inquire about the nature of the problems and whether other family members have had similar problems. Reassuring the client that technology has changed will do little to affect her fears and misses the opportunity to evaluate the risk for malignant hyperthermia. Encouraging the client to further express her concerns and reassuring her that her feelings are normal are important, but missing a familial tendency of malignant hyperthermia could be fatal.

 CN: Reduction of risk potential;  
CL: Synthesize


**23. 1.** Clients who have had long-term multiple exposures to latex products, such as would occur with six previous surgeries and recoveries, are at increased risk for latex allergies. The nurse should explore what types of surgeries these were, how involved the client's recoveries were, and whether signs of latex allergies have occurred in the past. Working as a sales clerk, having type 2 diabetes, or undergoing laser surgery does not expose a client to latex or increase the risk of latex allergy.

 CN: Health promotion and maintenance;  
CL: Analyze


**24. 3.** The nurse should assess the vital signs of the client who exhibits urticaria, rhinitis, and conjunctivitis a few seconds after coming in contact with rubber gloves, a plastic catheter, plastic I.V. tubing, and a plastic I.V. solution bag. The nurse should recognize that these symptoms indicate that a type I allergic reaction is occurring, that the client is responding to the latex, and that the reaction can proceed into anaphylactic shock. The client does not need to be distracted or assessed for pain. It is not necessary to lower the head of the bed.

 CN: Physiological adaptation;  
CL: Synthesize

**25. 4.** The nurse would ask the client whether he wears glasses to evaluate his preoperative cognitive-perceptual pattern. Asking about the client's swallowing pattern would evaluate his nutritional-metabolic pattern. Asking about his need for special equipment to walk would evaluate his activity-exercise pattern. Asking the client about his history of smoking would evaluate his health perception-health management pattern.

 CN: Physiological adaptation;  
CL: Analyze

**26. 3.** The client is at risk for a difficult intubation because the neck must be hyperextended to pass the endotracheal tube. Assessment of the pupils should not be limited. If the client is positioned appropriately during surgery, there is no risk of postoperative neck pain or limited neck movement.


 CN: Reduction of risk potential;  
CL: Analyze

**27. 1, 2, 3, 4.** Splinting the incision is important to avoid stress on the surgical site and to promote comfort so that the client will adhere to the plan of care. Inhaling and exhaling are important to bring in adequate oxygen and clear out carbon dioxide; however, closing one nostril when inhaling would be inappropriate and ineffective. The most important step is asking the client to hold the inhaled breath for about 5 seconds, which keeps the alveoli


expanded. This step should be stressed the most. Repeating the exercise 5 to 10 times hourly is the second most important point to emphasize in this teaching plan.

 CN: Reduction of risk potential;  
CL: Create


**28. 2.** The nurse should call the surgeon for a serum creatinine level of 2.6 mg/dL, which is higher than the normal range of 0.5 to 1.0 mg/dL. An elevated serum creatinine value indicates that the kidneys are not filtering effectively and has important implications for the surgical client because many anesthesia and analgesia medications need to be filtered out through the renal system. The red blood cell count, hemoglobin level, and blood urea nitrogen level are within normal limits and do not need to be reported to the surgeon.

 CN: Reduction of risk potential;  
CL: Analyze


**29. 1.** Midazolam hydrochloride causes antegrade amnesia or decreased ability to remember events that occurred around the time of sedation. Nausea, mild agitation, and blurred vision are adverse effects of Versed.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**30. 3.** The client should be encouraged to take slow, deep breaths because midazolam hydrochloride is a respiratory depressant. The nurse should assess the client's blood pressure, monitor the pulse oximeter, and keep the client calm and relaxed, but the client will slip into very shallow, ineffective breathing if not encouraged to deep-breathe.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**31. 1.** The nurse should have an Ambu bag in the client's room because midazolam hydrochloride can lead to respiratory arrest if it is administered too quickly. The client does not need to be shocked back into a normal rhythm or to receive epinephrine unless cardiac compromise developed after the respiratory arrest. The client would receive titrated dosing of flumazenil to reverse the Versed, but first the nurse should ventilate the client.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**32. 2.** Metoclopramide is an antiemetic given because of its gastric emptying ability, which is necessary in gastrointestinal procedures. It does not increase gastric pH, reduce anxiety, or inhibit respiratory secretions.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**33. 3.** Glycopyrrolate is an anticholinergic given for its ability to reduce oral and respiratory secretions before general anesthesia. Increased heart rate and respiratory rate would be adverse effects of the drug. Amnesia should not be an effect of the drug.

 CN: Pharmacological and parenteral therapies; CL: Apply


**34. 1.** The nurse can administer atropine sulfate, an anticholinergic, to a client with diabetes. Atropine is contraindicated in clients with glaucoma because it increases intraocular pressure. It is contraindicated in clients with urine retention because it relaxes smooth muscle in the urinary tract and can exacerbate the problem. It is contraindicated in clients with gastrointestinal obstruction because it relaxes smooth muscle in the gut and may worsen the obstruction.

 CN: Pharmacological and parenteral therapies; CL: Apply

**35. 3.** Because droperidol causes tachycardia and orthostatic hypotension, the client should be moved slowly after receiving this medication. Inapsine produces a tranquilizing effect and does affect the central nervous, respiratory, or psychoneurologic system, but the primary reason for moving the client slowly is the potential cardiovascular effects of hypotension.

 CN: Pharmacological and parenteral therapies; CL: Apply

**36. 2.** Research findings have shown that enoxaparin and low-dose heparin given 6 to 12 hours preoperatively reduce the incidence of deep vein thrombosis and pulmonary emboli by 60% in clients who are at risk for deep vein thrombosis, such as those who are placed in the lithotomy position. Lovenox has no effect on red blood cell production, postoperative bleeding, or tissue healing.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**37. 4.** The nurse does not need to ask about all drugs used in the last 18 months unless the client is still taking them. The nurse does need to know all drugs the client is currently taking, including herbs and vitamins, over-the-counter medications such as aspirin taken in the past 6 weeks, the amount of alcohol consumed, and use of illegal drugs, because these can interfere with the anesthetic and analgesic agents. Steroid use is of concern because it can suppress the adrenal cortex for up to 1 year, and supplemental steroids may need to be administered in times of stress such as surgery.


 CN: Reduction of risk potential;  
CL: Apply



**38. 2.** The nurse should notify the surgery department and document the past surgery in the chart in the preoperative notes so that the client's hip is not externally rotated and the hip dislocated while she is in the lithotomy position. The prosthesis should not be a problem as long as the perioperative nurse places the grounding pad away from the prosthesis site. The perioperative nurse will inform the rest of the team, but the primary reason to inform the perioperative nurse is related to safe positioning of the client. The surgeon can hand-write an addendum to the history and initial and date the entry. The history and physical information can then be retyped at a later date.

 CN: Reduction of risk potential;  
CL: Apply

**39. 3.** The nurse should notify the anesthesiologist because supplemental prednisone suppresses the adrenal cortex's natural ability to produce increased corticosteroids in times of stress such as surgery. The anesthesiologist may need to order supplemental steroid coverage during the perioperative period. The nurse should document the prednisone with current medications, but it is a priority to inform the anesthesiologist. Because the poison ivy is not in the surgical field, the surgeon does not need to be called regarding the skin disruption.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**40. 2.** The client who has a significant cigarette smoking history and an operative manipulation close to the diaphragm (the gallbladder is against the liver) is at increased risk for atelectasis and pneumonia. Postoperatively this client will be reluctant to deep-breathe because of pain, in addition to having residual lung damage from smoking. Therefore, the client is at greater-than-average risk for pulmonary complications. The client does not have an increased risk of prolonged immobility (unless slowed by a respiratory problem), deep vein thrombosis (as long as the client performs leg exercises), or delayed wound healing (as long as the client maintains appropriate nutrition).

 CN: Reduction of risk potential;  
CL: Analyze


**41. 4.** The purpose of separating the public from the restricted-attire area of the operating room is to provide an aseptic environment and prevent contamination of the environment by organisms. The client's privacy is protected, but the main purpose is infection control.

 CN: Safety and infection control;  
CL: Apply


**42. 1.** The 68-year-old client is at greater risk because an older adult client is more likely to have comorbid conditions, a less-effective immune system, and less collagen in the integumentary system.

 CN: Physiological adaptation;  
CL: Analyze


**43. 1.** The child having her 15th laser procedure for a hemangioma should not have a balloon unless it is latex free because this child has had numerous exposures to latex thus far. If she has not already developed some sensitivity, the nurse should help the family be aware of latex products to avoid when possible. A client who is having a tonsillectomy, inguinal hernia repair, or orchiopexy is probably having surgery for the first time and has not been exposed to latex, although it is a good practice to use latex-free products whenever possible and to inquire about past exposure.

 CN: Safety and infection control;  
CL: Synthesize

**44. 2.** An autotransfusion is acceptable for the client who is in danger of cardiac arrest. An autotransfusion cannot be collected from a client who has cancer, a contaminated wound, or contamination from *Escherichia coli* because of a ruptured bowel.

 CN: Pharmacological and parenteral therapies; CL: Apply

**45. 2.** After a scope or catheter has been inserted into the urethra, the mucosal membrane is irritated and the client feels the need to void even though the bladder may not be full. The nurse should encourage the client to force fluids to make the urine dilute. The client should not ignore the urge to void. The client should be encouraged to use the bathroom; there is no need to use the bedpan. The client does not need assistance to the bathroom because this procedure does not require any anesthesia except a topical anesthetic for the male client.


 CN: Basic care and comfort;  
CL: Synthesize

**46. 4.** Early ambulation is the most significant general nursing measure to prevent postoperative complications and has been advocated for more than 40 years. Walking the client increases vital capacity and maintains normal respiratory functioning, stimulates circulation, prevents venous stasis, improves gastrointestinal and genitourinary function, increases muscle tone, and increases wound healing. The client should maintain a healthy diet, manage pain, and have regular bowel movements. However, early ambulation is the most important intervention.


 CN: Reduction of risk potential;  
CL: Synthesize

## The Client Who Is Receiving or Recovering from Anesthesia

**47. 1.** The client is demonstrating signs of malignant hyperthermia. Unless the body is cooled and the influx of calcium into the muscle cells is reversed, lethal cardiac arrhythmia and hypermetabolism occur. The client's body temperature can rise as high as 109° F (42.8° C) as body muscles contract. Dantrolene, an I.V. skeletal muscle relaxant, is used to reverse muscle rigidity. Elevating the head of the bed will not reverse the hyperthermia. Adding fluids and inserting an indwelling urinary catheter are not immediately beneficial steps in reversing the progression of malignant hyperthermia.

 CN: Management of care; CL: Synthesize


**48. 2.** The nurse should first attempt to find out what the client's concerns are and address them. Providing too much information with details can increase the client's anxiety and does not address specific concerns. Padding the stirrups will provide comfort, but does not address concerns. Having an all-female team may or may not be the source of the client's concerns.

 CN: Psychosocial adaptation;  
CL: Synthesize

**49. 3.** The client is in the lithotomy position. The reverse Trendelenburg position is when the client is lying supine with the head lower than the rest of the body. A low Fowler's position is when the client is sitting up at a 30- to 45-degree angle. The prone position is when the client is lying face down.

 CN: Management of care; CL: Apply


**50. 4.** Airway flow is always the first assessment. Once the nurse establishes that the client has a patent airway, the pulse oximeter is applied to measure the oxygen saturation, the respiratory rate is counted, and the breath sounds are auscultated bilaterally.

 CN: Physiological adaptation;  
CL: Analyze


**51. 1.** The last area to regain sensation is the perineal area, and the nurse should check the client for a distended bladder. The client has received a large volume of I.V. fluids since the epidural was inserted, and the client may not feel the urge to void or may be unable to void. In that case, the nurse should obtain an order to catheterize the client before the bladder becomes so distended as to cause bladder spasms. The nurse should assess for a spinal headache, postoperative pain, and the client's ability to move after determining whether the bladder is distended.

 CN: Reduction of risk potential;  
CL: Analyze

**52. 3.** Spinal anesthesia is an extensive conduction nerve block that is produced when a local anesthetic is introduced into the subarachnoid space at the lumbar level. A few minutes after induction of a spinal anesthetic, anesthesia and paralysis affect the toes and perineum and then, gradually the legs and abdomen. When the autonomic nervous system is blocked, vasodilation occurs and hypotension occurs. The client will feel sensation to the toes before the perineal area. A spinal headache due to loss of fluid is a severe headache that occurs while in the upright position, but is relieved in the lying position.

 CN: Physiological adaptation;  
CL: Analyze


**53. 3.** The nurse should check the client's baseline data to ascertain whether the client's pupil has always been enlarged or this is a new finding. The preoperative assessment is valuable as the baseline for comparison of all subsequent assessments made throughout the perioperative period. The nurse may determine that a more involved neurologic examination is indicated or may choose to assess other signs using the Glasgow Coma Scale, administer oxygen, or call the surgeon, but the nurse still needs to know the baseline data before proceeding.

 CN: Physiological adaptation;  
CL: Synthesize

**54. 1.** The nurse should check the dressing for signs of bleeding to establish a baseline for future assessments of the dressing and to verify that there is no obvious sign of hemorrhage. The nurse does not need to empty peri-incisional drains at this time. All drains should have been emptied and reconstituted by the postanesthesia care nurse before the client was transferred to the surgical floor. Assessing the client's pain level and assessing the bladder are important; however, it is more important to assess the surgical site for bleeding because hemorrhage is a life-threatening complication of any surgical procedure.


 CN: Physiological adaptation;  
CL: Synthesize

**55. 2.** Adult clients are induced for general anesthesia by breathing in an inhalant anesthetic mixed with oxygen through a facial mask and receiving intravenous medication to make them sleepy. Clients are not induced with the premedication. Clients usually are not induced with the intravenous infusion or the mask alone.


 CN: Basic care and comfort;  
CL: Synthesize

**56. 4.** Children are induced for general anesthesia by giving them medication through a facial mask to make them sleepy. Children are not induced with an injection. Children usually are not induced by


use of a facial mask with I.V. administration started while they are still awake.

 CN: Basic care and comfort;  
CL: Synthesize


**57. 3.** Sodium pentothal, a short-acting barbiturate, can cause hypotension, which may be especially problematic for the client with impaired cardiac functioning. Sodium pentothal does not cause bradycardia, complete muscle relaxation, hypertension, or tachypnea.

 CN: Pharmacological and parenteral therapies; CL: Apply


**58. 1.** Propofol, a nonbarbiturate anesthetic, causes less nausea and vomiting because of a direct antiemetic action. It does not cause hypotension or skeletal muscle movement, and it does not act slowly.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**59. 4.** Desflurane and sevoflurane are volatile liquid anesthesia agents that are used for outpatient surgeries primarily because they are rapidly eliminated. They have the added benefits of being better tolerated and nonirritating to the respiratory tract, and they have predictable cardiovascular effects. However, rapid elimination is an important consideration for outpatient procedures.

 CN: Pharmacological and parenteral therapies; CL: Apply

**60. 3.** A heart rate of 150 bpm or greater, hypotension, and muscle rigidity are early signs of malignant hyperthermia. The nurse should quickly assemble emergency supplies and personnel because malignant hyperthermia is potentially fatal and rapidly fatal in more than 50% of cases. Rapid, extreme rise in temperature is a late sign. Another factor influencing the analysis is that the client has a large body frame, and having large, bulky muscles is a risk factor for malignant hyperthermia. The client's vital signs are well out of the range of normal; analysis of the data and swift intervention are indicated. Excessive blood loss is unlikely and the data do not support this conclusion. Although clients do have changes in vital signs when in acute pain, the nurse would expect the client to be hypertensive, not hypotensive.

 CN: Physiological adaptation;  
CL: Analyze

**61. 2.** One of the earliest signs of hypoxia is restlessness and agitation. Decreased level of consciousness and somnolence are later signs of hypoxia. Chills can be related to the anesthetic agent used but are not indicative of hypoxia. Urgency is not related to hypoxia.

 CN: Physiological adaptation;  
CL: Analyze

**62. 2, 3, 4, 5.** Flumazenil should be administered in small quantities such as 0.2 mg over 15 to 30 seconds but never as a bolus. Flumazenil may be given undiluted in incremental doses. Adverse effects of flumazenil may include shivering and hypotension. The nurse should monitor the client's level of consciousness while recovering from sedation. Flumazenil should be administered through a free-flowing I.V. line in a large vein because extravasation causes local irritation.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**63. 2.** It is important for the nurse to cover this client with warm blankets because he is at high risk for hypothermia secondary to age, spinal anesthesia, placement in a lithotomy position in the cool operating room for 1.5 hours, instillation of 4,000 mL of room temperature bladder irrigation, and ongoing bladder irrigation. Spinal anesthesia causes vasodilation, which results in heat loss from the core to the periphery. The nurse will empty the catheter drainage bag and hang new bags of irrigation as needed, but the client's potential for hypothermia should be addressed first. The client will not be turned at this time.

 CN: Reduction of risk potential;  
CL: Synthesize

**64. 3.** The client who is 5 feet 1 inch tall and weighs 200 lb would be expected to retain the anesthetic agents longer because adipose tissue absorbs the drug before the desired systemic effect is reached for anesthesia maintenance. Nursing interventions are aimed at encouraging the obese client to turn, cough, and deep-breathe despite feeling sleepy and tired. The sooner this client ambulates, the sooner the retained anesthesia will be worked out of the adipose tissue.


 CN: Reduction of risk potential;  
CL: Analyze

**65. 1.** The nurse should encourage the client to avoid holding his operated arm, the arm with the intravenous regional nerve block (Bier block), close to her face because she has no motor control over it. With the cast in place she could hit herself in the eye, nose, or mouth and cause soft-tissue damage. It is acceptable for the client to hold the operated arm with the unoperated arm or to use the unoperated arm. The nurse should administer the analgesic before the intravenous regional anesthetic completely wears off so that the pain does not peak before pain medication is administered.

 CN: Reduction of risk potential;  
CL: Synthesize

**66. 3.** The nurse should monitor the client's respirations closely for 4 to 6 hours because naloxone has a shorter duration of action than


opioids. The client may need repeated doses of naloxone to prevent or treat a recurrence of the respiratory depression. Naloxone is usually effective in a few minutes; however, its effects last only 1 to 2 hours and ongoing monitoring of the client's respiratory rate will be necessary. The client's dosage of morphine will be decreased or a new drug will be ordered to prevent another instance of respiratory depression.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**67. 3.** Abnormal coagulation test results have been associated with naloxone (Narcan), and the nurse should monitor surgical clients closely for bleeding. Dizziness, biliary colic, and urine retention are not associated with naloxone.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**68. 3.** The client who receives epidural anesthesia is at decreased risk for a headache because a noncutting needle is used instead of a side angle-cutting needle. The epidural needle is a 25G to 27G needle, which is much smaller than a 17G needle. The injection made for an epidural is an extradural, not a subarachnoid, injection as for spinal anesthesia. The onset of spinal anesthesia is faster because a larger dose of medication is usually administered.

 CN: Physiological adaptation; CL: Analyze


**69. 3.** Spinal anesthesia does not cause parasympathetic blockage. The spinal anesthetic agent usually is injected into the L2 subarachnoid space, where it produces sympathetic, sensory, and motor blockade.

 CN: Pharmacological and parenteral therapies; CL: Apply

**70. 0.5 mL.** Multiply 2.5 mg/5 mg by the unknown  $X$  mg/1 mL. Cross-multiply to get  $5X=2.5$  mL. Divide both sides of the equation by 5 to get  $X = 0.5$  mL.

 CN: Pharmacological and parenteral therapies; CL: Apply


**71. 3.** In order to prevent burns, the nurse should assess the client's temperature every 15 minutes when using an external warming device.

 CN: Safety and infection control; CL: Apply

### The Client Who Has Had Surgery

**72. 2, 3, 1, 4.** The oncoming nurse should first assess the client for pain. Next, the nurse should check the documentation and then validate with

the nurse who reported giving the medication that the medication had been given. Finally, the nurse should determine if there is a discrepancy between administration and documentation.

 CN: Management of care; CL: Synthesize

**73. 4.** Following surgery, clients are at risk for respiratory complications and should take the necessary actions to prevent these. The nurse should first be sure that the client understands how to do the exercises and the potential complications if they are not done. It is not the wife's responsibility to make the client do the exercise, but she can help. Increasing fluid intake and frequent turning are appropriate, but not sufficient for aerating the lungs.

 CN: Health promotion and maintenance; CL: Synthesize


**74. 3.** An indwelling urinary catheter increases the risk of urinary tract infection because microbes ascend the catheter and travel to the bladder. The nurse should try to facilitate the client's ability to void by using the sitting position for a woman or the standing position for a man and by running warm water over the perineum. If such conservative methods fail, the nurse should obtain an order to catheterize the client every 4 hours using a small French straight catheter until the client can void on his or her own.

 CN: Reduction of risk potential; CL: Synthesize

**75. 4.** The first cognitive response that returns after anesthesia is orientation to person. The nurse assesses this by asking the client his name. Orientation to place and time usually occurs after orientation by the nurse because of confusion from anesthesia and waking in an unfamiliar place. The nurse can then continue to assess and document the client's cognitive ability to remember information. The nurse does not need to notify the surgeon. The client's cognitive response is normal. It is not necessary to ask the wife to reorient the client; however, she can continue to talk to him and help him regain consciousness.

 CN: Physiological adaptation; CL: Synthesize

**76. 3.** Potassium in an I.V. solution may be irritating to a vein. The nurse should assess the I.V. site before taking any of the other actions listed. The infusion may have to be slowed and/or stopped, and the physician contacted. An outdated parenteral fluid setup does not cause pain, but may be a source of infection.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**77. 2.** The client's body temperature dropped 2.5° F from the preoperative to postoperative phase. The client lost heat during the preoperative period. The client has not had time to regain the heat she has lost and should not be discharged postoperatively until her postoperative vital signs, which include body temperature, are closer to her preoperative vital signs. The client's pulse rate, respiratory rate, and blood pressure have compensated according to the client's hypothermic state and will reflect changes as the client warms up. There are no indications that the client needs more pain medication, oxygen, or I.V. fluids.

 CN: Physiological adaptation;  
CL: Synthesize

**78. 1, 3, 4, 5.** When assessing a postoperative client for perfusion and the manifestation of shock, nursing assessment should include an inspection for cyanotic mucous membranes; cold, moist, pale skin; and the level of oxygen saturation in relation to hemoglobin. The nurse should also compare the client's postoperative vital signs with his preoperative vital signs to determine how much physiologic stress has occurred during the intraoperative period. A client who is perfusing well would have warm, dry skin. A client well hydrated would have good skin turgor. The nurse would also assess fluid status using the intake and output record. If hemoglobin and hematocrit were available, the values would be included in the assessment.


 CN: Management of care; CL: Analyze

**79. 3.** The nurse is helping the client manage her pain and comfort level. The nurse has completed her assessment of the client and should now dim the lights and create a quiet environment. Such non-pharmacologic measures as adjusting the light level in the room facilitate pain management. Decreasing stimulation from the environment, such as brightness to the optic nerve, promotes the client's ability to relax skeletal muscles and fall asleep. It is too soon to reassess vital signs. Checking that the family is comfortable is important but is not the next thing to do for this client. Increasing the oxygen flow rate is not indicated, and if needed should have been done before repositioning the client.


 CN: Management of care; CL: Synthesize

**80. 4.** When a postoperative client has a temperature elevation to greater than 100° F (37.8° C) in the first 24 hours after surgery, the temperature elevation is usually related to atelectasis. Because this client had upper abdominal surgery with manipulation around the diaphragm, the client is more prone to guarding the operative site and shallow breathing. Encouraging the client to take deep breaths and use incentive spirometry are appropriate measures to

prevent atelectasis and pulmonary infection. The nurse must assist the client in filling the alveoli in the lower posterior lobes of the lungs. An incentive spirometer is a good visual biofeedback instrument that the client had practiced with preoperatively. Changing the client's position from lying to sitting for deep breathing will expand alveoli in the lower posterior lobes. There is no indication that a surgical wound infection is occurring. An antibiotic is not indicated at this time. Pain medication will decrease respirations and the client is not indicating pain at the moment.

 CN: Physiological adaptation;  
CL: Synthesize

**81. 3.** The nurse should take the client's blood pressure. She is likely experiencing orthostatic hypotension. The PCA pump does not need to be discontinued because, as soon as the blood pressure stabilizes, the pain medication can be resumed. Administering oxygen is not necessary unless the oxygen saturation also drops. The client should sit in the chair until the blood pressure stabilizes.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**82.**

4. Splint the incisional site.

1. Inhale through the nose.

3. Exhale through pursed lips.

2. Cough deeply from the lungs.

The client must first splint the incision to avoid increased intolerable pain or he may not cooperate with the pulmonary ventilation. The next step is to inhale oxygen to expand the alveoli for a few seconds and then exhale carbon dioxide in successive steps 5 to 10 times. The client should try to cough on the end of the exhalation to remove retained secretions from the larger airways.


 CN: Reduction of risk potential;  
CL: Synthesize

**83. 3.** The client who has not had the gag reflex anesthetized is the client who had a repair of the carpal tunnel syndrome under local anesthesia because the area being anesthetized was the tissue in the wrist. The client who had a bronchoscopy received a local anesthetic on the vocal cords, and the nurse should check the gag reflex or ability to swallow before administering fluids. Clients who had general anesthesia or intravenous conscious sedation received medication for central nervous system sedation, and the nurse should assess the


level of consciousness and ability to swallow before administering fluids.

 CN: Reduction of risk potential;  
CL: Analyze


**84. 3.** When the urine output is less than 30 mL/hour, the nurse should assess for potential causes such as hypovolemia or hemorrhage. The nurse should assess and evaluate the client's vital signs, intake and output, dressing, and available laboratory values and notify the physician. Bowel obstruction, although possible after surgery, is characterized most notably by abdominal distention and absent bowel sounds, not decreased urine output. The nurse would not expect the client to have hypertension, but rather hypotension.

 CN: Physiological adaptation;  
CL: Synthesize

**85. 3.** A client who had a left thoracoscopy is placed in the lateral position, in which the most common injury is an injury to the brachial plexus. Numbness and tingling in the arm suggests a brachial plexus injury. There is no undue pressure on the ankles or knees during thoracic surgery.

 CN: Physiological adaptation;  
CL: Analyze

**86. 3.** Although any client may experience nausea and vomiting secondary to anesthetics or postoperative analgesics, the client who has had manipulation of the abdominal organs is more prone to postoperative nausea and vomiting than the client who has had a procedure such as a total joint replacement, open heart surgery, or a mastectomy.


 CN: Physiological adaptation;  
CL: Analyze

**87. 3.** The nurse should inform the client that as the incision heals uneven lumps might appear under the incision line because the collagen is growing new tissue at different rates. Eventually, the lumps will even out and the tissue will be smooth. The client can touch the incision with clean hands as needed to perform incisional care. The client should not clean the incision with hydrogen peroxide because it may dry out the natural skin oils. The surgeon will remove the staples for the client.

 CN: Reduction of risk potential;  
CL: Synthesize

**88. 2.** When a wound eviscerates (abdominal organs protruding through the opened incision), the nurse should cover the open area with a sterile dressing moistened with sterile normal saline and then cover it with a dry dressing. The surgeon should then be notified to take the client back to the operating room to close the incision under general anesthesia. The nurse should not press


the emergency alarm because this is not a cardiac or respiratory arrest. The nurse should have the visitors and family leave the room to decrease the chance of airborne contamination, but the primary focus should be on covering the wound with a moist, sterile covering.

 CN: Safety and infection control;  
CL: Synthesize

**89. 2, 3, 4.** WBC count should be above normal (4,500 to 11,000/mm<sup>3</sup>) with an acute infection or inflammatory response such as a postoperative wound infection. Redness and swelling beyond the incision line is expected with a wound infection. An elevated temperature such as 102° F (38.9° C) on the third to fourth postoperative day indicates an infection process rather than an inflammatory process. An elevation in the segmented neutrophils demonstrates that the most mature WBCs have responded to the invading bacteria at the incision site, which is an expected response. Typically, postoperative pain begins to lessen by the fourth day.

 CN: Physiological adaptation;  
CL: Analyze

**90. 4.** A wet-to-dry dressing should be able to dry out between dressing changes. Thus, the dressing should be moist, not dry, when applied. As the moist dressing dries, the wound will be debrided of necrotic tissue, exudate, and so forth. Normal saline is most commonly used to moisten the sponge; Burrow's solution will irritate the wound. The sponge should not be packed into the wound tightly because the circulation to the site could be impaired. The moist sponge should be placed so that all surfaces of the wound are in contact with the dressing. Then the sponge is covered and protected by a dry sterile dressing to prevent contamination from the external environment.


 CN: Safety and infection control;  
CL: Synthesize

**91. 3.** After emptying a Jackson-Pratt drainage bulb, the nurse should compress the bulb, plug it to establish suction, and then document the amount and type of drainage emptied. Irrigating a Jackson-Pratt drain is inappropriate because it could contaminate the wound. The Jackson-Pratt drain is not usually connected to wall suction. The purpose of the Jackson-Pratt drain is to remove bloody drainage from the deep tissues of the incision; clamping the drain would be counterproductive.


 CN: Reduction of risk potential;  
CL: Synthesize

**92. 1.** Performing leg exercises, including ankle pumping, ankle rotation, and quadriceps setting exercises, will help prevent stasis of blood in the lower extremities, which can lead to blood clot

formation. Encouraging the client to cough and deep-breathe is an important postoperative intervention; however, it is directed at preventing pneumonia, not pulmonary emboli. The nurse should not massage the calves because a deep vein thrombus could dislodge and travel to the pulmonary vasculature. Antiembolism stockings should be worn continuously during the postoperative period.

 CN: Physiological adaptation;  
CL: Synthesize

**93. 2.** Naloxone hydrochloride is the antidote for morphine sulfate. The signs of overdose on morphine sulfate are a respiration rate of 2 to 4 breaths/minute, bradycardia, and hypotension. Flumazenil is the antidote for midazolam. Doxacurium is a nondepolarizing muscle relaxant. Remifentanyl is an opioid used as an anesthetic adjunct.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**94. 2.** The client admitted for same-day surgery should not drive home after the surgical procedure because it is unsafe. Even without an anesthetic, the surgical event can be more stressful than anticipated. It is acceptable to have someone arrive after the surgery has started to take the client home. A taxi is permissible but not desirable.

 CN: Reduction of risk potential;  
CL: Evaluate

**95. 3.** The client has deficient knowledge when stating that pain from a laparoscopic cholecystectomy is related to a large incision and manipulation of tissue. The nurse should explain that there are four puncture sites for the incision and that gas is used to distend the abdominal cavity to keep the abdominal organs away from the operative site. There is no real manipulation of tissue to produce pain. The pain that clients do experience from this procedure is related to the gas, which irritates the diaphragm. The client should start on clear liquids and advance to bland foods until the gas is gone. Walking helps to eliminate the gas from the abdominal cavity within 12 to 24 hours after surgery.


 CN: Reduction of risk potential;  
CL: Evaluate

**96. 3.** The urine output does not have to be checked every 15 minutes for a client who has had an arthroscopy because this client probably does not have a catheter in place. If the client voids, the output would be recorded. Assessments every 15 minutes during the first hour would include vital signs, pulse oximeter values, and pain to monitor the client's comfort level and check for compartment syndrome. Neurovascular checks distal to the operative site are especially vital because a tourniquet was used proximal to the operative site during the


surgical procedure and because edema may develop during the postoperative period.

 CN: Reduction of risk potential;  
CL: Analyze


**97. 2.** Hypotension and tachycardia are common adverse effects of droperidol and should be monitored closely by the nurse. Hypotension and tachycardia are not common adverse effects of ondansetron hydrochloride, prochlorperazine, or promethazine.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**98. 1.** The nurse should assess but not disturb the epidural dressing because the catheter can be easily dislodged and organisms can easily be transmitted into the central nervous system. The nurse should not have to change the dressing at all if a waterproof dressing is applied over the epidural site. Even with strict aseptic technique, a drain into a sterile cavity is a direct route for transmission of organisms and places a client at increased risk of infection.

 CN: Pharmacological and parenteral therapies; CL: Apply

**99. 2.** The client who has epidural pain management postoperatively can ambulate because a low concentration of local analgesia causes sensory blockage only. The catheter is placed so that constant pain management plus patient-controlled administration of an analgesic dose can block sensory innervation. Motor function should not be affected since the catheter is placed above the dura lining the spinal fluid. If the catheter would move through the dura sac, spinal analgesia would occur, affecting motor function as well as sympathetic nervous system function.


 CN: Pharmacological and parenteral therapies; CL: Apply

**100. 3.** Portable wound suction units can be emptied and drained. The nurse should compress the unit after emptying to create suction before reinserting the plug. It is normal for the suction unit to be full six hours after surgery, and the nurse does not need to notify the surgeon. The drainage unit should be emptied when full or every 8 hours. The drain in the incision should remain in place until the surgeon removes it. While all drainage should be noted as output on the chart, recording the amount without emptying the drainage unit is not accurate nor is it safe practice.


 CN: Safety and infection control;  
CL: Synthesize

**101. 1.** The nurse should ask the location of the client's pain because Lortab is an opioid, which

can be constipating. By the third day, many clients become constipated and are feeling distended, with sharp, cramping pain due to gas, which is treated with ambulation, not more opioids. The client's emptying his bladder should not affect his pain level. The nurse should look at the client's chart to determine when the client's last dose of pain medication was administered, rather than asking the client. The client's statement regarding his pain level before the surgery is not relevant to whether the nurse should administer the Lortab.

 CN: Physiological adaptation;  
CL: Synthesize

**102. 1.** Blood and serous fluid is drained from the operative site to prevent hematoma formation or a collection of fluid that could become a site for infection. This also minimizes postoperative swelling, which can be painful. A simple explanation such as this is appropriate because the client is just waking up from surgery. Blood from the operative site can be collected through an autotransfusion system so that it can be transfused to the client during or immediately after surgery. However, strict guidelines about volume of blood lost, how quickly the device fills, and how long the blood has been out of the client's body govern whether the blood can be transfused. Therefore, although it is possible that the drainage system to which the client refers is an autotransfusion system, it is more likely that the client has a simple Hemovac drain. It is incorrect to tell a client not to worry about something even if she is in the drowsy state of awakening from anesthesia. It is inappropriate to ignore the client and give her something to make her drowsy instead of addressing his concerns.

 CN: Psychosocial adaptation;  
CL: Synthesize

**103. 1.** The purpose of the Jackson-Pratt drainage tube is to drain off the purulent drainage from the sterile peritoneal cavity and prevent peritonitis. A Jackson-Pratt drain cannot prevent bleeding. The Jackson-Pratt drain has no effect on pressure on the bladder. There is no reason to be concerned about pressure on the gallbladder.

 CN: Reduction of risk potential;  
CL: Apply

**104. 2.** Biliary drainage tubes (T tubes) are placed in the common bile duct and drain bile, which is dark yellow-orange. Serosanguineous drainage is thin and pinkish red. Bile is not clear and is not green unless it comes in contact with gastric fluid.


 CN: Reduction of risk potential;  
CL: Analyze

**105. 1.** Urinary elimination in the first 8 hours postoperatively is a requirement before the client

who has had an inguinal hernia repair can be discharged from same-day surgery. Ingestion of fluids without nausea and vomiting is important, but eating solid foods is not a requirement for discharge from same-day surgery. Being completely pain-free is an unrealistic expectation for the time frame and is not a requirement for leaving same-day surgery. However, the client should be comfortable and his pain should be controlled. It is not a requirement for the client to ambulate in the hallway, but the client should be able to sit up and go to the bathroom without assistance.

 CN: Reduction of risk potential;  
CL: Analyze

**106. 3.** The ability to self-dose is a requirement for the client to use PCA. Having a family member or court-appointed advocate present is not a requirement for initiating PCA. The nurse teaches the client about how to use PCA and monitors effectiveness of the pain medication; however, it is not necessary for the nurse to assist with the dosing.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**107. 2.** The client's body temperature should be assessed every 4 hours during the first 24 hours because the client is still at risk for hypothermia or malignant hyperthermia. The client does not need to be checked every 2 hours unless indicated by an abnormal finding.

 CN: Reduction of risk potential;  
CL: Apply

**108. 1.** The client's systolic blood pressure is dropping and the pulse pressure is narrowing, indicating impending shock. The nurse should notify the surgeon. Elevating the head of the bed will not increase the blood pressure. Administering pain medication could cause the blood pressure to drop further. The intake and output record may indicate decreased urine output related to shock but the nurse should first contact the health care provider.

 CN: Reduction of risk potential;  
CL: Synthesize

**109. 1.** The client who has been positioned in the lithotomy position under general anesthesia may experience discomfort in the shoulders postoperatively because the client is placed in the Trendelenburg position to expose the perineal area. The client's weight is then shifted toward the shoulders and the client experiences muscle soreness postoperatively.

 CN: Basic care and comfort;  
CL: Apply

**110. 2.** The client should drink a minimum of 2,500 mL of fluid per day (not 1,500 mL) to keep



secretions liquefied and easier to cough up and eliminate from the upper respiratory tract. The client should use pain medication before coughing. The nurse should monitor the client's breath sounds and temperature to detect early signs of infection. The nurse should assist with early ambulation.

 CN: Reduction of risk potential;  
CL: Synthesize

**111. 3.** The client should sit in an upright position when doing breathing exercises to allow for full chest expansion of both lungs and all fields and bases. Using an incentive spirometer every hour while awake is appropriate and allows the client visual feedback. Placing his hands lightly over the lower ribs and upper abdomen allows the client to see muscles of inspiration and expiration and is appropriate. Coughing deeply from the lungs after four deep breaths allows the client to effectively cough up secretions.

 CN: Reduction of risk potential;  
CL: Evaluate

**112. 2.** Muscle cramping is a sign of hypokalemia. Potassium is an electrolyte lost with nasogastric suctioning. Confusion is seen with hypercalcemia. Edema is seen with protein deficit or fluid volume overload. Tremors are seen with hypomagnesemia.


 CN: Reduction of risk potential;  
CL: Analyze

### Legal and Ethical Issues Associated with Surgery

**113. 3.** The most critical piece of information is the client identification bracelet. Misidentification of clients can result in serious harm to the client. The nurse also needs the admitting records and Addressograph labels as part of verifying the client's identification. The location of the family is not included in verifying identification.

 CN: Reduction of risk potential;  
CL: Synthesize

**114. 4.** The nurse is not required to have the anesthesia note on the chart before the client is transported to the operating room suite. The anesthesia record is on the chart after the surgical procedure is completed and is a good source of client information. The operative consent, history and physical information, and laboratory test results should be on the chart before the client is transported to the operating suite.

 CN: Management of care;  
CL: Apply

**115. 2.** When the client cannot sign the operative consent and it is a true life-saving emergency, consent may be obtained over the telephone from the client's next-of-kin or guardian. The surgeon must obtain the telephone consent, but if it is a true life-saving emergency the surgeon often is already in surgery, so the nurse makes the telephone call and another nurse witnesses the call. Some institutions have a special consent form for emergency surgery. Consent can be waived in situations in which no family is available; however, if the family can be reached by telephone before surgery, verbal consent is legally required.

 CN: Management of care;  
CL: Synthesize

**116. 3.** There are risks with both the surgical procedure and the general anesthesia required for a craniotomy. The risks involved in the procedure are a part of the informed consent. Other information that is part of an informed consent includes potential complications, expected benefits, inability of the surgeon to predict results, irreversibility of the procedure (if applicable), and other available treatments. Talking about the effects of the diabetes on healing, explaining how the craniotomy is performed, and explaining the consequences of declining treatment (e.g., death if the tumor is not removed) represent appropriate actions to provide information to the client.

 CN: Management of care;  
CL: Evaluate

**117. 2.** All health care facilities reimbursed under Medicare and Medicaid are required under the 1991 Patient Self-Determination Act to recognize clients' advance directives such as health care proxies or living wills. Advance directives are an important part of perioperative care and should be respected by all health care professionals caring for the client. The nurse should not be involved in specific questions regarding how the client is going to pay for health care services except as an advocate addressing the client's psychosocial needs.


 CN: Management of care; CL: Apply

**118. 2.** When the client cannot read or write, the consent can be read to the client and the client can sign in the presence of two witnesses. The client (not the next-of-kin) should always sign for himself unless he is a minor or not of sound mind. The court does not appoint a guardian for a person of sound mind just because he cannot read or write. Hospital personnel would not and could not sign a consent form for a client.


 CN: Management of care;  
CL: Apply

## Managing Care Quality and Safety

**119. 2, 3, 4.** The root cause of wrong-site surgery involves a breakdown in communication between the client and family and the health care team. Information retrieved from the client in the preoperative assessment, such as the client's name, surgical site, and procedure, should be verbally assessed and verified with medical records and radiographic diagnostic reports. This information should be compiled in a checklist that the intraoperative team can recheck, avoid unnecessary distraction and delay in the operating room. The nurse in the operating room is responsible for calling a "time-out" so that every surgical team member can double-check the correct site of surgery, verify the site using the operative consent form, and mark the operative site on the client. The client should mark the operative site in the preoperative period, not the surgeon, in order to avoid any miscommunication about the correct site of surgery. Showing the client an anatomic model will assist the client in understanding the location of the surgery, but it will not prevent anyone from identifying the wrong site on the client.

 CN: Safety and infection control;  
CL: Apply

**120. 4.** The nurse should first contact the physician because the order for the morphine is not complete. The purpose of The Joint Commission's National Patient Safety Goals is to promote specific improvements in client safety. A requirement to meet this goal is to standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. One abbreviation not to be used is MSO<sub>4</sub> because it can apply to morphine as well as magnesium sulfate. There is no mention of an IV system being needed. The morphine should not be in the medication cabinet because the order is not complete. Although pharmacy may offer a suggestion as to what the medication ordered is, the best means to confirm the intent of the order is to contact the physician who wrote the order.


 CN: Safety and infection control; CL: Synthesize

**121. 4.** The nurse should first call the Rapid Response Team (RRT), or medical emergency team that provides a team approach to evaluate and treat immediately clients with alterations in vital signs or neurological deterioration. The client's vital signs have changed since the client was in the PACU and immediate action is required to manage the changes; the staff in PACU are not responsible for managing

care once the client is transferred to the surgical unit. The respiratory therapist may be a part of the Rapid Response Team but should not be called first.

 CN: Management of care;  
CL: Synthesize


**122. 4.** The nurse anesthetist administers the anesthetic agent and monitors the client's physical status throughout the surgery; the nurse anesthetist must have knowledge of all known allergies for client safety. The completed chart (with the Preoperative Checklist) accompanies the client to the operating room; any unusual last-minute observations that may have a bearing on anesthesia or surgery are noted prominently at the front of the chart. The pre-anesthetic medication can cause light-headedness or drowsiness. The nurse in the scrub role provides sterile instruments and supplies to the surgeon during the procedure.

 CN: Safety and infection control;  
CL: Synthesize

**123. 1, 2, 4.** Nurses can delegate to the unlicensed assistive personnel (UAP) to observe clients and promote their comfort following surgery, and to empty and measure urinary catheter drainage bags. UAPs cannot teach clients; that is the responsibility of the registered nurse or respiratory therapist. UAPs cannot assess I.V. insertion sites, which is the responsibility of a registered nurse.

 CN: Management of care; CL: Synthesize

**124. 4.** The nurse should plan for two people, one at each side using a drawsheet, one person at the head, and one person at the feet to transfer an elderly, drowsy client with fragile skin to avoid shearing of the integumentary system. Using only two or three people allows for dragging of some part of the client, which leads to shearing of the dependent part.

 CN: Safety and infection control;  
CL: Synthesize

**125. 2.** The client must have an identification bracelet properly secured on her person before being transported to the operating room to ensure correct identification. It is incorrect to send the client without a properly secured identification bracelet. The perioperative nurse must verify the client's identification by checking for the same name on the chart, armband, and schedule and by the client's statement. The preoperative nurse may be asked to physically identify the client and obtain a new armband.

 CN: Management of care; CL: Synthesize

**TEST  
15**

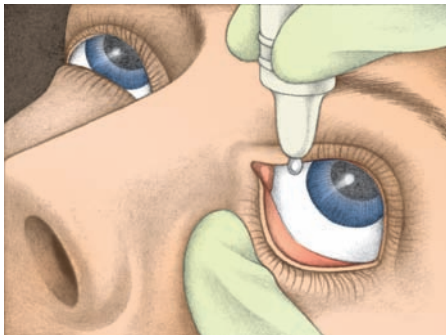
# The Client with Health Problems of the Eyes, Ears, Nose, and Throat

- The Client with Cataracts
- The Client with a Retinal Detachment
- The Client with Glaucoma
- The Client with Adult Macular Degeneration
- The Client Undergoing Nasal Surgery
- The Client with a Hearing Disorder
- The Client with Ménière's Disease
- The Client with Cancer of the Larynx
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Cataracts

**1.** The nurse is observing a student nurse administer eyedrops, as shown in the figure. What should the nurse instruct the student to do?

- 1. Move the dropper to the inner canthus.
- 2. Have the client raise her eyebrows.
- 3. Administer the drops in the center of the lower lid.
- 4. Have the client squeeze both eyes after administering the drops.



**2.** A client is having a cataract removed and will use eyeglasses after the surgery. The nurse should develop a teaching plan that includes which of the following? Select all that apply.

- 1. Images will appear to be one-third larger.
- 2. Look through the center of the glasses.
- 3. The changes will be immediate.
- 4. Use handrails when climbing stairs.
- 5. Stay out of the sun for 2 weeks.

**3.** The client has had a cataract removed. The nurse's discharge instructions should include which of the following?

- 1. Keep the head aligned straight.
- 2. Utilize bright lights in the home.
- 3. Use an eye shield at night.
- 4. Change the eye patch as needed.

**4.** The client with a cataract tells the nurse that she is afraid of being awake during eye surgery. Which of the following responses by the nurse would be the **most** appropriate?

- 1. "Have you ever had any reactions to local anesthetics in the past?"
- 2. "What is it that disturbs you about the idea of being awake?"
- 3. "By using a local anesthetic, you won't have nausea and vomiting after the surgery."
- 4. "There's really nothing to fear about being awake. You'll be given a medication that will help you relax."

**5.** A client tells the nurse his vision is blurred and hazy throughout the entire day. The nurse should recommend that the client do which of the following?

- 1. Purchase a pair of magnifying glasses.
- 2. Wear glasses with tinted lenses.
- 3. Schedule an appointment with an optician.
- 4. Schedule an appointment with an ophthalmologist.

**6.** The nurse is to instill drops of phenylephrine hydrochloride (Neo-Synephrine) into the client's eye prior to cataract surgery. Which of the following is the expected outcome?

- 1. Dilation of the pupil and blood vessels.
- 2. Dilation of the pupil and constriction of blood vessels.
- 3. Constriction of the pupil and constriction of blood vessels.
- 4. Constriction of the pupil and dilation of blood vessels.

**7.** A short time after cataract surgery, the client complains of nausea. The nurse should **first**:

- 1. Instruct the client to take a few deep breaths until the nausea subsides.
- 2. Explain that this is a common feeling that will pass quickly.
- 3. Tell the client to call the nurse promptly if vomiting occurs.
- 4. Medicate the client with an antiemetic, as ordered.

**8.** Which of the following is a potential complication following cataract surgery? Select all that apply.

- 1. Acute bacterial endophthalmitis.
- 2. Retrobulbar hemorrhage.
- 3. Rupture of the posterior capsule.
- 4. Suprachoroidal hemorrhage.
- 5. Vision loss.

**9.** The nurse is instructing the client about postoperative care following cataract removal. What position should the nurse teach the client to use?

- 1. Remain in a semi-Fowler's position.
- 2. Position the feet higher than the body.
- 3. Lie on the operative side.
- 4. Place the head in a dependent position.

**10.** After returning home, a client who has had cataract surgery will need to continue to instill eye drops in the affected eye. The client is instructed to apply slight pressure against the nose at the inner canthus of the eye after instilling the eyedrops. The rationale that supports applying pressure is that it:

- 1. Prevents the medication from entering the tear duct.
- 2. Prevents the drug from running down the client's face.
- 3. Allows the sensitive cornea to adjust to the medication.
- 4. Facilitates distribution of the medication over the eye surface.

**11.** To decrease intraocular pressure following cataract surgery, the nurse should instruct the client to avoid:

- 1. Lying supine.
- 2. Coughing.
- 3. Deep breathing.
- 4. Ambulation.

**12.** After cataract removal surgery, the client is instructed to report sharp pain in the operative eye because this could indicate which of the following postoperative complications?

- 1. Detached retina.
- 2. Prolapse of the iris.
- 3. Extracapsular erosion.
- 4. Intraocular hemorrhage.

### The Client with a Retinal Detachment

**13.** The client is diagnosed in the emergency department with a detached retina in the right eye. The nurse should do which of the following **first**?

- 1. Apply compresses to the eye.
- 2. Instruct the client to lie prone.
- 3. Remove all bed pillows.
- 4. Promote measures that limit mobility.

**14.** A client with detachment of the retina is to patch both eyes. The expected outcome of patching is to:

- 1. Reduce rapid eye movements.
- 2. Decrease the irritation caused by light entering the damaged eye.
- 3. Protect the injured eye from infection.
- 4. Rest the eyes to promote healing.

**15.** The client with retinal detachment in the right eye is extremely apprehensive. He states, "I'm afraid of going blind. It would be so hard to live that way." What factor should the nurse consider before responding to his statement?

- 1. Repeat surgery is impossible, so if this procedure fails, vision loss is inevitable.
- 2. The surgery will only delay blindness in the right eye, but vision is preserved in the left eye.
- 3. More and more services are available to help newly blind people adapt to daily living.
- 4. Optimism is justified because surgical treatment has a 90% to 95% success rate.

**16.** Which of the following statements would provide the **best** guide for activity during the rehabilitation period for a client who has been treated for retinal detachment?

- 1. Activity is resumed gradually, and the client can resume her usual activities in 5 to 6 weeks.
- 2. Activity level is determined by the client's tolerance; she can be as active as she wishes.
- 3. Activity level will be restricted for several months, so she should plan on being sedentary.
- 4. Activity level can return to normal and may include regular aerobic exercises.

**17.** Which of the following goals is a **priority** for a client who has undergone surgery for retinal detachment?

- 1. Control pain.
- 2. Prevent an increase in intraocular pressure.
- 3. Promote a low-sodium diet.
- 4. Maintain a darkened environment.

### The Client with Glaucoma

**18.** A client with glaucoma is to receive 3 gtt of acetazolamide (Diamox) in the left eye. What should the nurse do?

- 1. Ask the client to close his right eye while administering the drug in the left eye.
- 2. Have the client look up while the nurse administers the eyedrops.
- 3. Have the client lift his eyebrows while the nurse positions the hand with the dropper on the client's forehead.
- 4. Wipe the eyes with a tissue following administration of the drops.

**19.** A client who has been treated for chronic open-angle glaucoma (COAG) for 5 years asks the nurse, "How does glaucoma damage my eyesight?" The nurse's reply should be based on the knowledge that COAG:

- 1. Results from chronic eye inflammation.
- 2. Causes increased intraocular pressure.
- 3. Leads to detachment of the retina.
- 4. Is caused by decreased blood flow to the retina.

**20.** The nurse should assess clients with chronic open-angle glaucoma (COAG) for:

- 1. Eye pain.
- 2. Excessive lacrimation.
- 3. Colored light flashes.
- 4. Decreasing peripheral vision.

**21.** The expected outcome of using miotics to treat glaucoma is:

- 1. Paralyzing ciliary muscles.
- 2. Constricting intraocular vessels.
- 3. Constricting the pupil.
- 4. Relaxing ciliary muscles.

**22.** Which of the following should the nurse provide as part of the information to prepare the client for tonometry?

- 1. Oral pain medication will be given before the procedure.
- 2. It is a painless procedure with no adverse effects.
- 3. Blurred or double vision may occur after the procedure.
- 4. Medication will be given to dilate the pupils before the procedure.

**23.** A client uses timolol maleate (Timoptic) eye-drops. The expected outcome of this beta-adrenergic blocker is to control glaucoma by:

- 1. Constricting the pupils.
- 2. Dilating the canals of Schlemm.
- 3. Reducing aqueous humor formation.
- 4. Improving the ability of the ciliary muscle to contract.

**24.** The nurse observes the client instill eye-drops. The client says, "I just try to hit the middle of my eyeball so the drops don't run out of my eye." The nurse explains to the client that this method may cause:

- 1. Scleral staining.
- 2. Corneal injury.
- 3. Excessive lacrimation.
- 4. Systemic drug absorption.

**25.** Which of the following clinical manifestations should the nurse assess when a client has acute angle-closure glaucoma?

- 1. Gradual loss of central vision.
- 2. Acute light sensitivity.
- 3. Loss of color vision.
- 4. Sudden eye pain.

**26.** A client has been diagnosed with an acute episode of angle-closure glaucoma. The nurse plans the client's nursing care with the understanding that acute angle-closure glaucoma:

- 1. Frequently resolves without treatment.
- 2. Is typically treated with sustained bed rest.
- 3. Is a medical emergency that can rapidly lead to blindness.
- 4. Is most commonly treated with steroid therapy.

### The Client with Adult Macular Degeneration

**27.** The nurse should assess an older adult with macular degeneration for:

- 1. Loss of central vision.
- 2. Loss of peripheral vision.
- 3. Total blindness.
- 4. Blurring of vision.

**28.** A 75-year-old male client has a history of macular degeneration. While he is in the hospital, the **priority** nursing goal will be:

- 1. To provide education regarding community services for clients with adult macular degeneration (AMD).
- 2. To provide health care related to monitoring his eye condition.
- 3. To promote a safe, effective care environment.
- 4. To improve vision.

**29.** Although all of the following measures might be useful in reducing the visual disability of a client with adult macular degeneration (AMD), which measure should the nurse teach the client primarily as a safety precaution?

- 1. Wear a patch over one eye.
- 2. Place personal items on the sighted side.
- 3. Lie in bed with the unaffected side toward the door.
- 4. Turn the head from side to side when walking.

**30.** The nurse is assessing a client with macular degeneration. Identify the illustration that **best** depicts what clients with this disorder typically see.



**31.** When the nurse enters the client's room, the nurse perceives that the client is staring straight ahead. Which of the following is the **best** course of action for the nurse to take next?

- 1. Hold an interdisciplinary meeting on the client's behalf promptly.
- 2. Consult with psychiatry.
- 3. Listen to the client and observe the body language.
- 4. Address the client by first name upon entering the room.

### The Client Undergoing Nasal Surgery

**32.** A 27-year-old female is admitted for elective nasal surgery for a deviated septum. Which of the following would be an important initial clue that bleeding was occurring even if the nasal drip pad remained dry and intact?

- 1. Complaints of nausea.
- 2. Repeated swallowing.
- 3. Rapid respiratory rate.
- 4. Feelings of anxiety.

**33.** The client is ready for discharge after surgery for a deviated septum. Which of the following discharge instructions would be appropriate?

- 1. Avoid activities that elicit Valsalva's maneuver.
- 2. Take aspirin to control nasal discomfort.
- 3. Avoid brushing the teeth until the nasal packing is removed.
- 4. Apply heat to the nasal area to control swelling.

**34.** Which of the following statements would indicate to the nurse that the client who has undergone repair of her nasal septum has understood the discharge instructions?

- 1. "I should not shower until my packing is removed."
- 2. "I will take stool softeners and modify my diet to prevent constipation."
- 3. "Coughing every 2 hours is important to prevent respiratory complications."
- 4. "It is important to blow my nose each day to remove the dried secretions."

### The Client with a Hearing Disorder

**35.** To approach a deaf client, the nurse should do which of the following **first**?

- 1. Knock on the room's door loudly.
- 2. Close and open the vertical blinds rapidly.
- 3. Talk while walking into the room.
- 4. Get the client's attention.

**36.** A 75-year-old client who has been taking furosemide (Lasix) regularly for 4 months tells the nurse that he is having trouble hearing. What would be the nurse's **best** response to this statement?

- 1. Tell the client that because he is 75 years old, it is inevitable that his hearing should begin to deteriorate.
- 2. Have the client immediately report the hearing loss to his physician.
- 3. Schedule the client for audiometric testing and a hearing aid.
- 4. Tell the client that the hearing loss is only temporary; when his system adjusts to the furosemide, his hearing will improve.

**37.** The nurse has been assigned to a client who is hearing impaired and reads speech. Which of the following strategies should the nurse incorporate when communicating with the client? Select all that apply.

- 1. Avoiding being silhouetted against strong light.
- 2. Not blocking out the person's view of the speaker's mouth.
- 3. Facing the client when talking.
- 4. Having bright light behind so the individual can see.
- 5. Ensuring the client is familiar with the subject material before discussing.
- 6. Talking to the client while doing other nursing procedures.

**38.** The client with a hearing aid does not seem to be able to hear the nurse. The nurse should do which of the following?

- 1. Contact the client's audiologist.
- 2. Cleanse the hearing aid ear mold in normal saline.
- 3. Irrigate the ear canal.
- 4. Check the hearing aid's placement.

**39.** Sensorineural hearing loss results from which of the following conditions?

- 1. Presence of fluid and cerumen in the external canal.
- 2. Sclerosis of the bones of the middle ear.
- 3. Damage to the cochlear or vestibulocochlear nerve.
- 4. Emotional disturbance resulting in a functional hearing loss.

**40.** A 65-year-old male has hearing loss and a sensation of fullness in both ears. The nurse examines his ears with the understanding that a common cause of hearing loss in older adults is related to:

- 1. Accumulation of cerumen in the external canal.
- 2. Accumulation of cerumen in the internal canal.
- 3. External otitis.
- 4. Exostosis.

**41.** The **best** method to remove cerumen from a client's ear involves:

- 1. Inserting a cotton-tipped applicator into the external canal.
- 2. Irrigating the ear gently.
- 3. Using aural suction.
- 4. Using a cerumen curette.

**42.** To prepare the irrigation solution used for removal of cerumen, the nurse should use:

- 1. Normal saline.
- 2. Sterile water.
- 3. Antiseptic solution.
- 4. Warm tap water.

**43.** A client is about to have a tympanoplasty, and asks the nurse what the surgical procedure involves. The nurse begins the conversation by:

- 1. Assessing the client's understanding of what the physician has explained.
- 2. Describing the surgical procedure.
- 3. Educating the client that the procedure will close the perforation and prevent recurrent infection.
- 4. Informing the client that the procedure will improve hearing.

**44.** An older adult takes two 81 mg aspirin tablets daily to prevent a heart attack. The client reports having a constant "ringing" in both ears. How should the nurse respond to the client's comment?

- 1. Tell the client that "ringing" in the ears is associated with the aging process.
- 2. Refer the client to have a Weber test.
- 3. Schedule the client for audiometric testing.
- 4. Explain to the client that the "ringing" may be related to the aspirin.

### The Client with Ménière's Disease

**45.** A client has vertigo. Which of the following actions would be **most** appropriate for the nursing diagnosis of *Risk for injury* related to altered immobility and gait disturbances? Select all that apply.

- 1. The client assumes safe position when dizzy.
- 2. The client experiences no falls.
- 3. The client performs vestibular/balance exercises.
- 4. The client demonstrates family involvement.
- 5. The client keeps head still when dizzy.

**46.** The client with Ménière's disease is instructed to modify his diet. The nurse should explain that the **most** frequently recommended diet modification for Ménière's disease is:

- 1. Low sodium.
- 2. High protein.
- 3. Low carbohydrate.
- 4. Low fat.

**47.** Which of the following statements indicates the client understands the expected course of Ménière's disease?

- 1. "The disease process will gradually extend to the eyes."
- 2. "Control of the episodes is usually possible, but a cure is not yet available."
- 3. "Continued medication therapy will cure the disease."
- 4. "Bilateral deafness is an inevitable outcome of the disease."

**48.** The risk for injury during an attack of Ménière's disease is high. The nurse should instruct the client to take which immediate action when experiencing vertigo?

- 1. "Place your head between your knees."
- 2. "Concentrate on rhythmic deep breathing."
- 3. "Close your eyes tightly."
- 4. "Assume a reclining or flat position."

**49.** The nurse should assess the client with Ménière's disease for the intended outcomes of which of the following medications that are commonly used to manage the disease? Select all that apply.

- 1. Antihistamines.
- 2. Antiemetics.
- 3. Diuretics.
- 4. Non-steroidal anti-inflammatory drugs (NSAIDs).
- 5. Antipyretics.

**50.** A client with Ménière's disease continues to have disabling attacks of vertigo and elects to have a labyrinthectomy. A **priority** nursing diagnosis for the client before surgery is:

- 1. *Deficient diversional activity* related to inability to participate secondary to vertigo.
- 2. *Risk for injury* related to vertigo.
- 3. *Powerlessness* related to inability to influence effects of disease process
- 4. *Social isolation* related to hearing loss.

### The Client with Cancer of the Larynx

**51.** Following a laryngectomy, the nurse notices that the client has saliva collecting beneath the skin flaps. This finding is indicative of which of the following?

- 1. Skin necrosis.
- 2. Carotid artery rupture.
- 3. Stomal stenosis.
- 4. Development of a fistula.

**52.** The nurse is developing a care plan with a client who had a laryngectomy 3 days ago. The nurse should instruct the client to do which of the following to assure adequate nutrition. Select all that apply.

- 1. Weigh weekly and report weight loss.
- 2. When eating, sit and lean slightly forward.
- 3. Have serum albumin level checked regularly.
- 4. Administer enteral tube feedings as ordered.
- 5. Manipulate the nasogastric tube daily.

**53.** The client with a laryngectomy is being discharged. The nurse should determine that the client understands to do which of the following self-care measures? Select all that apply.

- 1. Provide humidification in the home.
- 2. Use a protective shield over the stoma for bathing.
- 3. Consume a liberal intake of fluids (2 to 3 L/day).
- 4. Limit spicy seasonings on food.
- 5. Follow a low-fiber diet.

**54.** After a total laryngectomy, the client has a feeding tube. The feeding tube is effective if the tube feedings:

- 1. Meet the fluid and nutritional needs of the client.
- 2. Prevent aspiration.
- 3. Prevent fistula formation.
- 4. Maintain an open airway.

**55.** Complications associated with a tracheostomy tube include:

- 1. Decreased cardiac output.
- 2. Damage to the laryngeal nerve.
- 3. Pneumothorax.
- 4. Acute respiratory distress syndrome (ARDS).

**56.** A **priority** goal for the hospitalized client who 2 days earlier had a total laryngectomy with creation of a new tracheostomy would be to:

- 1. Decrease secretions.
- 2. Instruct the client in caring for the tracheostomy.
- 3. Relieve anxiety related to the tracheostomy.
- 4. Maintain a patent airway.

### Managing Care Quality and Safety

**57.** The client with glaucoma is scheduled for a hip replacement. Which of the following orders would require clarification before the nurse carries it out?

- 1. Administer morphine sulfate.
- 2. Administer atropine sulfate.
- 3. Teach deep-breathing exercises.
- 4. Teach leg lifts and muscle-setting exercises.



**58.** To ensure safety for a hospitalized blind client, the nurse should:

- 1. Require that the client has a sitter for each shift.
- 2. Require that the client stays in bed until the nurse can assist.
- 3. Orient the client to the room environment.
- 4. Keep the side rails up when the client is alone.


**59.** The nurse is taking care of a client who had a laryngectomy yesterday. To assure client safety, the nurse should give “hand-off reports” at which of the following times? Select all that apply.

- 1. Change of shift.
- 2. Change of nurses.
- 3. When nurse goes to lunch.
- 4. When unit clerk goes to a staff meeting.
- 5. When new medication orders are written.

**60.** The nurse is admitting a client with glaucoma. The client brings prescribed eye drops from home and insists on using them in the hospital. The nurse should:

- 1. Allow the client to keep the eye drops at the bedside and use as prescribed on the bottle.
- 2. Place the eye drops in the hospital medication drawer and administer as labeled on the bottle.
- 3. Explain to the client that the physician will write an order for the eye drops to be used at the hospital.
- 4. Ask the client’s wife to assist the client in administering the eye drops while the client is in the hospital.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Cataracts

**1. 3.** The student has positioned the dropper and the client correctly to prevent injury to the client’s eye. The student should administer the drops in the center of the lower lid. Following administration of the eyedrops, the client should blink her eyes

to distribute the medication; squeezing or rubbing her eyes might cause the medication to drip out of the eye.

 CN: Safety and infection control;  
CL: Apply


**2. 1, 2, 4.** The use of glasses following cataract surgery does not totally restore binocular vision. Glasses will cause images to appear larger and peripheral vision will be distorted; the client should look through the center of the glasses and turn his or her head to view objects in the periphery. The client should also use caution when walking or climbing stairs until he or she has adjusted to the change in vision. Changes in vision following cataract surgery are not immediate and the nurse can instruct the client to be patient while adjusting to the changes. The client does not need to stay out of the sun, but should wear dark glasses to prevent discomfort from photophobia.

 CN: Physiological adaptation;  
CL: Create

**3. 3.** Using an eye shield at night prevents rubbing the eye. The head should be turned to the side to scan the entire visual field to compensate for impaired peripheral vision. Eye medications may initially cause sensitivity to bright light. The surgeon changes the eye patch on the second postoperative day.


 CN: Reduction of risk potential;  
CL: Synthesize

**4. 2.** The nurse should give a client who seems fearful of surgery an opportunity to express her feelings. Only after identifying the client’s concerns can the nurse intervene appropriately. Asking the client about previous reactions to local anesthetics may be warranted, but it does not address the client’s concerns in this instance. Telling the client that she will not have nausea or vomiting ignores the client’s feelings of fear and does not provide any data about the client’s feelings. More data would help the nurse plan care. Telling the client that there is nothing to be afraid of minimizes her feelings and does not address her concerns. Premature explanations and clichés do not provide needed assessment data and ignore the client’s feelings.


 CN: Psychosocial adaptation;  
CL: Synthesize

**5. 4.** An ophthalmologist is a physician who specializes in the treatment of disorders of the eye, and the nurse should advise the client to see a physician. An optician makes glasses and it is not known at this point what the best treatment for the client is. Magnifying glasses, or glasses with tinted lenses, do not correct hazy or blurred vision. If


glasses are needed to correct refractive errors, they should be prescription glasses.

 CN: Health promotion and maintenance;  
CL: Synthesize

**6. 2.** Instilled in the eye, phenylephrine hydrochloride (Neo-Synephrine) acts as a mydriatic, causing the pupil to dilate. It also constricts small blood vessels in the eye.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**7. 4.** A prescribed antiemetic should be administered as soon as the client complains of nausea following a cataract extraction. Vomiting can increase intraocular pressure, which should be avoided after eye surgery because it can cause complications. Deep breathing is unlikely to relieve nausea. Postoperative nausea may be common; however, it doesn't necessarily pass quickly and can lead to vomiting. Telling the client to call only if vomiting occurs ignores the client's need for comfort and intervention to prevent complications.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**8. 1, 5.** Acute bacterial endophthalmitis can occur in about 1 out of 1,000 cases. Organisms that are typically involved include *Staphylococcus epidermidis*, *S. aureus*, and *Pseudomonas* and *Proteus* species. Vision loss is one result of acute bacterial infection. In addition, vision loss can be the result of malposition of the intraocular lens implant or opacification of the posterior capsule. Retrobulbar hemorrhage is a complication that may occur right before surgery and is a result of retrobulbar infiltration of anesthetic agents. Rupture of the posterior capsule and suprachoroidal hemorrhage are both complications that can result during surgery.


 CN: Physiological adaptation;  
CL: Analyze

**9. 1.** The nurse should instruct the client to remain in a semi-Fowler's position or on the non-operative side. Positioning the feet higher than the body does not affect the operative eye; placing the head in a dependent position could increase pressure within the eyes.


 CN: Reduction of risk potential;  
CL: Synthesize

**10. 1.** Applying pressure against the nose at the inner canthus of the closed eye after administering eyedrops prevents the medication from entering the lacrimal (tear) duct. If the medication enters the tear duct, it can enter the nose and pharynx, where it may be absorbed and cause toxic symptoms. Eyedrops should be placed in the eye's lower


conjunctival sac. Applying pressure will not prevent the drug from running down the face as long as the drops are instilled in the eye. Pressure does not affect the cornea or facilitate distribution of the medication over the eye surface.

 CN: Pharmacological and parenteral therapies; CL: Apply

**11. 2.** Coughing is contraindicated after cataract extraction because it increases intraocular pressure. Other activities that are contraindicated because they increase intraocular pressure include: turning to the operative side, sneezing, crying, and straining. Lying supine, ambulating, and deep breathing do not affect intraocular pressure.


 CN: Physiological adaptation;  
CL: Synthesize

**12. 4.** Sudden, sharp pain after eye surgery should suggest to the nurse that the client may be experiencing intraocular hemorrhage. The physician should be notified promptly. Detached retina and prolapse of the iris are usually painless. Extracapsular erosion is not characterized by sharp pain.


 CN: Physiological adaptation;  
CL: Analyze

## The Client with a Retinal Detachment

**13. 4.** Promoting measures that limit mobility may prevent further injury. Following surgical repair of a detached retina, cool or warm compresses are applied to edematous eyelids, if ordered. The client should avoid lying face down, stooping, or bending pre-operatively. It is not necessary to remove all pillows.


 CN: Physiological adaptation;  
CL: Synthesize

**14. 1.** Patching the eyes helps decrease random eye movements that could enlarge and worsen retinal detachment. Although clients with eye injuries frequently are light-sensitive, and preventing infection is important, the specific goal is to reduce rapid eye movements. Resting the eye is an indirect way of stating the objective.


 CN: Physiological adaptation;  
CL: Evaluate

**15. 4.** Untreated retinal detachment results in increasing detachment and eventual blindness, but 90% to 95% of clients can be successfully treated with surgery. If necessary, the surgical procedure can be repeated about 10 to 14 days after the first procedure. Many more services are available for


newly blind people, but ideally this client will not need them. Surgery does not delay blindness.

 CN: Physiological adaptation;  
CL: Synthesize

**16. 1.** The scarring of the retinal tear needs time to heal completely. Therefore, resumption of activity should be gradual; the client may resume her usual activities in 5 to 6 weeks. Successful healing should allow the client to return to her previous level of functioning.


 CN: Basic care and comfort;  
CL: Synthesize

**17. 2.** After surgery to correct a detached retina, prevention of increased intraocular pressure is the priority goal. Control of pain with analgesics is the second goal. Following a low-sodium diet or maintaining a darkened environment is not a goal for this client.


 CN: Physiological adaptation;  
CL: Synthesize

### The Client with Glaucoma

**18. 2.** The client should look up while the nurse instills the eyedrops. The client will need to keep both eyes open while the nurse administers the drug. If the client raises his eyebrows while the nurse's hand is positioned on the eyebrows, the movement of the forehead may cause the dropper to move and injure the eye. The client should gently blink his eyes after the eyedrops have been instilled. Using a tissue to wipe the eyes could remove some of the medication; excess fluid can be removed with a cotton ball.


 CN: Pharmacological and parenteral therapies; CL: Apply

**19. 2.** In COAG, there is an obstruction to the outflow of aqueous humor, leading to increased intraocular pressure. The increased intraocular pressure eventually causes destruction of the retina's nerve fibers. This nerve destruction causes painless vision loss. The exact cause of glaucoma is unknown. Glaucoma does not lead to retinal detachment.


 CN: Physiological adaptation;  
CL: Analyze

**20. 4.** Although COAG is usually asymptomatic in the early stages, peripheral vision gradually decreases as the disorder progresses. Eye pain is not a feature of COAG but is common in clients with angle-closure glaucoma. Excessive lacrimation is not a symptom of COAG; it may indicate a blocked

tear duct. Flashes of light is a common symptom of retinal detachment.

 CN: Physiological adaptation;  
CL: Analyze


**21. 3.** A miotic agent constricts the pupil and contracts ciliary musculature. These effects widen the filtration angle and permit increased outflow of aqueous humor. Miotics also cause vasodilation of the intraocular vessels, where intraocular fluids leave the eye, also increasing aqueous humor outflow. Mydriatics cause cycloplegia, or paralysis of the ciliary muscle.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**22. 2.** Tonometry, which measures intraocular pressure, is a simple, noninvasive, and painless procedure that requires no particular preparation or postprocedure care and carries no adverse effects. It is not necessary to dilate the pupils for tonometry.

 CN: Reduction of risk potential;  
CL: Synthesize


**23. 3.** Timolol maleate (Timoptic) is commonly administered to control glaucoma. The drug's action is not completely understood, but it is believed to reduce aqueous humor formation, thereby reducing intraocular pressure. Timolol does not constrict the pupils; miotics are used for pupillary constriction and contraction of the ciliary muscle. Timolol does not dilate the canal of Schlemm.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**24. 2.** The cornea is sensitive and can be injured by eyedrops falling onto it. Therefore, eyedrops should be instilled into the lower conjunctival sac of the eye to avoid the risk of corneal damage. The drops do not cause scleral staining or excessive lacrimation. Systemic absorption occurs when eyedrops enter the tear ducts.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**25. 4.** Acute angle-closure glaucoma produces abrupt changes in the angle of the iris. Clinical manifestations include severe eye pain, colored halos around lights, and rapid vision loss. Gradual loss of central vision is associated with macular degeneration. The loss of color vision, or achromatopsia, is a rare symptom that occurs when a stroke damages the fusiform gyrus. It most often affects only half of the visual field.


 CN: Physiological adaptation;  
CL: Analyze

**26. 3.** Acute angle-closure glaucoma is a medical emergency that rapidly leads to blindness if left untreated. Treatment typically involves miotic drugs and surgery, usually iridectomy or laser therapy. Both procedures create a hole in the periphery of the iris, which allows the aqueous humor to flow into the anterior chamber. Bed rest does not affect the progression of acute angle-closure glaucoma. Steroids are not a treatment for acute angle-closure glaucoma; in fact, they are associated with the development of glaucoma.

 CN: Physiological adaptation; CL: Apply

### The Client with Adult Macular Degeneration


**27. 1.** Macular degeneration generally involves loss of central vision. Gradual blurring of vision can occur as the disease progresses and may result in blindness; however, loss of central vision is the most common finding. Tiny yellowish spots, known as drusen, develop beneath the retina. Loss of peripheral vision is characteristic of glaucoma.

 CN: Physiological adaptation;  
CL: Analyze

**28. 3.** AMD generally affects central vision. Confusion may result related to the changes in the environment and the inability to see the environment clearly. Therefore, providing safety is the priority goal in the care of this client. Educating him regarding community resources or monitoring his AMD may have been done at an earlier date or can be done after assessing his knowledge base and experience with the disease process. Improving his vision may not be possible.

 CN: Safety and infection control;  
CL: Synthesize

**29. 4.** To expand the visual field, the partially sighted client should be taught to turn the head from side to side when walking. Neglecting to do so may result in accidents. This technique helps maximize the use of remaining sight. A patch does not address the problem of hemianopsia. Appropriate client positioning and placement of personal items will increase the client's ability to cope with the problem but will not affect safety.

 CN: Safety and infection control;  
CL: Synthesize

**30.** In macular degeneration the center vision is blackened out and only the outer visual fields are clear.

 CN: Physiological adaptation;  
CL: Analyze




**31. 3.** By listening to the client should they speak and by noting body language, the nurse may be better able to ascertain the client's physical and cognitive status. The nurse should not utilize the first name of a client unless a client provides permission to do so. To consult with psychiatry would not be appropriate unless ordered by the primary care physician. An interdisciplinary meeting would not enable the nurse to understand why the client is staring straight ahead. Perhaps the client is only deep in thought.

 CN: Reduction of risk potential;  
CL: Synthesize

### The Client Undergoing Nasal Surgery


**32. 2.** Because of the dense packing, it is relatively unusual for bleeding to be apparent through the nasal drip pad. Instead, the blood runs down the throat, causing the client to swallow frequently. The back of the throat can be assessed with a flashlight. An accumulation of blood in the stomach may cause nausea and vomiting, but is not an initial sign of bleeding. Increased respiratory rate occurs in shock and is not an early sign of bleeding in the client after nasal surgery. Feelings of anxiety are not indicative of nasal bleeding.

 CN: Physiological adaptation;  
CL: Synthesize

**33. 1.** The client should be instructed to avoid any activities that cause Valsalva's maneuver (e.g., straining at stool, vigorous coughing, exercise) to reduce stress on suture lines and bleeding. The client should not take aspirin because of its antiplatelet properties, which may cause bleeding. Oral hygiene is important to rid the mouth of old dried blood and to enhance the client's appetite. Cool compresses, not heat, should be applied to decrease swelling and control discoloration of the area.


 CN: Reduction of risk potential;  
CL: Synthesize

**34. 2.** Constipation can cause straining during defecation, which can induce bleeding. Showering is not contraindicated. The client should take measures to prevent coughing. The client should avoid blowing her nose for 48 hours after the packing is removed. Thereafter, she should blow her nose gently using the open-mouth technique to minimize bleeding in the surgical area.


 CN: Physiological adaptation;  
CL: Evaluate

### The Client with a Hearing Disorder

**35. 4.** The nurse should avoid startling the client who is deaf and should obtain the attention of the client before speaking. The client who is deaf cannot hear knocking on the door or talking. Opening the blinds is not a helpful way to get the client's attention.

 CN: Psychosocial adaptation;  
CL: Synthesize

**36. 2.** Furosemide may cause ototoxicity. The nurse should tell the client to promptly report the hearing loss, dizziness, or tinnitus, to help prevent permanent ear damage. Hearing loss is not inevitable, and it is inappropriate to make assumptions about the cause of symptoms without a thorough evaluation. The client's system will not "adjust," and hearing loss will not resolve.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**37. 1, 2, 3, 5.** When working with a client who is hearing impaired and speech reads, the presenter must face the person directly and devote full attention to the communication process. In addition, it will be useful for the client that the speaker not be too silhouetted against strong light, that the speaker's mouth not be blocked from the client's view, and that there are no objects in the mouth of the speaker. Finally, it is recommended that the presenter provide the client with the needed information to study before reviewing. This will provide

the client with the ability to use contextual clues in speech reading.

 CN: Basic care and comfort;  
CL: Synthesize


**38. 4.** Inadequate amplification can occur when a hearing aid is not placed properly. The certified audiologist is licensed to dispense hearing aids. The ear mold is the only part of the hearing aid that may be washed frequently; it should be washed daily with soap and water. Irrigation of the ear canal is done to remove impacted cerumen or a foreign body.

 CN: Physiological adaptation;  
CL: Synthesize

**39. 3.** A sensorineural hearing loss results from damage to the cochlear or vestibulocochlear nerve. Presence of fluid and cerumen in the external canal or sclerosis of the bones of the middle ear results in a conductive hearing loss. Hearing loss resulting from an emotional disturbance is called a psychogenic hearing loss.

 CN: Physiological adaptation; CL: Apply


**40. 1.** Cerumen (ear wax) commonly gets impacted in older clients in the external canal. Otalgia is the "fullness" sensation or pain that an older client may experience when the cerumen becomes impacted. External otitis is an inflammation of the outer ear and would not explain the symptoms the client is experiencing. Exostosis is a bony growth that arises from the surface of a bone and would not explain the symptoms the client is experiencing.

 CN: Health promotion and maintenance;  
CL: Analyze

**41. 2.** Irrigation is the first strategy to loosen cerumen. Successful removal of the cerumen involves gentle irrigation behind the impacted cerumen. The flow of the water must be behind the impaction to remove the cerumen from the canal. A cotton-tipped applicator or other device is not appropriate because it can cause damage to the eardrum. Use of aural suction or a cerumen curette is appropriate only if the impacted cerumen cannot be removed by irrigation.

 CN: Reduction of risk potential;  
CL: Apply

**42. 1.** Normal saline is the solution that is generally used to irrigate the ear. Sterile water will cause tissue damage. An antiseptic solution is not typically used unless an infection is present. Warm tap water may cause tissue damage.


 CN: Pharmacological and parenteral therapies; CL: Apply

**43. 1.** The nurse should first assess the client's knowledge base. Working within the framework

of the client's knowledge and educational level, the nurse then can describe the procedure and its benefits.

 CN: Reduction of risk potential;  
CL: Synthesize

**44. 4.** Tinnitus (ringing in the ears) is an adverse effect of aspirin. Aspirin contains salicylate, which is an ototoxic drug that can induce reversible hearing loss and tinnitus. The nurse should encourage the client to inform the physician of the symptom. Tinnitus is not a function of aging. The Weber test and audiometric testing are useful for determining hearing loss but are not necessarily helpful in the management or diagnosis of drug-induced tinnitus.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

### The Client with Ménière's Disease


**45. 1, 2, 3, 5.** Assessment of vertigo, including history, onset, description of attacks, duration, frequency, and associated ear symptoms, is important. Vestibular/balance therapy or exercises should be taught and practiced. The client needs to be instructed to sit down when dizzy and decrease the amount of head movement. The client will benefit from recognizing whether he or she experiences an "aura" before an attack so appropriate action can be taken. Finally, it is recommended that the client keep the eyes open and look straight ahead when lying down. These expected outcomes will prevent the problem of injury. Family involvement is essential when dealing with a client experiencing vertigo but is not applicable for this particular nursing diagnosis.

 CN: Reduction of risk potential;  
CL: Synthesize


**46. 1.** A low-sodium diet is frequently an effective mechanism for reducing the frequency and severity of the disease episodes. About three-quarters of clients with Ménière's disease respond to treatment with a low-salt diet. A diuretic may also be ordered. Other dietary changes, such as high protein, low carbohydrate, and low fat, do not have an effect on Ménière's disease.

 CN: Basic care and comfort; CL: Apply

**47. 2.** There is no cure for Ménière's disease, but the wide range of medical and surgical treatments allows for adequate control in many clients. The disease often worsens, but it does not spread to the eyes. The hearing loss is usually unilateral.

 CN: Physiological adaptation;  
CL: Evaluate


**48. 4.** The client needs to assume a safe and comfortable position during an attack, which may last several hours. The client's location when the attack occurs may dictate the most reasonable position. Ideally, the client should lie down immediately in a reclining or flat position to control the vertigo. The danger of a serious fall is real. Placing the head between the knees will not help prevent a fall and is not practical because the attack may last several hours. Concentrating on breathing may be a useful distraction, but it will not help prevent a fall. Closing the eyes does not help prevent a fall.

 CN: Safety and infection control;  
CL: Synthesize

**49. 1, 2, 3.** Since the symptoms of Ménière's disease are associated with a change in the fluid volume of the inner ear, a wide variety of medications may be used in an attempt to control the signs/symptoms of Ménière's disease, including antihistamines, antiemetics, tranquilizers, and diuretics. NSAIDs and antipyretics play no significant role in Ménière's disease management.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**50. 2.** The client's *Risk for injury* related to vertigo is the highest priority nursing diagnosis preoperatively. The client should be instructed how to manage attacks of vertigo safely. *Deficient diversional activity* related to inability to participate secondary to vertigo is an appropriate nursing diagnosis, but it is not a priority. *Powerlessness* related to inability to influence effects of the disease process is a possible diagnosis, but more data are required before making such a diagnosis. *Social isolation* related to hearing loss is a possible diagnosis for the client after surgery. The client retains the ability to hear with Ménière's disease; however, total hearing loss is a possible complication of labyrinthectomy.

 CN: Physiological adaptation;  
CL: Analyze

### The Client with Cancer of the Larynx

**51. 4.** A salivary fistula is suspected when there is saliva collecting beneath skin flaps or leaking through the suture line or drain site. Salivary fistula or skin necrosis usually precedes carotid artery rupture. Stomal stenosis may be present when there is suprasternal and intercostal retractions and difficult breathing.

 CN: Physiological adaptation;  
CL: Analyze

**52. 1, 2, 3, 4.** The nurse should monitor nutritional status through frequent weighing and checking the serum albumin level. The nurse also should administer enteral tube feedings until there is sufficient healing of pharynx, and the client can consume sufficient oral feedings to meet body needs. The nurse should avoid manipulation of the nasogastric tube during this time so it does not disrupt the suture line. The nurse should place the client in sitting position, leaning slightly forward, which allows the larynx to move forward and the hypopharynx to partially open; the epiglottis normally prevents fluid and food from entering the larynx during swallowing.

 CN: Physiological adaptation; CL: Create


**53. 1, 2, 3.** The nurse should advise the client to provide humidification at home. Instruct the client to use a protective shield for bathing, showering, or shampooing or cutting hair to prevent aspiration. The nurse can also encourage the client to obtain a fluid intake of 2 to 3 L daily to help liquefy secretions. To counteract any loss of smell and impairment of taste sensation, the client can add additional seasoning to food. The client should follow a high-fiber diet and use stool softeners because the client may not be able to hold the breath and bear down for bowel movements.

 CN: Health promotion and maintenance; CL: Evaluate

**54. 1.** The goal of postoperative care is to maintain physiologic integrity. Therefore, inserting a feeding tube is a strategy to ensure the fluid and nutritional needs of the client as the surgical site is healing. The feeding tube does help prevent aspiration by preventing ingested fluid from leaking through the wound into the trachea before healing occurs; however, the primary rationale is to meet the client's nutritional and fluid needs. A tracheoesophageal fistula is a rare complication of total laryngectomy and may occur if radiation therapy has compromised wound healing. A feeding tube does not help maintain an open airway.


 CN: Reduction of risk potential; CL: Evaluate

**55. 2.** Tracheostomy tubes carry several potential complications, including laryngeal nerve damage, bleeding, and infection. Tracheostomy tubes alone do not affect cardiac output or cause acute respiratory distress. The tube is inserted in the trachea, not the lung, so there is no risk of pneumothorax.

 CN: Physiological adaptation; CL: Apply


**56. 4.** The main goal for a client with a new tracheostomy is to maintain a patent airway. A fresh tracheostomy frequently causes bleeding and excess

secretions, and clients may require frequent suctioning to maintain patency. Decreasing secretions may be a component of a client's care after laryngectomy and tracheostomy, and relieving anxiety is always an important goal; however, the primary goal is to maintain a patent airway. Instruction in care of a tracheostomy is a priority later in the client's recovery.

 CN: Physiological adaptation; CL: Synthesize

## Managing Care Quality and Safety

**57. 2.** Atropine sulfate causes pupil dilation. This action is contraindicated for the client with glaucoma because it increases intraocular pressure. The drug does not have this effect on intraocular pressure in people who do not have glaucoma. Morphine causes pupil constriction. Deep-breathing exercises will not affect glaucoma. The client should resume taking all medications for glaucoma immediately after surgery.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**58. 3.** The priority goal of care for a client who is blind is safety and preventing injury. The initial action is to orient the client to a new environment. Taking time to identify the objects and where they are located in the room can achieve this goal. It is unrealistic to have someone stay with the client at all times or for the client to stay in bed until the nurse can assist. Using side rails creates unnecessary barriers and may be a safety hazard.

 CN: Safety and infection control; CL: Synthesize

**59. 1, 2, 3.** Effective communication is essential when managing client safety and preventing errors. "Handoff reports" should be made at shift change, when there is a change of nurses or when the nurse leaves the unit, and when the client is discharged or transfers to another unit. There does not need to be a handoff report when the unit clerk leaves the unit or when new medication orders are written.

 CN: Safety and infection control; CL: Apply

**60. 3.** In order to prevent medication errors, clients may not use medications they bring from home; the physician will order the eye drops as required. It is not safe to place the eye drops in the client's medication box or to permit the client to use them at the bedside. The nurse should ask the wife to take the eye drops home.

 CN: Safety and infection control; CL: Synthesize

**TEST  
16**

# The Client with Health Problems of the Integumentary System

- The Client with Burns
- The Client with General Problems of the Integumentary System
- The Client with a Pressure Ulcer
- The Client with Skin Cancer
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Burns

**1.** There has been a fire in an apartment building. All residents have been evacuated, but many are burned. Which clients should be transported to a burn center for treatment? Select all that apply.

- 1. An 8-year-old with third-degree burns over 10% of his body surface area (BSA).
- 2. A 20-year-old who inhaled the smoke of the fire.
- 3. A 50-year-old diabetic with first- and second-degree burns on his left forearm (about 5% of his BSA).
- 4. A 30-year-old with second-degree burns on the back of his left leg.
- 5. A 40-year-old with second-degree burns on his right arm (about 10% of his BSA).

**2.** The nurse in the immediate care clinic is assessing an 80-year-old client who lives with his son's family and has scald burns on his hands and both forearms (first- and second-degree burns on 10% of his body surface area). What should the nurse do **first**?

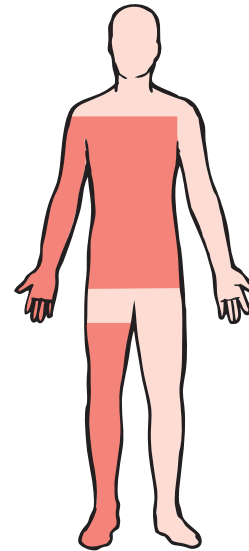
- 1. Clean the wounds with warm water.
- 2. Apply antibiotic cream.
- 3. Refer the client to a burn center.
- 4. Cover the burns with a sterile dressing.

**3.** During the emergent (resuscitative) phase of burn injury, which of the following indicates that the client is requiring additional volume with fluid resuscitation?

- 1. Serum creatinine level of 2.5 mg/dL.
- 2. Little fluctuation in daily weight.
- 3. Hourly urine output of 60 mL.
- 4. Serum albumin level of 3.8.

**4.** A client is admitted to the hospital after sustaining burns to the chest, abdomen, right arm, and right leg. The shaded areas in the illustration indicate the burned areas on the client's body. Using the "rule of nines," the nurse would determine that about what percentage of the client's body surface has been burned?

- 1. 18%.
- 2. 27%.
- 3. 45%.
- 4. 64%.



**5.** A **priority** nursing diagnosis for a client with burns during the emergent period would be:

- 1. *Excess fluid volume.*
- 2. *Imbalanced nutrition: Less than body requirements.*
- 3. *Risk for injury (falling).*
- 4. *Risk for infection.*



**6.** Which of the following activities should the nurse include in the plan of care for a client with burn injuries to be carried out about one-half hour **before** the daily whirlpool bath and dressing change?

- 1. Soak the dressing.
- 2. Remove the dressing.
- 3. Administer an analgesic.
- 4. Slit the dressing with blunt scissors.

**7.** The client with a major burn injury receives total parenteral nutrition (TPN). The expected outcome is to:

- 1. Correct water and electrolyte imbalances.
- 2. Allow the gastrointestinal tract to rest.
- 3. Provide supplemental vitamins and minerals.
- 4. Ensure adequate caloric and protein intake.

**8.** An advantage of using biologic burn grafts such as porcine (pigskin) grafts is that they appear to help:

- 1. Encourage formation of tough skin.
- 2. Promote the growth of epithelial tissue.
- 3. Provide for permanent wound closure.
- 4. Facilitate development of subcutaneous tissue.

**9.** Which of the following factors would have the **least** influence on the survival and effectiveness of a burn victim's porcine grafts?

- 1. Absence of infection in the wounds.
- 2. Adequate vascularization in the grafted area.
- 3. Immobilization of the area being grafted.
- 4. Use of analgesics as necessary for pain relief.

**10.** The nurse should plan to begin rehabilitation efforts for the burn client:

- 1. Immediately after the burn has occurred.
- 2. After the client's circulatory status has been stabilized.
- 3. After grafting of the burn wounds has occurred.
- 4. After the client's pain has been eliminated.

**11.** During the early phase of burn care the nurse should assess the client for?

- 1. Hypernatremia.
- 2. Hyponatremia.
- 3. Metabolic alkalosis.
- 4. Hyperkalemia.

**12.** Which of the following clients with burns will **most** likely require an endotracheal or tracheostomy tube? A client who has:

- 1. Electrical burns of the hands and arms causing arrhythmias.
- 2. Thermal burns to the head, face, and airway resulting in hypoxia.
- 3. Chemical burns on the chest and abdomen.
- 4. Secondhand smoke inhalation.

**13.** A client is receiving fluid replacement with Lactated Ringer's after 40% of his body was burned 10 hours ago. The assessment reveals: temperature 36.2° C; heart rate 122; blood pressure 84/42; CVP 2 mm Hg; and urine output 25 mL for the last 2 hours. The I.V. rate is currently at 375 mL/hour. Using the SBAR (Situation-Background-Assessment-Recommendation) technique for communication, the nurse calls the healthcare provider with the recommendation for:

- 1. Furosemide (Lasix).
- 2. Fresh frozen plasma.
- 3. I.V. rate increase.
- 4. Dextrose 5%.

**14.** After the initial phase of the burn injury, the client's plan of care will focus **primarily** on:

- 1. Helping the client maintain a positive self-concept.
- 2. Promoting hygiene.
- 3. Preventing infection.
- 4. Educating the client regarding care of the skin grafts.

**15.** The rate at which I.V. fluids are infused is based on the burn client's:

- 1. Lean muscle mass and body surface area (BSA) burned.
- 2. Total body weight and BSA burned.
- 3. Total BSA and BSA burned.
- 4. Height and weight and BSA burned.

**16.** The nurse is conducting a focused assess of the gastrointestinal system of a client with a burn injury. The nurse should assess the client for:

- 1. Paralytic ileus.
- 2. Gastric distention.
- 3. Hiatal hernia.
- 4. Curling's ulcer.

**17.** In the acute phase of burn injury, which pain medication would **most** likely be given to the client to decrease the perception of the pain?

- 1. Oral analgesics such as ibuprofen (Motrin) or acetaminophen (Tylenol).
- 2. Intravenous opioids.
- 3. Intramuscular opioids.
- 4. Oral antianxiety agents such as lorazepam (Ativan).

**18.** Using the Parkland Formula, calculate the hourly rate of fluid replacement with Lactated Ringer's solution during the first 8 hours for a client weighing 75 kg with total body surface area (TBSA) burn of 40%.

\_\_\_\_\_ mL/hour.

### The Client with General Problems of the Integumentary System

**19.** The nurse is assessing an older adult's skin. The assessment will involve inspecting the skin for color, pigmentation, and vascularity. The critical component in the nurse's assessment is noting the:

- 1. Similarities from one side to the other.
- 2. Changes from the normal expected findings.
- 3. Appearance of age-related wrinkles.
- 4. Skin turgor.

**20.** Which of the following changes are associated with normal aging?

- 1. The outer layer of skin is replaced with new cells every 3 days.
- 2. Subcutaneous fat and extracellular water decrease.
- 3. The dermis becomes highly vascular and assists in the regulation of body temperature.
- 4. Collagen becomes elastic and strong.

**21.** Which of the following should the nurse expect to assess as normal skin changes in an elderly client? Select all that apply.

- 1. Diminished hair on scalp and pubic areas.
- 2. Dusky rubor of left lower extremity.
- 3. Solar lentigo.
- 4. Wrinkles.
- 5. Xerosis.
- 6. Yellow pigmentation.

**22.** The nurse will anticipate which of the following problems that can result for the older adult undergoing abdominal surgery?

- 1. Increased scarring.
- 2. Decreased melanin and melanocytes.
- 3. Decreased healing.
- 4. Increased immunocompetence.

**23.** Health maintenance and promotion activities are especially important for the older adult. Which of the following activities reflects a health maintenance activity for an otherwise healthy older adult?

- 1. Drinks 1,500 mL of fluids per day.
- 2. Consumes a balanced diet of 1,200 calories per day.
- 3. Walks briskly for 10 minutes three times per week.
- 4. Sleeps at least 8 hours each night.

**24.** Which of the following characteristics would put a client at the **greatest** risk for impaired wound healing after abdominal surgery?

- 1. Age 75 years.
- 2. Age 30 years, with poorly controlled diabetes.
- 3. Age 55 years, with myocardial infarction.
- 4. Age 60 years, with peripheral vascular disease.

**25.** An 82-year-old female has several ecchymotic areas on her left arm. The nurse should further assess the client for:

- 1. Elder abuse.
- 2. Self-inflicted injury.
- 3. Increased capillary fragility and permeability.
- 4. Increased blood supply to the skin.

**26.** A 90-year-old male complains of feeling cold in his room even though the thermostat is set at 75° F (24° C). The client probably feels cold because older adults have:

- 1. Increased cellular cohesion.
- 2. Increased moisture content of the stratum corneum.
- 3. Slower cellular renewal time.
- 4. Decreased ability to thermoregulate.

**27.** Palpation of the skin provides the nurse useful information regarding:

- 1. Bruising of the skin.
- 2. Color of the skin.
- 3. Hair distribution.
- 4. Turgor of the skin.

**28.** A **priority** nursing diagnosis for an adult female who has pruritus and is continuously scratching the affected areas and demonstrates agitation and anxiety regarding the itching sensation would be:

- 1. *Risk for infection* related to pruritus.
- 2. *Ineffective health maintenance* related to lack of knowledge of the disease process.
- 3. *Impaired skin integrity* related to dehydration from the treatment medications.
- 4. *Social isolation* related to poor self-image.

**29.** The nurse is applying a hand mitt restraint for a client with pruritis (see figure). The nurse should **first**:

- 1. Verify the physician order to use the restraint.
- 2. Secure the mitt with ties around the wrist tied to the bed frame.
- 3. Place a folded pillow under the wrist.
- 4. Place the mitt on top of the hand.



**30.** An older adult client in stage 2 of Parkinson's disease is being discharged with cellulitis of the right lower extremity. Which of the following nursing diagnoses will guide the discharge teaching? Select all that apply.

- 1. *Ineffective tissue perfusion* related to decreased cardiac output.
- 2. *Impaired skin integrity* related to barrier changes of the skin.
- 3. *Risk for injury* related to environmental hazards.
- 4. *Impaired verbal communication* related to dysarthria.
- 5. *Activity intolerance* related to painful lower extremity.

**31.** An alert and oriented elderly client is admitted to the hospital for treatment of cellulitis of the left shoulder after an arthroscopy. Which fall prevention strategy is **most** appropriate for this client?

- 1. Keep all the lights on in the room at all times.
- 2. Use a nightlight in the bathroom.
- 3. Keep all four side rails up at all times.
- 4. Place the client in a room with a camera monitor.

**32.** Prevention of skin breakdown and maintenance of skin integrity among older clients is important because they are at greater risk secondary to:

- 1. Altered balance.
- 2. Altered protective pressure sensation.
- 3. Impaired hearing ability.
- 4. Impaired visual acuity.

### The Client with a Pressure Ulcer

**33.** The nurse is assessing a client with dark skin for presence of a Stage I pressure ulcer. The nurse should:

- 1. Use a fluorescent light source to assess the skin.
- 2. Inspect the skin only when the Braden score is above 12.
- 3. Look for skin color that is darker than the surrounding tissue.
- 4. Avoid touching the skin during inspection.

**34.** The nurse is assessing a hospitalized older client for the presence of pressure ulcers. The nurse notes that the client has a 1" × 1" area on his sacrum in which there is skin breakdown as far as the dermis. What should the nurse note on the chart?

- 1. Stage I pressure ulcer.
- 2. Stage II pressure ulcer.
- 3. Stage III pressure ulcer.
- 4. Stage IV pressure ulcer.

**35.** A Stage II pressure ulcer is characterized by:

- 1. Redness in the involved area.
- 2. Muscle spasms in the involved area.
- 3. Pain in the involved area.
- 4. Tissue necrosis in the involved area.

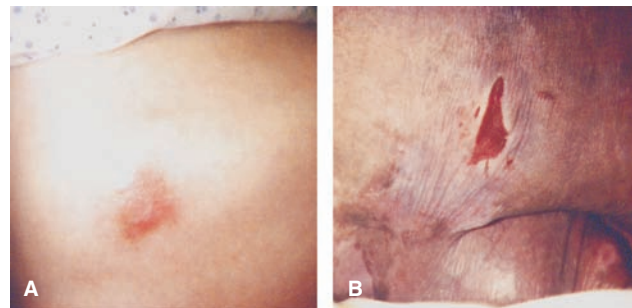
**36.** The nurse is planning care for an 80-year-old client with a pressure ulcer (see figure). The nurse should do which of the following? Select all that apply.

- 1. Elevate the head of the bed to 50 degrees.
- 2. Obtain daily cultures
- 3. Cover with protective dressing
- 4. Reposition the client every 2 hours
- 5. Request an alternating-pressure mattress



**37.** The nurse is using home telehealth monitoring to manage care for an 80-year-old who is home bound. The client spends most of the day in bed. Two months ago, the nurse detected sacral redness from friction and shearing force of being in bed. Last month, the client had increased sacral redness and the area was classified as a Stage I pressure ulcer. On this visit, the nurse is assessing the sacral area using a video camera. The nurse compares the site from a visit made 1 month ago (see figure part A) to the assessment made at this visit (see figure part B). Upon comparing the change of the pressure ulcer from this visit to the previous visit, the nurse should do which of the following **first**?

- 1. Instruct the home health aid to reposition the client every 2 hours while the client is awake.
- 2. Ask the client's daughter to purchase a foam mattress.
- 3. Contact the physician to request a hydrocolloid dressing.
- 4. Suggest that the client ask a neighbor to purchase antibiotic cream at the drugstore.



## The Client with Skin Cancer

**38.** Which of the following factors places a client at **greatest** risk for skin cancer?

- 1. Fair skin and history of chronic sun exposure.
- 2. Caucasian race and history of hypertension.
- 3. Dark skin and family history of skin cancer.
- 4. Dark skin and history of hypertension.

**39.** A nurse is providing teaching to a client about skin cancer. Which of the following should the nurse explain are risk factors for skin cancer? Select all that apply.

- 1. Increasing age.
- 2. Exposure to chemical pollutants.
- 3. Long-term exposure to the sun.
- 4. Increased pigmentation.
- 5. Genetics.
- 6. Immunosuppression.

**40.** The nurse is developing a program on skin cancer prevention for a community group. Which of the following should be included in the program? Select all that apply.

- 1. Purchase sunscreen containing benzophenones to block UVA and UVB rays.
- 2. Use sunscreen with a minimum of 15 sun protection factor (SPF).
- 3. Obtain genetic screening to identify risk of melanoma.
- 4. Apply sunscreen only on sunny days, especially between 10 AM and 2 PM.
- 5. Have a pigmented lesion biopsied by shaving if it looks suspicious.
- 6. Rub baby oil to lubricate skin before going out in the sun.

**41.** A client with malignant melanoma asks the nurse about the prognosis. The nurse should base a response that informs the client that the prognosis depends on:

- 1. The amount of ulceration of the lesion.
- 2. The age of the client.
- 3. The location of the lesion on the body.
- 4. The thickness of the lesion.

## Managing Care Quality and Safety

**42.** The nurse finds an unlicensed assistive personnel massaging the reddened bony prominences of a client on bed rest. The nurse should:

- 1. Reinforce the aide's use of this intervention over the bony prominences.
- 2. Explain that massage is effective because it improves blood flow to the area.
- 3. Inform the aide that massage is even more effective when combined with lotion during the massage.
- 4. Instruct the aide that massage is contraindicated because it decreases blood flow to the area.

**43.** The nurse manager on the orthopedic unit is reviewing a report that indicates that in the last month five clients were diagnosed with pressure ulcers. The nurse manager should:

- 1. Use benchmarking procedures to compare the findings with other nursing units in the hospital.
- 2. Ask the staff education department to conduct an educational session about preventing pressure ulcers.
- 3. Institute a quality improvement plan that identifies contributing factors, proposes solutions, and sets improvement outcomes.
- 4. Conduct a chart audit to determine which nurses on which shifts were giving nursing care to the clients with pressure ulcers.

**44.** A client has been admitted with draining foot lesions. The nurse should do which of the following? Select all that apply.

- 1. Place the client in a room with negative air pressure.
- 2. Admit the client to a semi-private room.
- 3. Admit the client to a private room.
- 4. Post a "contact isolation" sign on the door.
- 5. Wear a protective gown when in the client's room.
- 6. Wear latex-free gloves when providing direct care.

**45.** The nurse is to administer an antibiotic to a client with burns now, but there is no medication in the client's medication box. What should the nurse do **first**?

- 1. Inform the unit's shift coordinator.
- 2. Contact the client's physician.
- 3. Call the pharmacy department.
- 4. Borrow the medication from another client.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Burns

**1. 1, 2, 3.** Clients who should be transferred to a burn center include children under age 10 or adults over age 50 with second- and third-degree burns on 10% or greater of their body surface area (BSA), clients between ages 11 and 49 with second- and third-degree burns over 20% of their BSA, clients of any age with third-degree burns on more than 5% of their BSA, clients with smoke inhalation, and clients with chronic diseases, such as diabetes and heart or kidney disease.

🔑 CN: Management of care; CL: Analyze

**2. 3.** The nurse should have the client transported to a burn center. The client's age and the extent of the burns require care by a burn team and the client meets triage criteria for referral to a burn center. Because of the age of the client and the extent of the burns, the nurse should not treat the burn. Scald burns are not at high risk for infection and do not need to be cleaned, covered, or treated with antibiotic cream at this time.

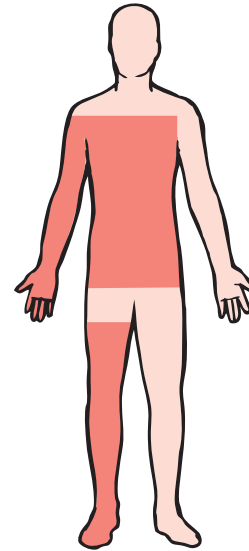
🔑 CN: Physiological adaptation;  
CL: Synthesize

**3. 1.** Fluid shifting into the interstitial space causes intravascular volume depletion and decreased perfusion to the kidneys. This would result in an increase in serum creatinine. Urine output should be frequently monitored and adequately maintained with intravenous fluid resuscitation that would be increased when a drop in urine output occurs. Urine output should be at least 30 mL/hour. Fluid replacement is based on the Parkland or Brooke formula and also the client's response by monitoring urine output, vital signs, and CVP readings. Daily weight is important to monitor for fluid status. Little fluctuation in weight suggests that there is no fluid retention and the intake is equal to output. Exudative loss of albumin occurs in burns causing a decrease in colloid osmotic pressure. The normal serum albumin is 3.5 to 5 gm/dL.

🔑 CN: Physiological adaptation;  
CL: Analyze

**4. 3.** According to the rule of nines, this client has sustained burns on about 45% of the body surface. The right arm is calculated as being 9%, the right leg is 18%, and the anterior trunk is 18%, for a total of 45%.

🔑 CN: Physiological adaptation; CL: Apply



**5. 4.** Infection is a priority problem for the burned victim because of the loss of skin integrity and alteration in body defenses. Excess fluid or imbalanced nutrition is not a priority during the emergent period. A risk for falling is not a priority for this client because the client would be on bed rest and most likely in a critical care unit.


🔑 CN: Physiological adaptation;  
CL: Analyze

**6. 3.** Removing dressings from severe burns exposes sensitive nerve endings to the air, which is painful. The client should be given a prescribed analgesic about one-half hour before the dressing change to promote comfort. The other activities are done as part of the whirlpool and dressing change process and not one-half hour beforehand.


🔑 CN: Reduction of risk potential;  
CL: Synthesize

**7. 4.** Nutritional support with sufficient calories and protein is extremely important for a client with severe burns because of the loss of plasma protein through injured capillaries and an increased metabolic rate. Gastric dilation and paralytic ileus commonly occur in clients with severe burns, making oral fluids and foods contraindicated. Water and electrolyte imbalances can be corrected by administration of I.V. fluids with electrolyte additives, although TPN typically includes all necessary electrolytes. Resting the gastrointestinal tract may help prevent paralytic ileus, and TPN provides vita-


mins and minerals; however, the primary reason for starting TPN is to provide the protein necessary for tissue healing.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**8. 2.** Biologic dressings such as porcine grafts serve many purposes for a client with severe burns. They enhance the growth of epithelial tissues, minimize the overgrowth of granulation tissue, prevent loss of water and protein, decrease pain, increase mobility, and help prevent infection. They do not encourage growth of tougher skin, provide for permanent wound closure, or facilitate growth of subcutaneous tissue.

 CN: Physiological adaptation; CL: Apply

**9. 4.** Analgesic administration to keep a burn victim comfortable is important but is unlikely to influence graft survival and effectiveness. Absence of infection, adequate vascularization, and immobilization of the grafted area promote an effective graft.

 CN: Physiological adaptation; CL: Evaluate

**10. 2.** Rehabilitation efforts are implemented as soon as the client's condition is stabilized. Early emphasis on rehabilitation is important to decrease complications and to help ensure that the client will be able to make the adjustments necessary to return to an optimal state of health and independence. It is not possible to completely eliminate the client's pain; pain control is a major challenge in burn care.


 CN: Basic care and comfort; CL: Synthesize

**11. 4.** Immediately after a burn, excessive potassium from cell destruction is released into the extracellular fluid. Hyponatremia is a common electrolyte imbalance in the burn client that occurs within the first week after being burned. Metabolic acidosis usually occurs as a result of the loss of sodium bicarbonate.

 CN: Reduction of risk potential; CL: Analyze

**12. 2.** Airway management is the priority in caring for a burn client. Tracheostomy or endotracheal intubation is anticipated when significant thermal and smoke inhalation burns occur. Clients who have experienced burns to the face and neck usually will be compromised within 1 to 2 hours. Electrical burns of the hands and arms, even with cardiac arrhythmias, or a chemical burn of the chest and abdomen is not likely to result in the need for intubation. Secondhand smoke inhalation does influence an individual's respiratory status but does


not require intubation unless the individual has an allergic reaction to the smoke.

 CN: Physiological adaptation; CL: Analyze

**13. 3.** The decreased urine output, low blood pressure, low CVP, and high heart rate indicate hypovolemia and the need to increase fluid volume replacement. Furosemide is a diuretic that should not be given due to the existing fluid volume deficit. Fresh frozen plasma is not indicated. It is given for clients with deficient clotting factors who are bleeding. Fluid replacement used for burns is Lactated Ringer's solution, Normal Saline, or albumin.

 CN: Management of care; CL: Synthesize


**14. 3.** The inflammatory response begins when a burn is sustained. As a result of the burn, the immune system becomes impaired. There is a decrease in immunoglobulins, changes in white blood cells, alterations of lymphocytes, and decreased levels of interleukin. The human body's protective barrier, the skin, has been damaged. As a result, the burn client becomes vulnerable to infections. Education and interventions to maintain a positive self-concept would be appropriate during the rehabilitation phase. Promoting hygiene helps the client feel comfortable; however, the primary focus is on reducing the risk for infection.

 CN: Safety and infection control; CL: Synthesize

**15. 2.** During the first 24 hours, fluid replacement for an adult burn client is based on total body weight and BSA burned. Lean muscle mass considers only muscle mass; replacement is based on total body weight. Total surface area is estimated by taking into account the individual's height and weight. Height is not a common variable used in formulas for fluid replacement.


 CN: Physiological adaptation; CL: Apply

**16. 4.** Curling's ulcer, or gastrointestinal ulceration, occurs in about half of the clients with a burn injury. The incidence of ulceration appears proportional to the extent of the burns and the ulceration is believed to be caused by hypersecretion of gastric acid and compromised gastrointestinal perfusion. Paralytic ileus and gastric distention do not result from hypersecretion of gastric acid and stress. Hiatal hernia is not necessarily a potential complication of a burn injury.

 CN: Physiological adaptation; CL: Analyze

**17. 2.** The severe pain experienced by burn clients requires opioid analgesics. In addition, opioids such as morphine sedate and alleviate apprehension. Oral analgesics such as ibuprofen

or acetaminophen are unlikely to be strong enough to effectively manage the intense pain experienced by the client who is severely burned. Because of the altered tissue perfusion from the burn injury, intravenous medications are preferred. Antianxiety agents are not effective against pain.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**18. 750 mL/hour.** Lactated Ringer's solution 4 mL  $\times$  weight in kg  $\times$  TBSA; half given over the first 8 hours and half given over the next 16 hours.

$$4 \text{ mL} \times 75 \text{ kg} \times 40 = 12,000 \text{ mL or}$$

$$\frac{4 \text{ mL} \times 75 \text{ kg} \times 40}{8 \text{ hours}} \times \frac{1}{2} = \frac{750 \text{ mL}}{2 \text{ hour}}$$


$$12,000 \text{ mL} \times \frac{1}{2} = 6,000 \text{ mL}$$

$$\frac{6,000 \text{ mL}}{8 \text{ hours}} = 750 \text{ mL/hour}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

### The Client with General Problems of the Integumentary System

**19. 2.** Noting changes from the normal expected findings is the most important component when assessing an older client's integumentary system. Comparing one extremity with the contralateral extremity (i.e., comparing one side with the other) is an important assessment step; however, the most important component is noting changes from an expected normal baseline. Noting wrinkles related to age is not of much consequence unless the client is admitted for cosmetic surgery to reduce the appearance of age-related wrinkling. Noting skin turgor is an assessment of fluid status, not an assessment of the integumentary system.

 CN: Health promotion and maintenance; CL: Analyze

**20. 2.** With age, there is a decreased amount of subcutaneous fat, muscle laxity, degeneration of elastic fibers, and collagen stiffening. The outer layer of skin is almost completely replaced every 3 to 4 weeks. The vascular supply diminishes with age. Collagen thins and diminishes with age.


 CN: Health promotion and maintenance; CL: Analyze

**21. 1, 3, 4, 5.** Skin changes associated with aging include the following: Diminished hair on scalp and pubic areas, solar lentigo (liver spots), wrinkles, and xerosis (dryness). Dusky rubor of the left lower

extremity may indicate the individual has a venous stasis problem in the affected extremity and is generally associated with "unsuccessful aging." Yellow pigmentation of the skin that may be associated with liver inflammation is generally known as jaundice.

 CN: Health promotion and maintenance; CL: Analyze


**22. 3.** Normal aging consists of decreased proliferative capacity of the skin. Decreased collagen synthesis slows capillary growth, impairs phagocytosis among older clients, and results in slow healing. Increased scarring is not a result of age-related skin changes. Both melanin and melanocytes give color to the skin and hair but are increased with aging. There is a decrease in the immunocompetence of the aging client.

 CN: Health promotion and maintenance; CL: Analyze

**23. 1.** Drinking at least six 8-oz glasses of fluid per day helps the client stay well hydrated. Maintaining optimal fluid balance is important for all body systems. Caloric intake varies according to an individual's size and activity level. An intake of 1,200 calories/day may be insufficient for some older clients. Walking 10 minutes/day is useful, but an otherwise healthy older client should try to walk 20 minutes/day. It is important to get adequate rest; however, the amount of sleep needed varies with the individual.

 CN: Health promotion and maintenance; CL: Evaluate

**24. 2.** Poorly controlled diabetes is a serious risk factor for postoperative wound infection. Other factors that delay wound healing include advanced age, nutritional deficiencies (vitamin C, protein, zinc), inadequate blood supply, use of corticosteroid, infection, mechanical friction on the wound, obesity, anemia, and poor general health.

 CN: Reduction of risk potential; CL: Analyze

**25. 3.** The aging process involves increased capillary fragility and permeability. Older clients have a decreased amount of subcutaneous fat. Therefore, there is an increased incidence of bruise-like lesions caused by collection of extravascular blood in the loosely structured dermis. In addition, older clients do not always realize that injury has occurred because of a diminished awareness of pain, touch, and peripheral vibration. There are no data to support elder abuse or self-inflicted bruises. Blood supply to the skin declines with aging.

 CN: Health promotion and maintenance; CL: Analyze

**26. 4.** Older clients have a decreased thermoregulation that is related to decreased blood supply and reabsorption of body fat. As a result, older adults are at risk for hypothermia. Cellular cohesion and moisture content diminish with age and cellular renewal time is slowed; however, these do not result in impaired thermoregulation.

 CN: Health promotion and maintenance;  
CL: Analyze

**27. 4.** Assessment of the integumentary system includes both inspection and palpation. Palpation involves assessing temperature, turgor, moisture, and texture. Observing bruises and color and detecting hair distribution are inspection.

 CN: Health promotion and maintenance;  
CL: Analyze

**28. 1.** *Risk for infection* related to pruritus is the priority nursing diagnosis because it has been documented that the client continues to scratch the affected areas. Satisfactory control of the itching sensation and discomfort associated with scratching may relieve the agitation and anxiety. More information is required regarding the knowledge level of the client and her disease process, but learning cannot take place when an individual's attention is distracted with pruritus. Impaired skin integrity is a potential problem if the client continues to scratch the affected areas and destroys the skin, but the risk of infection deserves priority attention because of the client's anxiety. There are no data to support that the client has a poor self-image.

 CN: Reduction of risk potential;  
CL: Analyze

**29. 1.** Before using any restraints, the nurse must verify that a physician has written an order for the restraint. The mitt does not need to be secured with ties. The client can move the hand as needed. It is not necessary to place a pillow under the wrist. The nurse should place the mitt on the palmar surface of the hand.

 CN: Safety and infection control;  
CL: Synthesize

**30. 2, 3.** Usual aging is associated with dry skin; however, seborrhea (oily skin and dandruff) is one result of the biochemical changes associated with Parkinson's disease. The client with Parkinson's disease has a higher risk of skin breakdown due to the moist and oily skin. To maintain skin integrity, a client with Parkinson's disease needs frequent skin care and aeration of the skin. Gait instability in a client with Parkinson's disease is a result of muscle rigidity, change in the center of gravity, and gait shuffling. Because of these changes in gait and balance, the client is at higher risk for injuries in the

environment, such as hitting furniture or obstacles in the client's path. As a result, the environment should be evaluated for potential injury or falls. Tissue perfusion and verbal communication are not problems typically associated with Parkinson's disease. The client should not experience activity intolerance from the cellulitis or Parkinson's disease.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**31. 2.** Many falls occur when older clients attempt to get to the bathroom at night. The risk is even greater in an unfamiliar environment. Use of a nightlight in the bathroom enables the older adult client to see the way to the bathroom. Keeping the lights on in the room at all times may contribute to sensory overload and prevent adequate rest. Raised side rails paradoxically contribute to falls when the older client tries to climb over them to get to the bathroom. The upper side rails may be raised, but it is not recommended that all four side rails be elevated. Camera monitoring can be used but does nothing to prevent a fall.


 CN: Safety and infection control;  
CL: Synthesize

**32. 2.** Pressure ulcers usually occur over bony prominences. An alteration in the protective pressure sensation results from a decline in the number of Meissner's and pacinian corpuscles. Older adults do have altered balance that may result in falls, but not skin breakdown. Impaired hearing and vision do not contribute to pressure ulcers.

 CN: Reduction of risk potential;  
CL: Analyze

### The Client with a Pressure Ulcer

**33. 3.** When assessing a client with dark skin, the nurse should observe for skin that is darker, brownish, purplish, or bluish compared to surrounding skin. Fluorescent light casts a blue light making skin assessment difficult; natural or halogen light sources help to accurately assess the skin. Risk assessment using the Braden Scale should be performed on all clients. A Braden score of 12 indicates a high risk for pressure ulcer and the lower the Braden score, the higher the risk (no risk 19–23, at risk 15–18, moderate risk 13–14, high risk 10–12, and very high risk 9 or below). The nurse should touch the skin to assess consistency and temperature differences.

 CN: Physiological adaptation;  
CL: Analyze


**34. 2.** Stage I pressure ulcers appear as non-blanching macules that are red in color. Stage II ulcers have breakdown of the dermis. Stage III




ulcers have full-thickness skin breakdown. In stage IV ulcers, the bone, muscle, and supporting tissue are involved. The nurse should immediately initiate plans to relieve the pressure, ensure good nutrition, and protect the area from abrasion.

 CN: Reduction of risk potential;  
CL: Analyze

**35. 3.** A stage II skin breakdown involves epidermal sloughing and pain. Redness without blanching is noted in stage I. Stage III involves tissue necrosis with subcutaneous involvement. Stage IV involves muscle or bone destruction. Muscle spasms are not a criterion used in the staging process.

 CN: Physiological adaptation;  
CL: Analyze

**36. 3, 4, 5.** The client has a Stage II pressure ulcer. The nurse should take measures to relieve the pressure, treat the local infection, and protect the wound. The nurse should keep the ulcer covered with a protective dressing. The client should turn every 2 hours and use an alternating-pressure mattress to relieve pressure on the buttocks. The head of the bed should be elevated no more than 30 degrees. All wounds have bacteria and obtaining frequent cultures (unless ordered otherwise) are not necessary.

 CN: Safety and infection control;  
CL: Synthesize

**37. 3.** The pressure ulcer has changed from Stage I to Stage II and requires the use of a protective dressing. Repositioning and use of foam mattresses are appropriate interventions for Stage I pressure ulcers. There is no indication that the ulcer is infected.

 CN: Reduction of risk potential;  
CL: Synthesize

### The Client with Skin Cancer

**38. 1.** Caucasians who have fair skin and a high exposure to ultraviolet light are at increased risk for malignant neoplasms of the skin. The other risk factors include exposure to tar and arsenicals and family history. History of hypertension is a coronary artery disease risk factor. Clients with dark skin have increased melanin and are not as prone to skin cancer.

 CN: Health promotion and maintenance;  
CL: Analyze

**39. 1, 2, 3, 5, 6.** Risk factors associated with skin cancer include: Age, exposure to chemical pollutants, exposure to the sun, genetics, and immunosuppression. As individuals age, the risk of developing

skin cancer increases. Long-time exposure to the sun and exposure to chemical pollutants (nitrates, coal, tar, etc.) increases the risk of skin cancer. Individuals who have less skin pigmentation (i.e., fair, blue-eyed people) have a higher risk of skin cancer because they tend to incur sunburns rather than tan. Family history plays a role in cancer. Regardless, immunosuppressed individuals are at a higher risk for the development of any type of cancer, as the body's defenses are not functioning properly.

 CN: Health promotion and maintenance;  
CL: Apply

**40. 1, 2.** Sunscreen should be applied 20 to 30 minutes before going outside, even in cloudy weather. Sunscreen with a minimum of 15 SPF should be used. Sunscreen containing benzophenones block both UVA and UVB rays. The rays of the sun are most dangerous between 10 a.m. and 2 p.m. Genetic screening is not indicated, although a mutated gene has been identified in some families with high incidence of melanoma. A prior diagnosis of melanoma and having a first-degree relative diagnosed with melanoma increases a person's risk. Lesions should not be shave-biopsied; excisional biopsy technique is used. Baby oil will increase the adverse effects of sun exposure; sunscreen protection should be used.

 CN: Health promotion and maintenance;  
CL: Create

**41. 4.** Tumor or lesion thickness is the predictive factor for survival. Cutaneous melanoma that is confined to the epidermis has a high cure rate. Asymmetry, border, color, and diameter are known as the "ABCDs" of melanoma. Thus, the amount of ulceration, age, and location are not clearly associated with the prognosis.

 CN: Health promotion and maintenance;  
CL: Synthesis

### Managing Care Quality and Safety

**42. 4.** Massaging areas that are reddened due to pressure is contraindicated because it further reduces blood flow to the area. The UAP should not massage the bony prominences or use lotion on the area. Massage does improve circulation and blood flow to muscle areas; however, because the area is reddened, the client is at risk for further skin breakdown.

 CN: Management of care; CL: Synthesize

**43. 3.** The problem of pressure ulcers in hospitalized clients is best addressed by using quality improvement techniques to identify the problem, determining strategies for improvement, and setting

goals for outcomes. Benchmarking for comparison will indicate where this nursing unit compares with other units, but does not address the problem for this unit; having clients with pressure ulcers on any unit is not acceptable. Educational programs are more effective after there is an understanding of the problem. Chart audits and blaming do not solve the problem or address quality improvement measures.

 CN: Management of care; CL: Synthesize

**44. 3, 4, 5.** Infection control policies must be followed to prevent the spread of infection. Until the pathogens are identified, the client must be isolated in a private room. Utilizing contact isolation, wearing a protective isolation gown and clean gloves, in addition to following isolation protocol to exit the room, may aid in the prevention of spread of infectious agents to others. A draining foot lesion does

not require a negative air pressure room, which is primarily reserved for preventing spread of tuberculosis. Latex free gloves are not needed unless the client has a latex allergy.

 CN: Safety and infection control;  
CL: Synthesize

**45. 3.** By contacting the pharmacy to report the absence of the medication, the pharmacy can bring the medication to the client's medication box. From there on, the pharmacy can make sure the correct medications are present. Contacting the shift coordinator or the client's physician will not correct the original cause of the variance. It is never appropriate to "borrow" a medication from another client.

 CN: Management of care; CL: Synthesize

**TEST  
17**

# Responding to Emergencies, Mass Casualties, and Disasters

- Emergencies
- Mass Casualties
- Disasters
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## Emergencies

**1.** Three hours ago a client was thrown from a car into a ditch, and he is now admitted to the emergency department in a stable condition with vital signs within normal limits, alert and oriented with good coloring and an open fracture of the right tibia. For which signs and symptoms should the nurse be especially alert?

- 1. Hemorrhage.
- 2. Infection.
- 3. Deformity.
- 4. Shock.

**2.** A client is admitted to the emergency department with a full thickness burn to his right arm. Upon assessment, the arm is edematous, fingers are mottled, and radial pulse is now absent. The client states that the pain is 8 on a scale of 1 to 10. The nurse should:

- 1. Administer morphine sulfate I.V. push for the severe pain.
- 2. Call the physician to report the loss of the radial pulse.
- 3. Continue to assess the arm every hour for any additional changes.
- 4. Instruct the client to exercise his fingers and wrist.

**3.** A middle-aged man collapses in the emergency department waiting room. The triage nurse should **first**:

- 1. Gently shake the victim and ask him to state his name.
- 2. Perform the chin-tilt to open the victim's airway.
- 3. Feel for any air movement from the victim's nose or mouth.
- 4. Watch the victim's chest for respirations.

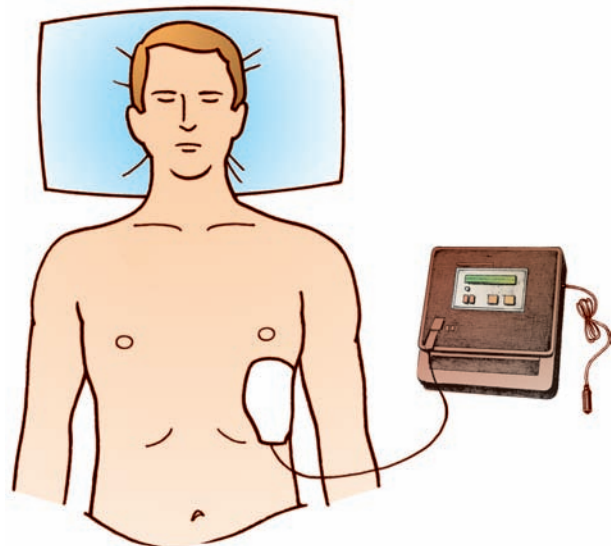
**4.** Proper hand placement for chest compressions during cardiopulmonary resuscitation (CPR) is essential to reduce the risk of which complication?

- 1. Gastrointestinal bleeding.
- 2. Myocardial infarction.
- 3. Emesis.
- 4. Rib fracture.

**5.** The American Heart Association (AHA) guidelines urge greater availability of automated external defibrillators (AEDs) and people trained to use them. AEDs are used in cardiac arrest situations for:

- 1. Early defibrillation in cases of atrial fibrillation.
- 2. Cardioversion in cases of atrial fibrillation.
- 3. Pacemaker placement.
- 4. Early defibrillation in cases of ventricular fibrillation.

**6.** Indicate on the illustration below where the nurse would place the other electrode of the automated external defibrillator (AED) on a victim who has collapsed and does not have a pulse.



**7.** A client is admitted to the emergency department after being found in a daze walking away from her burning car after an accident. She was not injured in the accident, but the other driver died. She states, “I can’t handle it anymore. There’s no point to it all.” The crisis nurse recommends hospital admission based on the identification of which **priority** nursing diagnosis?

- 1. *Ineffective coping* related to burning of the car as evidenced by walking around in a daze.
- 2. *Decisional conflict* related to burning of the car as evidenced by a lack of knowledge of what to do next.
- 3. *Disturbed thought processes* related to causing a death as evidenced by the inability to think clearly.
- 4. *Risk for suicide* related to the traumatic events of an accident as evidenced by statements of helplessness and hopelessness.

### Mass Casualties

**8.** Several clients have come to the emergency department after a possible bioterrorist act of arsenic overexposure. The nurse should assess these clients for which signs or symptoms immediately following the poisoning? Select all that apply.

- 1. Violent vomiting.
- 2. Severe diarrhea.
- 3. Abdominal pain.
- 4. Sensory neuropathy.
- 5. Persistent cough.

**9.** Thirty people are injured in a train derailment. Which client should be transported to the hospital **first**?

- 1. A 20-year-old who is unresponsive and has a high injury to his spinal cord.
- 2. An 80-year-old who has a compound fracture of the arm.
- 3. A 10-year-old with a laceration on his leg.
- 4. A 25-year-old with a sucking chest wound.

**10.** An explosion at a chemical plant produces flames and smoke. More than 20 persons have burn injuries. Which victims should be transported to a burn center? Select all that apply.

- 1. The victim with chemical spills on both arms.
- 2. The victim with third-degree burns of both legs.
- 3. The victim with first-degree burns of both hands.
- 4. The victim in respiratory distress.
- 5. The victim who inhaled smoke.

**11.** An apartment fire spreads to seven apartment units. Victims suffer burns, minor injuries, and broken bones from jumping from windows. Which client should be transported **first**?

- 1. A woman who is 5 months pregnant with no apparent injuries.
- 2. A middle-aged man with no injuries who has rapid respirations and coughs.
- 3. A 10-year-old with a simple fracture of the humerus who is in severe pain.
- 4. A 20-year-old with first-degree burns on her hands and forearms.

**12.** There is a shooting in a shopping mall. Three victims with gunshot wounds are brought to the emergency department. What should the nurse do to preserve forensic evidence? Select all that apply.

- 1. Cut around blood stains to remove clothing.
- 2. Place each item of clothing in a separate paper bag.
- 3. Hang wet clothing to dry.
- 4. Refrain from documenting client statements.
- 5. Place bullets in a sterile container.

**13.** An airplane crash results in mass casualties. The nurse is directing personnel to tag all victims. Which information should be placed on the tag? Select all that apply.

- 1. Triage priority.
- 2. Identifying information when possible (such as name, age, and address).
- 3. Medications and treatments administered.
- 4. Presence of jewelry.
- 5. Next of kin.

**14.** A car accident involves four vehicles on a remote interstate. The nearest emergency department is 15 minutes away. Which victim should be transported by helicopter to the nearest hospital?

- 1. 10-year-old with a simple fracture of the femur who is crying and cannot find his parents.
- 2. Middle-aged woman with cold, clammy skin and a heart rate of 120 bpm who is unconscious.
- 3. Middle-aged man with severe asthma and a heart rate of 120 bpm who is having difficulty breathing.
- 4. 70-year-old man with a severe headache who is conscious.

**15.** A small airplane crashes in a neighborhood of 10 houses. One of the victims appears to have a cervical spine injury. What should first-aid for this victim include? Select all that apply.

- 1. Establish an airway with the jaw-thrust maneuver.
- 2. Immobilize the spine.
- 3. Logroll the victim to a side-lying position.
- 4. Elevate the feet 6" (15.2 cm).
- 5. Place a cervical collar around the neck.

- 16.** Thirty-two children are brought to the emergency department after a school bus accident. Two children were killed along with the three people in the car that caused the crash. Before the victims arrive, in addition to ensuring that the hospital staff are prepared for the emergency, which step should the nurse anticipate carrying out?
- 1. Calling the nearest crisis response team.
  - 2. Alerting the news media.
  - 3. Notifying the hospital volunteer office.
  - 4. Calling the school to inform teachers of the accident.

## Disasters

- 17.** A suspected outbreak of anthrax has been transmitted by skin exposure. A client is admitted to the emergency department with lesions on the hands. The physician prescribes antibiotics and sends the client home. What should the nurse instruct the client to do? Select all that apply.
- 1. Take the prescribed antibiotics for 60 days.
  - 2. Avoid contact with other members of the family during the treatment period.
  - 3. Wear a mask for 60 days.
  - 4. Expect the skin lesions to clear up within 1 to 2 weeks.
  - 5. Wash hands frequently.

- 18.** A severe acute respiratory syndrome (SARS) epidemic is suspected in a community of 10,000 people. As clients with SARS are admitted to the hospital, what type of precautions should the nurse institute?
- 1. Enteric precautions.
  - 2. Hand-washing precautions.
  - 3. Reverse isolation.
  - 4. Standard precautions.

- 19.** Several clients who work in the same building are brought to the emergency department. They all complain of similar clinical manifestations, including fever, headache, a rash over the entire body, and abdominal pain with vomiting and diarrhea. Upon initial assessment, the nurse finds that each client has low blood pressure and has developed petechiae in the area where the blood pressure cuff was inflated. Which isolation precautions should the nurse initiate?
- 1. Contact isolation with double-gloving and shoe covers.
  - 2. Respiratory isolation with positive pressure rooms.
  - 3. Enteric precautions.
  - 4. Reverse isolation.

- 20.** Several clients come to the emergency department with suspected contamination by the Ebola virus. What should the nurse do? Select all that apply.
- 1. Call in extra staff to assist with the possibility of more clients with the same condition.
  - 2. Isolate all the suspected clients in the emergency department in one area.
  - 3. Call housekeeping for diluted household bleach.
  - 4. Restrict visitors from the emergency department.
  - 5. Quarantine all contacts.

- 21.** A number of clients have come to the emergency department after a possible bioterrorist act of arsenic overexposure. The nurse should assess these clients for which signs or symptoms immediately following the poisoning? Select all that apply.
- 1. Violent vomiting.
  - 2. Severe diarrhea.
  - 3. Abdominal pain.
  - 4. Sensory neuropathy.
  - 5. Persistent cough.

## Managing Care Quality and Safety

- 22.** A client who was a victim of a gunshot wound was treated in the emergency department and died. What should the nurse direct the unlicensed assistive personnel (UAP) to do during post-mortem care? Select all that apply.
- 1. Remove all tubes and I.V. lines.
  - 2. Cover the body with a sheet.
  - 3. Notify the family.
  - 4. Transport the body to the morgue.
  - 5. Notify the chaplain.

- 23.** The nurse in the emergency department is administering an order for 20 mg intravenous furosemide (Lasix) which is to be given immediately. The nurse scans the client's identification band and the medication barcode. The medication administration system does not verify that furosemide is ordered for this client; however, the furosemide is prepared in the accurate unit dose for intravenous infusion. The nurse should do which of the following **next**?
- 1. Contact the pharmacist immediately to check the order and the barcode label for accuracy.
  - 2. Administer the medication now, knowing the medication is labeled and the client is identified.
  - 3. Report the problem to the information technology team to have the barcode system recalibrated.
  - 4. Ask another nurse to verify the medication and the client so the medication can be given now.


**24.** The nurse notices a pair of nervous-acting individuals entering the emergency department. When reporting suspicious activity, the nurse should include which of the following in the report? Select all that apply.

- 1. Vehicle/s description.
- 2. Current location of parties involved.
- 3. Names and phone numbers of parties involved.
- 4. Relationship to hospitalized client.
- 5. Tone of voice of each party involved.

**25.** There has been an increase in medication errors and errors in ordering laboratory studies in the emergency department. The nurse manager is conducting a staff education session on when to use “read-back” procedures. “Read-back” procedures should be performed in which of the following situations? Select all that apply.

- 1. When a medication order or critical lab result is received verbally or over the telephone.
- 2. When any verbal or phone order is received.
- 3. Whenever a written order or printed critical test result is received.
- 4. When the unit secretary takes a phone order.
- 5. When the agency uses computerized health care records.


## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### Emergencies

**1. 2.** Because of the degree of contamination of the open fracture and the time that has passed since the accident, the risk of infection is very high. Therefore, the nurse should be especially alert for signs and symptoms of possible existing infection or early signs of infections, such as debris in the wound site, temperature abnormalities, results of laboratory studies (such as complete blood cell count and wound culture and sensitivities), or heat or redness around or in the wound. Because the client’s vital signs and cardiovascular status are stable at this time, hemorrhage is not the primary


concern. The client is talking coherently at this point, so his mentation does not suggest that he is in shock. However, assessment for signs and symptoms of hemorrhage and shock would certainly be ongoing. The fracture would be corrected by surgery as soon as possible, thereby minimizing the risk of deformity.

 CN: Physiological adaptation;  
CL: Analyze


**2. 2.** Circulation can be impaired by circumferential burns and edema causing compartment syndrome. Early recognition and treatment of impaired blood supply is key. The physician should be informed since an escharotomy (incision through full thickness eschar) is frequently performed to restore circulation. Pain management is important for burn clients, but restoration of circulation is the priority. Assessments should be performed more frequently. Exercise will not restore the obstructed circulation.

 CN: Safety and infection control;  
CL: Synthesize

**3. 1.** Calling the victim’s name and gently shaking the victim is used to establish unresponsiveness. The head-tilt, chin-lift maneuver is used to open the victim’s airway. Feeling for any air movement from the victim’s nose or mouth indicates whether the victim is breathing on his own. The rescuer can watch the victim’s chest for respirations to see if the victim is breathing.

 CN: Physiological adaptation;  
CL: Synthesize

**4. 4.** Proper hand placement during chest compressions is essential to reduce the risk of rib fractures, which may lead to pneumothorax and other internal injuries. Gastrointestinal bleeding and myocardial infarction are generally not considered complications of CPR. Although the victim may vomit during CPR, this is not associated with poor hand placement, but rather with distention of the stomach.

 CN: Physiological adaptation;  
CL: Apply

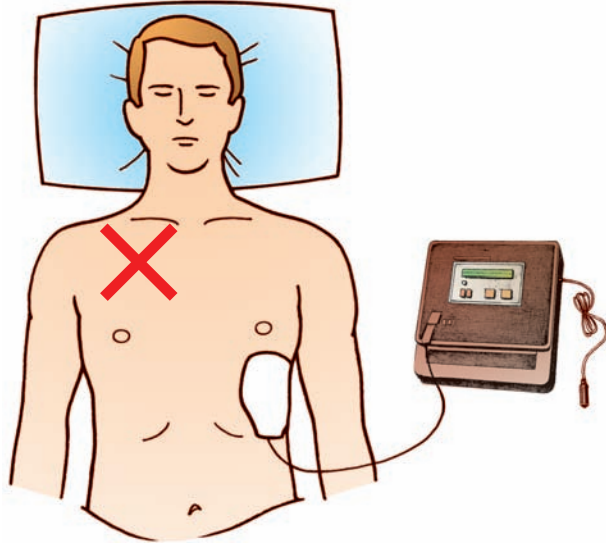
**5. 4.** AEDs are used for early defibrillation in cases of ventricular fibrillation. The AHA places major emphasis on early defibrillation for ventricular fibrillation and use of the AED as a tool to increase sudden cardiac arrest survival rates.

 CN: Reduction of risk potential;  
CL: Apply


**6. One electrode is placed to the right of the upper sternum just below the right clavicle. The other is placed, as shown, over the fifth or**

sixth intercostal space at the left anterior axillary line.

 CN: Reduction of risk potential;  
CL: Apply



**7. 4.** The client is demonstrating helplessness and hopelessness during a crisis, as evidenced by her statement, “I can’t handle it. There is no point to it.” Feelings of helplessness and hopelessness are common factors associated with suicidal ideation. Therefore, the client must be hospitalized to ensure safety to herself. Ineffective coping affects interventions. Not knowing what to do next reflects a request for help in making a decision. However, these diagnoses have less priority when compared with the client’s risk for suicide. Disturbed thought processes would be evidenced by delusions, such as “The devil set my car on fire,” not just the inability to think clearly.

 CN: Psychosocial adaptation;  
CL: Analyze

## Mass Casualties

**8. 1, 2, 3.** When arsenic overexposure occurs, the symptoms include violent nausea, vomiting, abdominal pain, skin irritation, severe diarrhea, laryngitis, and bronchitis. Dehydration can lead to shock and death. After the acute phase, bone marrow depression, encephalopathy, and sensory neuropathy occur. A persistent cough is not a sign of arsenic exposure.

 CN: Physiological adaptation;  
CL: Analyze

**9. 4.** During a disaster, the nurse must make difficult decisions about which persons to treat first. The guidelines for triage offer general priorities for

immediate, delayed, minimal, and expectant care. The client with a sucking chest wound needs immediate attention and will likely survive. The 80-year-old is classified as delayed; emergency response personnel can immobilize the fracture and cover the wound. The 10-year-old has minimal injuries and can wait to be treated. The client with a spinal cord injury is not likely to survive and should not be among the first to be transported to the health care facility.

 CN: Management of care; CL: Analyze

**10. 1, 2, 3, 5.** Victims with chemical burns, second- and third-degree burns over more than 20% of their body surface area, and those with inhalation injuries should be transported to a burn center. The victim with first-degree burns of his hands can be treated with first-aid on the scene and referred to a health care facility.

 CN: Management of care;  
CL: Analyze

**11. 2.** The man with respiratory distress and coughing should be transported first because he is probably experiencing smoke inhalation. The pregnant woman is not in imminent danger or likely to have a precipitous delivery. The 10-year-old is not at risk for infection and could be treated in an outpatient facility. First-degree burns are considered less urgent.

 CN: Management of care; CL: Analyze

**12. 2, 3.** Preserving forensic evidence is essential for investigative purposes following injuries that may be caused by criminal intent. The nurse should put each item of clothing in a separate paper bag and label it; wet clothing should be hung to dry. The nurse should not cut or otherwise unnecessarily handle clothing, particularly clothing with such evidence as blood or body fluids. The nurse should document carefully the client’s description of the incident and use quotes around the client’s exact words where possible. The documentation will become a part of the client’s record and can be subpoenaed for subsequent investigation. The nurse should not handle bullets from the client because they are an important piece of forensic evidence.

 CN: Management of care; CL: Apply

**13. 1, 2, 3.** Tracking victims of disasters is important for casualty planning and management. All victims should receive a tag, securely attached, that indicates the triage priority, any available identifying information, and what care, if any, has been given along with time and date. Tag information should be recorded in a disaster log and used to track victims and inform families. It is not necessary to document the presence of jewelry or next of kin.

 CN: Management of care; CL: Apply

**14. 2.** The middle-aged woman is likely in shock. She is classified as a triage level I, requiring immediate care. The child with moderate trauma is classified as triage level III (urgent and should be treated within 30 minutes). The man with asthma and the man with the severe headache are classified as triage level II (emergent), and can be transported by ambulance and reach the hospital within 15 minutes.

 CN: Management of care; CL: Analyze

**15. 1, 2.** The victim of a neck injury should be immobilized and moved as little as possible. It is also important to ensure an open airway; this can be accomplished with the jaw-thrust maneuver, which does not require tilting the head. The victim should not be rolled to a side-lying position nor have his feet elevated. Both actions can cause additional injury to the spinal cord. Placing a cervical collar causes movement of the spinal column and should not be done as a first-aid measure.


 CN: Management of care; CL: Synthesize

**16. 1.** The children and their families are at risk for experiencing a crisis. Disaster teams are available for crisis intervention in such emergencies. Usually the news media monitors emergency radio frequencies and most likely are aware of the accident already. Although volunteers may help in some ways, they are not responsible for crisis intervention. Calling the school might be done, but the emergency issues take precedence.

 CN: Psychosocial adaptation;  
CL: Synthesize


## Disasters

**17. 1, 4.** Anthrax is treated with antibiotics and the client must continue the prescription for 60 days, even if symptoms do not persist. The client may have skin lesions at the point of contact, with macula or papule formation; the eschar will fall off in 1 to 2 weeks. Clients with anthrax are not contagious; the client does not need to follow isolation procedures at home. Anthrax from skin exposure is not transmitted by respiratory contact and the client does not need to wear a mask.

 CN: Safety and infection control;  
CL: Synthesize

**18. 4.** Transmission of SARS can be contained by following standard (universal) precautions, which include masks, gowns, eye protection, hand washing, and safe disposal of needles and sharps. The disease is spread by the respiratory, not enteric, route. Hand washing alone is not sufficient to prevent

transmission. Reverse isolation (protection of the client) is not sufficient to prevent transmission.

 CN: Safety and infection control;  
CL: Synthesize

**19. 1.** The nurse should institute treatment for hemorrhagic fever viruses, including contact isolation with double-gloving and shoe covers, strict hand hygiene, and protective eyewear. The nurse should start respiratory isolation with negative pressure rooms, not positive pressure rooms. Enteric precautions are not needed because the virus is spread by droplet and contact. Reverse isolation protects the client; in this situation, the health care team also needs protection.

 CN: Reduction of risk potential;  
CL: Synthesize

**20. 2, 3, 4.** The nurse should isolate all the suspected clients in the emergency department in one area and restrict visitors from the emergency department to minimize exposure to others. The nurse should also obtain diluted household bleach (1:100) to decontaminate areas suspected of coming in contact with the virus. There is no indication at this time that extra staff is needed, so the nurse should not call in extra staff, to minimize exposure to health care workers. It is not necessary to quarantine contacts until a diagnosis is confirmed. In addition, it is the role of the public health officer to issue the quarantine if needed.

 CN: Safety and infection control;  
CL: Synthesize

**21. 1, 2, 3.** When arsenic overexposure occurs, the signs and symptoms include violent nausea, vomiting, abdominal pain, skin irritation, severe diarrhea, laryngitis, and bronchitis. Dehydration can lead to shock and death. After the acute phase, bone marrow depression, encephalopathy, and sensory neuropathy occur.

 CN: Physiological adaptation;  
CL: Analyze


## Managing Care Quality and Safety

**22. 2, 4.** The UAP can cover the body and transport it to the morgue. Deaths by gunshot wound are considered reportable deaths. All evidence in a reportable death, including tubes and I.V. lines, should remain intact until the coroner has been contacted. The health care provider should be the one to notify the family. The nurse should be the one to notify the chaplain.

 CN: Management of care; CL: Synthesize




**23. 1.** The nurse should contact the pharmacist first to be sure the medication is labeled for administration to this client. The nurse should not administer the drug until all safety precautions have been observed; the nurse should also not ask another nurse to verify the medication or client. Later, if the problem cannot be resolved with re-labeling the medication, the nurse or pharmacist can contact the information technology team to check the barcode system.

 CN: Safety and infection control; CL: Synthesize

**24. 1, 2.** All suspicious individuals or activities should be reported as soon as possible to the security department. When reporting an incident, nurses/employees should provide the following: (a) type of incident; (b) persons involved/physical description; (c) vehicles involved and description; (d) date and time the incident occurred; (e) location where the incident occurred; (f) weapons involved;

and (g) current location of parties involved. All reports of threats, actual episodes of violence, or suspicious individuals or activities must be investigated.

 CN: Safety and infection control; CL: Synthesize

**25. 1, 2.** A National Patient Safety Goal of The Joint Commission is to improve the effectiveness of communication among caregivers. For verbal or telephone orders, or for telephone reporting of critical test results, one must verify the complete order or test result by having the individual receiving the information record “read-back” the complete order or test result. The Unit Secretary is not a licensed health care professional who has a Scope of Practice or the authority to receive orders or results. The type of charting system used by the health care agency is not a factor in using “read back” orders.

 CN: Safety and infection control; CL: Synthesize

# 4

## The Nursing Care of Clients with Psychiatric Disorders and Mental Health Problems

### TEST 1

### Mood Disorders

- The Client with Major Depression
- The Client with Bipolar Disorder, Manic Phase
- The Client with Suicidal Ideation and Suicide Attempt
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

#### The Client with Major Depression

**1.** The nurse is planning care with a Mexican-American client who is diagnosed with depression. The client believes in “mal ojo” (the evil eye), and uses treatment by a root healer. The nurse should do which of the following?

- 1. Avoid talking to the client about the root healer.
- 2. Explain to the client that Western medicine has a scientific, not mystical, basis.
- 3. Explain that such beliefs are superstitious and should be forgotten.
- 4. Involve the root healer in a consultation with the client, physician and nurse.

**2.** After a period of unsuccessful treatment with Elavil (amitriptyline), a woman diagnosed with depression is switched to Parnate (tranylcypromine). Which statement by the client indicates the client understands the side effects of Parnate?

- 1. “I need to increase my intake of sodium.”
- 2. “I must refrain from strenuous exercise.”
- 3. “I must refrain from eating aged cheese or yeast products.”
- 4. “I should decrease my intake of foods containing sugar.”

**3.** A client is scheduled for the first electroconvulsive therapy (ECT) treatment in the morning. The client has been unable to sleep, but at 10 p.m. refused to take Restoril as the nurse suggested. The client is still unable to sleep at 11:15 p.m. In what order should the nurse do the following?

1. Sit quietly with the client.

2. Encourage the use of Restoril.

3. Offer use of MP3 player with relaxing music.

4. Discuss specific concerns.

**4.** The client is receiving 6 mg of selegiline transdermal system (Emsam) every 24 hours for major depression. The nurse should judge teaching about Emsam to be effective when the client makes which statement?

- 1. "I need to avoid using the sauna at the gym."
- 2. "I can cut the patch and use a smaller piece."
- 3. "I need to wait until the next day to put on a new patch if it falls off."
- 4. "I might gain at least 10 lb from Emsam."

**5.** A client has been taking 30 mg of duloxetine hydrochloride (Cymbalta) twice daily for 2 months because of depression and vague aches and pains. While interacting with the nurse, the client discloses a pattern of drinking a 6-pack of beer daily for the past 10 years to help with sleep. What should the nurse do **first**?

- 1. Refer the client to the dual diagnosis program at the clinic.
- 2. Share the information at the next interdisciplinary treatment conference.
- 3. Report the client's beer consumption to the physician.
- 4. Teach the client relaxation exercises to perform before bedtime.

**6.** A client was admitted to the inpatient unit 3 days ago with a flat affect, psychomotor retardation, anorexia, hopelessness, and suicidal ideation. The physician prescribed 75 mg of venlafaxine extended release (Effexor XR) to be given every morning. The client interacted minimally with the staff and spent most of the day in his room. As the nurse enters the unit at the beginning of the evening shift, the client is smiling and cheerfully greets the nurse. He appears to be relaxed and joins the group for community meeting before supper. What should the nurse interpret as the most likely cause of the client's behavior?

- 1. The Effexor is helping the client's symptoms of depression significantly.
- 2. The client's sudden improvement calls for close observation by the staff.
- 3. The staff can decrease their observation of the client.
- 4. The client is nearing discharge due to the improvement of his symptoms.

**7.** The nurse is conducting an intake interview with an Asian American female who reports sadness, physical and mental fatigue, anxiety, and sleep disturbance. Prior to the client's time with the physician, it is important for the nurse to obtain information about the client's use of which of the following? Select all that apply.

- 1. Tea.
- 2. Herbal medicine.
- 3. Breathing exercise.
- 4. Massage.
- 5. Folk healer.

**8.** The client is taking 50 mg of lamotrigine (Lamictal) daily for bipolar depression. The client shows the nurse a rash on his arm. What should the nurse do?

- 1. Report the rash to the physician.
- 2. Explain that the rash is a temporary adverse effect.
- 3. Give the client an ice pack for his arm.
- 4. Question the client about recent sun exposure.

**9.** The nurse is reviewing the laboratory report with the client's lithium level taken that morning prior to administering the 5 p.m. dose of lithium. The lithium level is 1.8 mEq/L. The nurse should:

- 1. Administer the 5 p.m. dose of lithium.
- 2. Hold the 5 p.m. dose of lithium.
- 3. Give the client 8 oz (236 mL) of water with the lithium.
- 4. Give the lithium after the client's supper.

**10.** A nurse is conducting a psychoeducational group for family members of clients hospitalized with depression. Which family member's statement indicates a need for additional teaching?

- 1. "My husband will slowly feel better as his medicine takes effect over the next 2 to 4 weeks."
- 2. "My wife will need to take her antidepressant medicine and go to group to stay well."
- 3. "My son will only need to attend outpatient appointments when he starts to feel depressed again."
- 4. "My mother might need help with grocery shopping, cooking, and cleaning for a while."

**11.** The nurse is distinguishing between delusions experienced by a client diagnosed with major depression with psychotic features and the delusions of a client diagnosed with schizophrenia. The essential difference is:

- 1. Major depression delusions are more likely to be negative than schizophrenic delusions.
- 2. Major depression delusions clear up less quickly than schizophrenic delusions.
- 3. Major depression delusions are more likely than schizophrenic delusions to require long-acting depot antipsychotic medication given intramuscularly.
- 4. Major depression delusions are more mood congruent than schizophrenic delusions.

**12.** A 16-year-old client is prescribed 10 mg of paroxetine (Paxil) at bedtime for major depression. The nurse should instruct the client and parents to monitor the client closely for which adverse effect?

- 1. Headache.
- 2. Nausea.
- 3. Fatigue.
- 4. Agitation.

**13.** The nurse is assessing the outcomes of care for a client who has an Axis I diagnosis of major depression. Following the initiation of treatment, arrange the symptoms in chronological order from the one that improves first to the one that improves last.

1. Self-esteem.

2. Sleep.

3. Energy level.

4. Appetite.

**14.** A client who has had three episodes of recurrent endogenous depression within the past 2 years states to the nurse, “I want to know why I’m so depressed.” Which of the following statements by the nurse is most helpful?

- 1. “I know you’ll get better with the right medication.”
- 2. “Let’s discuss possible reasons underlying your depression.”
- 3. “Your depression is most likely caused by a brain chemical imbalance.”
- 4. “Members of your family seem very supportive of you.”

**15.** A client diagnosed with major depression spends most of the day lying in bed with the sheet pulled over his head. Which of the following approaches by the nurse is **most** therapeutic?

- 1. Wait for the client to begin the conversation.
- 2. Initiate contact with the client frequently.
- 3. Sit outside the client’s room.
- 4. Question the client until he responds.

**16.** The client exhibits a flat affect, psychomotor retardation, and depressed mood. The nurse attempts to engage the client in an interaction but the client does not respond to the nurse. Which response by the nurse is most appropriate?

- 1. “I’ll sit here with you for 15 minutes.”
- 2. “I’ll come back a little bit later to talk.”
- 3. “I’ll find someone else for you to talk with.”
- 4. “I’ll get you something to read.”

**17.** After a few minutes of conversation, a female client who is depressed wearily asks the nurse, “Why pick me to talk to? Go talk to someone else.” Which of the following replies by the nurse is **best**?

- 1. “I’m assigned to care for you today, if you’ll let me.”
- 2. “You have a lot of potential, and I’d like to help you.”
- 3. “I’ll talk to someone else later.”
- 4. “I’m interested in you and want to help you.”

**18.** A client is receiving paroxetine (Paxil) 20 mg every morning. After taking the first three doses, the client tells the nurse that the medication upsets his stomach. Which of the following instructions should the nurse give to the client?

- 1. “Take the medication an hour before breakfast.”
- 2. “Take the medication with some food.”
- 3. “Take the medication at bedtime.”
- 4. “Take the medication with 4 oz of orange juice.”

**19.** The physician orders fluoxetine (Prozac) orally every morning for a 72-year-old client with depression. Which transient adverse effect of this drug requires immediate action by the nurse?

- 1. Nausea.
- 2. Dizziness.
- 3. Sedation.
- 4. Dry mouth.

**20.** Which of the following statements by a client taking trazodone (Desyrel) as prescribed by the physician indicates to the nurse that further teaching about the medication is needed?

- 1. “I will continue to take my medication after a light snack.”
- 2. “Taking Desyrel at night will help me to sleep.”
- 3. “My depression will be gone in about 5 to 7 days.”
- 4. “I won’t drink alcohol while taking Desyrel.”

**21.** A 62-year-old female client with severe depression and psychotic symptoms is scheduled for electroconvulsive therapy (ECT) tomorrow morning. The client’s daughter asks the nurse, “How painful will the treatment be for Mom?” The nurse should respond by saying which of the following?

- 1. “Your mother will be given something for pain before the treatment.”
- 2. “The physician will make sure your mother doesn’t suffer needlessly.”
- 3. “Your mother will be asleep during the treatment and will not be in pain.”
- 4. “Your mother will be able to talk to us and tell us if she’s in pain.”

**22.** A client who experienced sleep disturbances, feelings of worthlessness, and an inability to concentrate for the past 3 months was fired from her job a month ago. The client tells the nurse, "My boss was wonderful! He was understanding and a really nice man." The nurse interprets the client's statement as representing the defense mechanism of reaction formation. Which of the following would be the best response by the nurse?

- 1. "But, I don't understand, wasn't he the one who fired you?"
- 2. "Tell me more about having to work while not being able to sleep or concentrate."
- 3. "It must have been hard to leave a boss like that."
- 4. "It sounds like he would hire you back if you asked."

**23.** During a group session, a client who is depressed tells the group that he lost his job. Which of the following responses by the nurse is **best**?

- 1. "It must have been very upsetting for you."
- 2. "Would you tell us about your job?"
- 3. "You'll find another job when you're better."
- 4. "You were probably too depressed to work."

**24.** During an interaction with the nurse, a client states, "My husband has supported me every time I've been hospitalized for depression. He'll leave me this time. I'm an awful wife and mother. I'm no good. Nothing I do is right." Based on this information, which of the following nursing diagnoses should the nurse identify when developing the client's plan of care?

- 1. *Impaired social interaction* related to unsatisfactory relationships as evidenced by withdrawal.
- 2. *Chronic low self-esteem* related to lack of self-worth as evidenced by negative statements.
- 3. *Risk for self-directed violence* related to feelings of guilt as evidenced by statements of suicidal ideation.
- 4. *Ineffective coping* related to hospitalizations as evidenced by impaired judgment.

**25.** A male client who is very depressed exhibits psychomotor retardation, a flat affect, and apathy. The nurse observes the client to be in need of grooming and hygiene. Which of the following nursing actions is **most** appropriate?

- 1. Explaining the importance of hygiene to the client.
- 2. Asking the client if he is ready to shower.
- 3. Waiting until the client's family can participate in the client's care.
- 4. Stating to the client that it's time for him to take a shower.

**26.** A client who is depressed states, "I'm an awful person. Everything about me is bad. I can't do anything right." Which of the following responses by the nurse is **most** therapeutic?

- 1. "Everybody around here likes you."
- 2. "I can see many good qualities in you."
- 3. "Let's discuss what you've done correctly."
- 4. "You were able to bathe today."

**27.** When developing the teaching plan for the family of a client with severe depression who is to receive electroconvulsive therapy (ECT), which of the following information should the nurse include?

- 1. Some temporary confusion and disorientation immediately after a treatment is common.
- 2. During an ECT treatment session, the client is at risk for aspiration.
- 3. Clients with severe depression usually do not respond to ECT.
- 4. The client will not be able to breathe independently during a treatment.

**28.** Which of the following comments indicates that a client understands the nurse's teaching about sertraline (Zoloft)?

- 1. "Zoloft will probably cause me to gain weight."
- 2. "This medicine can cause delayed ejaculations."
- 3. "Dry mouth is a permanent side effect of Zoloft."
- 4. "I can take my medicine with St. John's wort."

**29.** The client with recurring depression will be discharged from the psychiatric unit. Which suggestion to the family is **best** to help them prepare for the client's return home?

- 1. Discourage visitors while the client is at home.
- 2. Provide for a schedule of activities outside the home.
- 3. Involve the client in usual at-home activities.
- 4. Encourage the client to sleep as much as possible.

**30.** A client with major depression is to be discharged home tomorrow. When preparing the client's discharge plan, which of the following areas is **most** important for the nurse to review with the client?

- 1. Future plans for going back to work.
- 2. A conflict encountered with another client.
- 3. Results of psychological testing.
- 4. Medication management with outpatient follow-up.

**31.** A client with major depression and psychotic features is admitted involuntarily to the hospital. He will not eat because his “bowels have turned to jelly,” which the client states is punishment for his wickedness. The client requests to leave the hospital. The nurse denies the request because commitment papers have been initiated by the physician. Which of the following should the nurse identify as a criterion for the client to be legally committable?

- 1. Evidence of psychosis.
- 2. Being gravely disabled.
- 3. Risk of harm to self or others.
- 4. Diagnosis of mental illness.

**32.** The client who has been taking venlafaxine (Effexor) 25 mg P.O. three times a day for the past 2 days states, “This medicine isn’t doing me any good. I’m still so depressed.” Which of the following responses by the nurse is **most** appropriate?

- 1. “Perhaps we’ll need to increase your dose.”
- 2. “Let’s wait a few days and see how you feel.”
- 3. “It takes about 2 to 4 weeks to receive the full effects.”
- 4. “It’s too soon to tell if your medication will help you.”

**33.** The client states to the nurse, “I take citalopram (Celexa) 40 mg every day like my physician prescribed. I have also been taking St. John’s wort 750 mg daily for the past 2 weeks.” Which of the following indicate that the client is developing serotonin syndrome? Select all that apply.

- 1. Confusion.
- 2. Restlessness.
- 3. Constipation.
- 4. Diaphoresis.
- 5. Ataxia.

**34.** When teaching the client with atypical depression about foods to avoid while taking phenelzine (Nardil), which of the following should the nurse include?

- 1. Roasted chicken.
- 2. Salami.
- 3. Fresh fish.
- 4. Hamburger.

**35.** A client is taking phenelzine (Nardil) 15 mg P.O. three times a day. The nurse is about to administer the 1 p.m. dose when the client tells the nurse that about having a throbbing headache. Which of the following should the nurse do **first**?

- 1. Give the client an analgesic ordered p.r.n.
- 2. Call the physician to report the symptom.
- 3. Administer the client’s next dose of phenelzine.
- 4. Obtain the client’s vital signs.

**36.** A female client with severe depression and weight loss has not eaten since admission to the hospital 2 days ago. Which of the following approaches should the nurse include when developing this client’s plan of care to ensure that she eats?

- 1. Serving the client her meal trays in her room.
- 2. Sitting with the client and spoon-feeding if required.
- 3. Calling the family to bring the client food from home.
- 4. Explaining the importance of nutrition in recovery.

**37.** After administering a prescribed medication to a client who becomes restless at night and has difficulty falling asleep, which of the following nursing actions is **most** appropriate?

- 1. Sitting quietly with the client at the bedside until the medication takes effect.
- 2. Engaging the client in interaction until the client falls asleep.
- 3. Reading to the client with the lights turned down low.
- 4. Encouraging the client to watch television until the client feels sleepy.

**38.** Which of the following behaviors exhibited by a client with depression should lead the nurse to determine that the client is ready for discharge?

- 1. Interactions with staff and peers.
- 2. Sleeping for 4 hours in the afternoon and 4 hours at night.
- 3. Verbalization of feeling in control of self and situations.
- 4. Statements of dissatisfaction over not being able to perform at work.

**39.** The client with major depression and suicidal ideation has been taking bupropion (Wellbutrin) 100 mg P.O. four times daily for 5 days. Assessment reveals the client to be somewhat less withdrawn, able to perform activities of daily living with minimal assistance, and eating 50% of each meal. At this time, the nurse should monitor the client specifically for which of the following behaviors?

- 1. Seizure activity.
- 2. Suicide attempt.
- 3. Visual disturbances.
- 4. Increased libido.

**40.** Which of the following outcomes should the nurse include in the initial plan of care for a client who is exhibiting psychomotor retardation, withdrawal, minimal eye contact, and unresponsiveness to the nurse’s questions?

- 1. The client will initiate interactions with peers.
- 2. The client will participate in milieu activities.
- 3. The client will discuss adaptive coping techniques.
- 4. The client will interact with the nurse.

**41.** When preparing a teaching plan for a client about imipramine (Tofranil), which of the following substances should the nurse tell the client to avoid while taking the medication?

- 1. Caffeinated coffee.
- 2. Sunscreen.
- 3. Alcohol.
- 4. Artificial tears.

**42.** The client with depression who is taking imipramine (Tofranil) states to the nurse, "My doctor wants me to have an electrocardiogram (ECG) in 2 weeks, but my heart is fine." Which response by the nurse is **most** appropriate?

- 1. "It's routine practice to have ECGs periodically because there is a slight chance that the drug may affect the heart."
- 2. "It's probably a precautionary measure because I'm not aware that you have a cardiac condition."
- 3. "Try not to worry too much about this. Your doctor is just being very thorough in monitoring your condition."
- 4. "You had an ECG before you were prescribed imipramine and the procedure will be the same."

**43.** When assessing a client who is receiving tricyclic antidepressant therapy, which of the following should alert the nurse to the possibility that the client is experiencing anticholinergic effects? Analyze

- 1. Tremors and cardiac arrhythmias.
- 2. Sedation and delirium.
- 3. Respiratory depression and convulsions.
- 4. Urine retention and blurred vision.

**44.** A client with depression who is taking doxepin (Sinequan) 100 mg P.O. at bedtime has dizziness on arising. Which of the following suggestions is **most** appropriate?

- 1. "Try taking a hot shower."
- 2. "Get up slowly and dangle your feet before standing."
- 3. "Stay in bed until you are feeling better."
- 4. "You need to limit the fluids you drink."

**45.** The physician orders mirtazapine (Remeron) 30 mg P.O. at bedtime for a client diagnosed with depression. The nurse should:

- 1. Give the medication as ordered.
- 2. Question the physician's order.
- 3. Request to give the medication in the morning.
- 4. Give the medication in three divided doses.

**46.** A client taking mirtazapine (Remeron) is disheartened about a 20 lb weight gain over the past 3 months. The client tells the nurse, "I stopped taking my Remeron 15 days ago. I don't want to get depressed again, but I feel awful about my weight." Which response by the nurse is most appropriate?

- 1. "Focusing on diet and exercise alone should control your weight."
- 2. "Your depression is much better now, so your medication is helping you."
- 3. "Look at all the positive things that have happened to you since you started Remeron."
- 4. "I hear how difficult this is for you and will help you approach the doctor about it."

**47.** When developing a teaching plan for a client about the medications prescribed for depression, which of the following components is **most** important for the nurse to include? Create

- 1. Pharmacokinetics of the medication.
- 2. Current research related to the medication.
- 3. Management of common adverse effects.
- 4. Dosage regulation and adjustment.

**48.** The client diagnosed with severe major depression has been taking Lexapro 10 mg (escitalopram) daily for the past 2 weeks. Which of the following parameters should the nurse monitor most closely at this time?

- 1. Suicidal ideation.
- 2. Sleep.
- 3. Appetite.
- 4. Energy level.

**49.** A client taking paroxetine (Paxil) 40 mg P.O. every morning tells the nurse that her mouth "feels like cotton." Which of the following statements by the client necessitates further assessment by the nurse?

- 1. "I'm sucking on ice chips."
- 2. "I'm using sugarless gum."
- 3. "I'm sucking on sugarless candy."
- 4. "I'm drinking 12 glasses of water every day."

**50.** The client with depression has been consistent with taking 12.5 mg of paroxetine (Paxil) extended release daily. The nurse judges the client to be benefiting from this drug therapy when the client demonstrates which of the following behaviors? Select all that apply.

- 1. Takes 2-hour evening naps daily.
- 2. Completes homework assignments.
- 3. Decreases pacing.
- 4. Increases somatization.
- 5. Verbalizes feelings.

**51.** A client diagnosed with major depression has sleep and appetite disturbances, a flat affect and is withdrawn. The client has been taking fluvoxamine (Luvox) 50 mg twice daily for 5 days. Which client behavior is most important to report to the next shift?

- 1. Client's flat affect.
- 2. Client's interacting with a visitor.
- 3. Client sleeping from 11 p.m. to 6 a.m.
- 4. Client spending the entire evening in her room.

**52.** Which of the following is the **best** predictor of a client's favorable response to the choice of an antidepressant?

- 1. The drug's side effect profile.
- 2. The client's age at diagnosis.
- 3. The cost of the medication.
- 4. A favorable response by a family member.

**53.** A nurse is educating a client who has been diagnosed with dysthymia about possible treatment for the disorder. Which response by the nurse is most appropriate?

- 1. "Antidepressants, particularly the SSRI group, offer you the best treatment for your dysthymia."
- 2. "Doctors recommend that clients experiencing dysthymia receive electroconvulsive therapy (ECT) to treat their disorder."
- 3. "Because you have a mild, though long-lasting dysthymic mood, psychotherapy can usually bring improvement with less likelihood of the need for medication."
- 4. "Since your dysthymia indicates a long-lasting mild depression, long-term psychoanalysis would be the best treatment for you."

### The Client with Bipolar Disorder, Manic Phase

**54.** A client is brought to the hospital by police and admitted involuntarily. She is diagnosed as having bipolar disorder, manic phase. The physician orders lithium 300 mg by mouth three times a day. The client refuses her morning dose of lithium. The nurse should next:

- 1. Force the client to take the lithium because of the client's involuntarily admission status.
- 2. Contact the physician to change the lithium order to be given intramuscularly.
- 3. Inform the client that she retains the right to refuse medication despite her involuntary admission.
- 4. Tell the client that certain privileges will be revoked if she does not take the medication.

**55.** A young adult client diagnosed with bipolar disorder has been managing the disorder effectively with medication and treatment for several years. The client suddenly becomes manic. The nurse reviews the client's medication record. Which of the following medications may have contributed to the development of his manic state?

- 1. Elavil (amitriptyline).
- 2. Prednisone.
- 3. BuSpar (buspirone).
- 4. Neurotonin (gabapentin).

#### Medication Record

Elavil (amitriptyline) 50 mg po daily at bedtime  
 Prednisone 20 mg po daily  
 BuSpar (buspirone HCl) 5 mg po three times a day  
 Neurontin (gabapentin) 300 mg po three times a day

**56.** The client with acute mania has been admitted to the inpatient unit voluntarily. The nurse approaches the client with medication to be taken orally as ordered by the physician. The client states, "I don't need that stuff." Which response by the nurse is **best**?

- 1. "You can't refuse to take this medication."
- 2. "If you don't take it orally, I'll give you a shot."
- 3. "The medication will help you feel calmer."
- 4. "I'll get you some written information about the medication."

**57.** A nurse observes a male client who is hyperactive and intrusive sitting very close to a female client with his arm around her shoulders. The nurse hears the male client tell a sexually explicit joke. The nurse approaches the client and asks him to walk down the hallway. Which of the following statements by the nurse should benefit the client?

- 1. "She will not want to be around you with that kind of talk."
- 2. "Telling sexual jokes and touching others is not permitted here."
- 3. "You need to be careful about what you say to other people."
- 4. "I think a time-out in your room would be appropriate now."

**58.** A client states to a nurse, "Hey sweetie, you're looking good today." Which of the following responses by the nurse is **best**?

- 1. "Thank you for being so kind and thoughtful."
- 2. "I know you are only teasing me."
- 3. "My name is Molly, and I am a nurse on the unit today."
- 4. "I am not here to receive compliments from clients."



**59.** A client with acute mania fails to respond to a nurse's interventions to decrease his agitation. The nurse has attempted to defuse the client's anger, but the client refuses to participate in interventions that would lower anxiety. Which action should the nurse take next?

- 1. Seclude the client.
- 2. Restrain the client.
- 3. Medicate the client.
- 4. Control the client.

**60.** The client with mania is irritable and insulting to a nursing assistant. The nursing assistant states, "I can't believe Mark is so rude. Shouldn't he be overly happy?" Which of the following responses by the nurse should help the nursing assistant understand the client's behavior?

- 1. "It's our responsibility to listen to him even though we might not like what he's saying."
- 2. "We must reprimand Mark for doing that because there is no reason for him to behave like that."
- 3. "I will go and speak to him about his behavior and make sure he understands that he needs to control what he is saying."
- 4. "I know it's difficult but Mark is a client whose irritable mood is a symptom of his mania."

**61.** Which milieu activity should the nurse recommend to a client with acute mania? Select all that apply.

- 1. Scheduled rest periods.
- 2. Relaxation exercises.
- 3. Listening to soft music.
- 4. Watching television.
- 5. Aerobic exercises.

**62.** A nurse is assessing a client experiencing hypomania who wants to stop her mood stabilizing medication because she is "feeling good," has a high energy level and thinks she is productive at work. Which response by the nurse is most appropriate?

- 1. "Maybe you really don't need your medication anymore."
- 2. "If you stop your medication, your behavior will quickly spiral out of control."
- 3. "I believe you were hospitalized the last time you stopped your medication."
- 4. "Why don't you cut your medication dosage in half for a while and see how you respond?"

**63.** The client with acute mania is prescribed 600 mg of lithium (lithium carbonate) P.O. three times per day. The physician also orders 5 mg of haloperidol (Haldol) P.O. at bedtime. Which action should the nurse take?

- 1. Administer the medication as ordered.
- 2. Question the physician about the order.
- 3. Administer the Haldol, but not the lithium.
- 4. Consult with the nursing supervisor before administering the medications.

**64.** The client with an Axis I diagnosis of bipolar disorder, manic phase, states to the nurse, "I'm the Queen of England. Bow before me." The nurse interprets this statement as important to document as which of the following areas of the mental status examination?

- 1. Psychomotor behavior.
- 2. Mood and affect.
- 3. Attitude toward the nurse.
- 4. Thought content.

**65.** The client is laughing and telling jokes to a group of clients. Suddenly, the client is crying and talking about a death in the family. A moment later, the client is laughing and joking again. The nurse should:

- 1. Call the psychiatrist for an order for Ativan as needed.
- 2. Place the client in seclusion and call the psychiatrist for an order for the seclusion.
- 3. Ignore the client's behavior in order not to give the client too much attention.
- 4. Ask the client to come to a quiet area to talk to the nurse individually.

**66.** A client with acute mania exhibits euphoria, pressured speech, and flight of ideas. The client has been talking to the nurse nonstop for 5 minutes and lunch has arrived on the unit. Which of the following should the nurse do next?

- 1. Excuse self while telling the client to come to the dining room for lunch.
- 2. Tell the client he needs to stop talking because it's time to eat lunch.
- 3. Do not interrupt the client but wait for him to finish talking.
- 4. Walk away and approach the client in a few minutes before the food gets cold.

**67.** A female client with acute mania brings six suitcases and three shopping bags of personal belongings on admission to the unit. When informed that some of the suitcases and bags need to be returned home with her husband because of a lack of storage space, the client begins to use profanity against the nurse. Which of the following responses by the nurse is most therapeutic?

- 1. "You're acting inappropriately."
- 2. "I won't tolerate your talking to me like that."
- 3. "Swearing and profanity are unacceptable here."
- 4. "We don't want to put you in seclusion yet."

**68.** The husband of a client who is experiencing acute mania and is swearing and using profanity apologizes to the nurse for his wife's behavior. Which of the following replies by the nurse is most therapeutic?

- 1. "This must be difficult for you."
- 2. "It's okay. We've heard worse."
- 3. "How long has she been like this?"
- 4. "She needs some medication."

**69.** The nurse overhears a client with acute mania who is euphoric and flirtatious attempting to be sexually inappropriate with other clients by talking about a sexual exploit to a group of clients seated at a table. Which of the following should the nurse do next?

- 1. Continue walking down the hall, ignoring the conversation.
- 2. Speak to the client later in private while saying nothing at this time.
- 3. Tell the client others may not want to hear about sex, and invite him to play a game of ping-pong.
- 4. Inform the client that if he continues to talk about sex no one will want to be around him.

**70.** The client with acute mania states to the nurse, "I'm the prince of peace and can save the world. Those against me will find me and take me to another world. They will come. I know it." The client is beginning to scan the room and starts to repeat his delusion. Which of the following responses by the nurse is **most** therapeutic?

- 1. "Describe the people who will come."
- 2. "The staff and I will protect you."
- 3. "You are not the prince of peace. Your name is Joe."
- 4. "Let's walk around the unit for a while."

**71.** A client with bipolar disorder, manic phase, is scheduled for a chest radiograph. Before taking the client to the radiology department, the nurse should:

- 1. Give a thorough explanation of the procedure.
- 2. Explain the procedure in simple terms.
- 3. Call security to be on standby for possible problems.
- 4. Cancel the appointment until the client can go unescorted.

**72.** A client exhibiting euphoria, hyperactivity, and distractibility cannot remain seated at meal-times long enough to eat an adequate amount of food. When developing the client's plan of care, the nurse anticipates providing the client with "finger food" to eat while moving about the unit. Which of the following foods should the nurse include in the client's plan of care?

- 1. Bacon, lettuce, and tomato sandwich.
- 2. Cheeseburger.
- 3. Ice cream cone.
- 4. Cut-up vegetables.

**73.** The client with bipolar disorder, manic phase, appears at the nurse's station wearing a transparent shirt, miniskirt, high heels, 10 bracelets, and 8 necklaces. Her makeup is overdone and she is not wearing underwear. A pair of inverted underpants is on her head. The nurse should:

- 1. Tell the client to dress appropriately while out of her room.
- 2. Ask the client to put on hospital pajamas until she can dress appropriately.
- 3. Instruct the client to go to her room and change clothes.
- 4. Escort the client to her room and assist with choosing appropriate attire.

**74.** A client diagnosed with bipolar disorder and experiencing acute mania states to the nurse, "Where is my son? I love Lucy. Rain, rain go away. Dogs eat dirt." Another client approaches the nurse and says, "Man, is he ever nuts! He's driving me crazy with all his weird talk." Which response by the nurse to the second client is most appropriate?

- 1. "I agree. He's a little hard to take sometimes."
- 2. "Just walk away and leave him alone. There is nothing else you can do."
- 3. "I realize his behavior bothers you, but he can't control it right now."
- 4. "I'll give him some medication so he won't bother you."

**75.** The client with mania is skipping up and down the hallway practically running into other clients. The nurse should include which of the following activities in the client's plan of care?

- 1. Leading a group activity.
- 2. Watching television.
- 3. Reading the newspaper.
- 4. Cleaning the dayroom tables.

**76.** A client admitted to the nursing unit with bipolar disorder, manic phase, is accompanied by his wife. The wife states that her husband has been overly energetic and happy, talking constantly, purchasing many unneeded items, and sleeping about 4 hours a night for the past 5 days. When completing the client's daily assessment, the nurse should be especially alert for which of the following findings?

- 1. Exhaustion.
- 2. Vertigo.
- 3. Gastritis.
- 4. Bradycardia.

**77.** The wife of a client with bipolar disorder, manic phase, states to the nurse, “He’s acting so crazy. What did he do to get this way?” The nurse bases the response on the understanding of which of the following about this disorder?

- 1. It is caused by underlying psychological difficulties.
- 2. It is caused by disturbed family dynamics in the client’s early life.
- 3. It is the result of an imbalance of chemicals in the brain.
- 4. It is the result of a genetic inheritance from someone in the family.

**78.** A client experiencing acute mania has been taking lithium carbonate 600 mg P.O. three times daily for 14 days. The client’s serum lithium level is 1.8 mEq/L. The nurse should:

- 1. Call the health care provider, hold next dose of lithium and push fluids.
- 2. Call the health care provider, start an IV and put client on bed rest.
- 3. Call the health care provider, then transfer client to a medical intensive care unit.
- 4. Inform the client that the lithium level is within normal limits.

**79.** A client diagnosed with bipolar disorder asks the nurse why it is necessary to have a serum lithium level drawn every 3 to 4 months. The nurse’s response should be based on which of the following?

- 1. To monitor compliance with the medication.
- 2. To prevent toxicity related to the drug’s therapeutic range.
- 3. To monitor the client’s white blood cell count.
- 4. To comply with the drug manufacturer’s requirements.

**80.** The physician orders determination of the serum lithium level tomorrow for a client with bipolar disorder, manic phase, who has been receiving lithium 300 mg P.O. three times daily for the past 5 days. At which of the following times should the nurse plan to have the blood specimen obtained?

- 1. Before bedtime.
- 2. After lunch.
- 3. Before breakfast.
- 4. During the afternoon.

**81.** A client will be discharged on lithium carbonate 600 mg three times daily. When teaching the client and his family about lithium therapy, the nurse determines that teaching has been effective if the client and family state that they will notify the prescribing health care provider immediately if which of the following occur? Select all that apply.

- 1. Nausea.
- 2. Muscle weakness.
- 3. Vertigo.
- 4. Fine hand tremor.
- 5. Vomiting.
- 6. Anorexia.

**82.** After the nurse teaches a client with bipolar disorder about lithium therapy, which of the following client statements indicates the need for additional teaching?

- 1. “It’s important to keep using a regular amount of salt in my diet.”
- 2. “It’s okay to double my next dose of lithium if I forget a dose.”
- 3. “I should drink about 8 to 10 eight-ounce glasses of water each day.”
- 4. “I need to take my medicine at the same time each day.”

**83.** A client with acute mania is to receive lithium carbonate 600 mg P.O. three times daily and 2 mg of haloperidol (Haldol) P.O. at bedtime. The nurse should:

- 1. Refuse to give the medications as ordered.
- 2. Give the lithium only.
- 3. Request a decreased dosage of lithium.
- 4. Give the medications as ordered.

**84.** After the nurse teaches a client about bipolar disorder, which of the following statements indicates that the client has developed insight about the diagnosis?

- 1. “I enjoy feeling high. I don’t need much sleep then and get really creative.”
- 2. “My medicine really helped me. I know I won’t need it in about another week.”
- 3. “I’m cured now. I was really wild for a while even though I got into trouble.”
- 4. “I know I’m getting sick when I don’t need much sleep and start buying things.”

**85.** During morning community meeting, a client with bipolar disorder, manic phase, interrupts others to the point where no one can finish their statements. The nurse should tell the client:

- 1. “Please stop interrupting others. You can speak when it’s your turn.”
- 2. “Stop talking. It’s time for you to leave the meeting.”
- 3. “If you can’t control yourself, we’ll have to take action.”
- 4. “Please behave like an adult. Your behavior is childish.”

**86.** The physician orders valproic acid (Depakene) for a client with bipolar disorder who has achieved limited success with lithium carbonate (Lithane). Which of the following should the nurse include in the client's medication teaching plan?

- 1. Follow-up blood tests are unnecessary.
- 2. The tablet can be crushed if necessary.
- 3. Drowsiness and upset stomach are common side effects.
- 4. Consumption of a moderate amount of alcohol is safe.

**87.** The client with bipolar disorder, manic phase, has a valproic acid (Depakote) level of 15 µg/mL. Which of the following client behaviors should the nurse judge to be due to this level of valproic acid? Select all that apply.

- 1. Irritability.
- 2. Grandiosity.
- 3. Anhedonia.
- 4. Hypersomnia.
- 5. Flight of ideas.

**88.** The client with rapid-cycling bipolar disorder who is about to receive his 5 p.m. dose of carbamazepine (Tegretol) tells the nurse he has a sore throat and chills. Which of the following should the nurse do next?

- 1. Administer the dose of carbamazepine.
- 2. First, give the client acetaminophen (Tylenol) as ordered p.r.n.
- 3. Report the symptoms to the physician in the morning.
- 4. Call the physician to report the symptoms.

**89.** A client's wife states, "I don't know what to do sometimes. It's so hard having a husband with a mental illness like bipolar disorder." After talking with the client's wife about her feelings and difficulties, which of the following actions is most appropriate?

- 1. Suggest that the wife see her physician.
- 2. Give the wife information about a support group.
- 3. Recommend that the wife talk with her close friend.
- 4. Have the wife share her feelings with her husband.

**90.** The client with bipolar disorder is approaching discharge after being hospitalized with her first episode of acute mania. The client's husband asks the nurse what he can do to help her. Which of the following recommendations for the husband should the nurse anticipate including in the teaching plan?

- 1. Help the client to be free from worry and anxiety.
- 2. Communicate openly and offer support.
- 3. Relieve the client of all responsibilities.
- 4. Remind the client to control her symptoms.

**91.** The client with bipolar disorder states to the nurse, "I guess the medication does help me after all. When I stopped taking it, I started to have trouble sleeping and my thoughts were racing." The nurse should tell the client:

- 1. "I'm happy you realize that you started to get symptoms when you stopped your medication."
- 2. "Although it took a long time, you finally do understand that you need your medication."
- 3. "Why didn't you go to the community mental health center for help?"
- 4. "Didn't your family tell you that you were getting sick again?"

**92.** A client who is acutely manic and very anxious begins to pace, bump into furniture, and preach loudly. The nurse should:

- 1. Walk with the client until he calms down.
- 2. Tell the client to go to his room.
- 3. Ask the client to sit in on a group therapy session.
- 4. Administer haloperidol (Haldol) ordered p.r.n.

**93.** A client experiencing a manic episode has been talking loudly, pacing the unit and trying to draw other clients into debates about the value of self-determination. Arrange in order the steps a nurse should take to help calm this client.

1. Use oral medication to decrease anxiety and increase appropriate social interaction.

2. Talk with the client about the anxiety and stress the client is feeling.

3. Take client to a quiet area, such as his/her room, to decrease stimuli.

4. Teach the client coping strategies to deal with stressors.

**94.** The client with bipolar disorder, manic phase, states, "You're looking good. I'm taking you out to dinner." Which of the following replies by the nurse is most therapeutic?

- 1. "I don't want to go out to dinner."
- 2. "I can't go out to dinner with you."
- 3. "It doesn't matter how I look, the answer is no."
- 4. "I'm Chris Smith, a nurse working on this unit."

**95.** After the nurse administers haloperidol (Hal-dol) 5 mg P.O. to a client with acute mania, the client refuses to lie down on her bed, runs out on the unit, pushes clients in her vicinity out of the way, and screams threatening remarks to the staff. Which of the following should the nurse do next?

- 1. Follow the client and ask her to calm down.
- 2. Tell the client to lie down on the sofa in the community room.
- 3. Seclude the client and use restraints if necessary.
- 4. Tell the staff to ignore the client's remarks.

**96.** As the nurse is turning off the television, a client with bipolar disorder, manic phase, says, "I want the television on so I can watch the late show. I'm not tired and you can't tell me what to do. I want it on!" The nurse should tell the client:

- 1. "I'll let you watch television just this once. Don't tell anyone about this."
- 2. "I'll turn the television off when you get sleepy. Don't ask me to do this again."
- 3. "Television hours are from 7 to 10 p.m. It's 10 p.m., and the television goes off so everyone can sleep."
- 4. "The television goes off at 10 p.m. I've been telling you this for the past three evenings."

### The Client with Suicidal Ideation and Suicide Attempt

**97.** The nurse manager in the emergency department (ED) is conducting an in-service for the nursing staff about screening clients for suicide. One of the nurses states, "Questioning adolescents about suicide will only increase their thinking about self-harm and they would not admit it to me anyhow." How should the nurse manager respond?

- 1. "You could be correct. Let's assess only adults because they'll be more honest."
- 2. "We will limit the assessment to adolescents with psychiatric diagnoses."
- 3. "It's a myth that talking about suicide leads to suicide attempts. Adolescents will disclose suicidal thoughts when asked directly."
- 4. "If you think the adolescent is not telling you the truth, you can question the parents."

**98.** When assessing a client for suicidal risk, which of the following methods of suicide should the nurse identify as **most** lethal?

- 1. Aspirin overdose.
- 2. Use of a gun.
- 3. Head-banging.
- 4. Wrist-cutting.

**99.** The nurse manager overhears two staff members talking in the snack room. One of the staff members states, "Her superficial cuts are just a means of getting our attention. She never should have been admitted. I hope she's out of here soon." Which of the following responses by the nurse manager is most appropriate?

- 1. "It's our job to help her no matter how we feel about her or what she did. She'll be discharged soon."
- 2. "I won't tolerate that kind of discussion from my staff. Now, it is time for you to go back to work."
- 3. "I know it's hard to understand, but we need to do the best we can even though she'll be back."
- 4. "No matter what the intent, all suicidal behavior is serious and deserves our serious consideration."

**100.** The history of a female client who has just been admitted to the unit and is very depressed reveals a weight loss of 10 lb in 2 weeks, sleeping 3 hours a night, and poor hygiene. The client states, "I'm no good to anyone. Everyone would be better off without me." Which of the following questions should the nurse ask **first**?

- 1. "What do you mean?"
- 2. "Are you thinking about hurting yourself?"
- 3. "Doesn't your family care about you?"
- 4. "What happened to make you think that?"

**101.** When developing the plan of care for a client with suicidal ideation, developing goals to address which of the following is a priority?

- 1. Self-esteem.
- 2. Sleep.
- 3. Hygiene.
- 4. Safety.

**102.** Which of the following questions should the nurse ask to best determine the seriousness of a client's suicidal ideation?

- 1. "How are you planning on harming yourself?"
- 2. "Have you made out a will?"
- 3. "Does your family know you're here?"
- 4. "How long have you been thinking about harming yourself?"

**103.** The nursing assistant states to the nurse, "My client talks about how awful and useless she is. Sometimes she sounds angry for no reason. I'm tired of listening to her." Which of the following responses by the nurse is **most** appropriate?

- 1. "I'll switch your assignment to someone who's less depressed and less tiring."
- 2. "It's important for you to listen to her because she needs to verbalize how she is feeling."
- 3. "Don't worry about it. I know you haven't done anything to make her angry."
- 4. "Clients with depression are hard to deal with, but don't take what they say seriously."

**104.** A client states, “I’m so tired of living and just want to end it all.” Which of the following responses is **most** therapeutic?

- 1. “I’ll walk with you to your room so that you can get some rest.”
- 2. “Perhaps after your son visits you’ll feel better about things.”
- 3. “You’re in a lot of pain now but you will feel better. I’m here to help you.”
- 4. “You are very depressed right now and want to die but you need to focus on life.”

**105.** A client who was recently discharged from the psychiatric unit telephones the unit to speak to the nurse. The client states that she took her children to the neighbors’ house and has turned on the gas to kill herself. She is home alone and gives the nurse her address. Which of the following actions should the nurse do next?

- 1. Refer the caller to a 24-hour suicide hotline.
- 2. Tell the caller that another nurse will telephone the police.
- 3. Ask the caller whether she telephoned her physician.
- 4. Instruct the caller to telephone her family for help.

**106.** A client walks into the clinic and tells the nurse she wants to die because her boyfriend broke up with her. The client states, “I’ll show him, he’ll be sorry.” The nurse notes which of the following as the underlying theme and method to deal with the client?

- 1. Sadness—ask client to reveal how long she has felt this way.
- 2. Escape—ask client to indicate from what she wants to escape.
- 3. Loneliness—ask client to state who she believes to be her friends.
- 4. Retaliation—ask client about her specific plans to harm herself and/or her boyfriend.

**107.** The client has been hospitalized for major depression and suicidal ideation. Which of the following statements indicates to the nurse that the client is improving?

- 1. “I couldn’t kill myself because I don’t want to go to hell.”
- 2. “I don’t think about killing myself as much as I used to.”
- 3. “I’m of no use to anyone anymore.”
- 4. “I know my kids don’t need me anymore since they’re grown.”

**108.** The client states to the nurse at the outpatient clinic, “I don’t feel ready to go back to work. It’s only been a week since I left the hospital.” Assessment reveals a flat affect, disheveled appearance, poor posture, and minimal eye contact during interaction. The nurse asks the client whether he is thinking about harming himself. The client tells the nurse he has a loaded revolver at home and will probably use it. Which of the following should the nurse do next?

- 1. Tell the client to go and remove the gun from his home.
- 2. Ask the client to call the nurse every hour when he gets home.
- 3. Ask the client to promise not to harm himself.
- 4. Initiate plans for hospitalization immediately.

**109.** The widow of a client who successfully completed suicide tearfully says, “I feel guilty because I’m so angry at him for killing himself. It must have been what he wanted.” After assisting the widow with dealing with her feelings, which of the following is **most** helpful?

- 1. Referring her to a group for survivors of suicide.
- 2. Encouraging her to receive counseling from a chaplain.
- 3. Providing her with the local suicide hotline number.
- 4. Suggesting she receive individual therapy by the nurse.

**110.** The husband of a client to be discharged from the hospital after an episode of major depression and a suicide attempt asks, “What can I do if she tries to kill herself again?” Which of the following responses is **most** appropriate?

- 1. “Don’t worry. She’ll be okay as long as she takes her medication.”
- 2. “She told me she wants to live so I don’t think she’ll try again.”
- 3. “Let’s talk about some behavioral clues and resources that can help.”
- 4. “Tell her about your concern and just take care of her.”

**111.** A client with depression is exhibiting a brighter affect, ability to attend to hygiene and grooming tasks, and beginning participation in group activities. The nurse asks the client to identify three of her strengths. After much hesitation and thinking, the client can state she is usually a nice person, a good cook, and a hard worker. Which of the following should the nurse do next?

- 1. Ask the client to identify an additional three strengths.
- 2. Volunteer the client to lead the cooking group later in the day.
- 3. Educate the client about the importance of medication.
- 4. Reinforce the client for identifying and sharing her strengths.

**112.** The friend of a client with depression and suicidal ideation asks the nurse, “How should I act around her?” Which of the following responses by the nurse is best?

- 1. “Try to cheer her up.”
- 2. “Be caring and genuine.”
- 3. “Control your expressions.”
- 4. “Avoid asking how she’s feeling.”

**113.** A client with depression and suicidal ideation voices feelings of self-doubt and powerlessness and is very dependent on the nurse for most aspects of her care. According to Erikson’s stages of growth and development, the nurse determines the client to be manifesting problems in which of the following stages?

- 1. Trust versus mistrust.
- 2. Autonomy versus shame/doubt.
- 3. Initiative versus guilt.
- 4. Industry versus inferiority.

**114.** A 68-year-old client has improved with medication and treatment and no longer experiences suicidal ideation. She can manage her diabetic care and understands her diet requirements. She will be discharged to live alone in her apartment. Visits by which of the following caregivers are most important for the nurse to arrange before the client’s discharge?

- 1. Psychiatric home care nurse.
- 2. Medical social worker.
- 3. Her minister.
- 4. Occupational therapist.

**115.** A client who overdosed on barbiturates is being transferred to the inpatient psychiatric unit from the intensive care unit. Assessing the client for which of the following needs should be a priority for the nurse receiving the client in the intensive care unit?

- 1. Nutrition.
- 2. Sleep.
- 3. Safety.
- 4. Hygiene.

**116.** A client is brought to the psychiatric unit from the emergency department (ED) escorted by ED staff and a security officer. The client’s shoulder is bandaged and his arm is in a sling because of a self-inflicted gunshot wound to his shoulder. Later, the client’s wife follows with a bag of her husband’s belongings. Which of the following nursing actions is **most** appropriate at this time?

- 1. Tell the wife to take her husband’s things home because he is suicidal.
- 2. Instruct the wife to unpack the bag and put her husband’s things in the dresser.
- 3. Ask the wife whether the bag contains anything dangerous.
- 4. Inspect the bag and its contents in the presence of the client and his wife.

**117.** A suicidal client is placed in the seclusion room and given lorazepam (Ativan) because she tried to harm herself by banging her head against the wall. After 10 minutes, the client starts to bang her head against the wall in the seclusion room. Which of the following should the nurse do next?

- 1. Tell the client to stop doing that and act like a responsible adult.
- 2. Place the client in leather restraints.
- 3. Call the physician for additional medication orders.
- 4. Instruct a staff member to sit in the room with the client.

**118.** A client lives in a group home and visits the community mental health center regularly. During one visit with the nurse, the client states, “The voices are telling me to hurt myself again.” Which of the following questions by the nurse is **most** important to ask?

- 1. “When do you hear the voices?”
- 2. “Are you going to hurt yourself?”
- 3. “How long have you heard the voices?”
- 4. “Why are the voices starting again?”

**119.** A 20-year-old client diagnosed with paranoid schizophrenia is recovering from his first psychotic break. Before discharge from the hospital, the client becomes depressed and states, “I don’t want this illness. I’m about to begin my junior year in college.” Which of the following issues would be **most** important for the nurses to address at this time?

- 1. Disturbed thought process.
- 2. Disturbed sensory perceptions.
- 3. Communication problems.
- 4. Potential for medication non-compliance.

**120.** The nurse is teaching two nursing assistants who are new to the inpatient unit about caring for a client who is suicidal. The nurse determines that additional teaching is needed when which of the following statements is made?

- 1. “I need to check the client precisely at 15-minute intervals.”
- 2. “Documenting suicide checks is absolutely necessary.”
- 3. “Clients on one-to-one suicide precautions can never be left alone.”
- 4. “All clients using razors must be supervised by staff.”

**121.** Which of the following activities should the nurse recommend to the client on an inpatient unit when thoughts of suicide occur?

- 1. Keeping track of feelings in a journal.
- 2. Reading a magazine.
- 3. Talking with the nurse.
- 4. Playing a card game with other clients.

**122.** Which of the following amounts of medications is appropriate for a client who is being treated with imipramine (Tofranil) on an outpatient basis for recurring depression and suicidal ideation to have at one time?

- 1. A 30-day supply.
- 2. A 21-day supply.
- 3. A 14-day supply.
- 4. A 7-day supply.

**123.** The client with recurrent depression and suicidal ideation tells the nurse, “I can’t afford this medicine anymore. I know I’ll be okay without it.” The nurse should:

- 1. Inform the physician of the client’s statement.
- 2. Ask the social worker to find assistance for the client.
- 3. Schedule a follow-up appointment in 3 months.
- 4. Ask the client whether a family member could help.

### Managing Care Quality and Safety

**124.** A client is suicidal and not responding to the antidepressants prescribed to him over the last 2 months. This morning, after talking to his wife, the client verbally agrees to electroconvulsive therapy (ECT), but refuses to sign the consent form saying it is “evil.” The nurse should:

- 1. Proceed with treatment because he has given verbal consent.
- 2. Have his wife sign the consent form as next of kin.
- 3. Inform his wife that his refusal to sign means treatment must be withheld unless the client later signs the document or a court hearing is held.
- 4. Tell the client that he will not be released from the hospital as soon as originally promised due to his refusal.

**125.** Which of the following reactions to learning about a diagnosis of being HIV positive would put the client at the greatest need of intervention by the nurse?

- 1. A person who is angry, hostile, and alienated from their family.
- 2. A person obsessed with cleanliness and showers many times a day.
- 3. A person unable to make decisions, who is helpless and tearful.
- 4. A person who says “I have found a solution for this mess.”

**126.** Which of the following represents a breach of the nursing Code of Ethics regarding the rights of clients in psychiatric care situations?

- 1. Nurse discusses client’s care with out-of-town family members that the client has formally indicated are allowed to know about the client’s hospital care.
- 2. Nurse discusses the client’s history and hospital course of treatment with a consulting physician.
- 3. Nurse discusses with a friend the progress of a local celebrity being cared for at the hospital.
- 4. Nurse discusses the client’s care with the admission coordinator of a retirement home that the client plans to enter after discharge from the hospital.

**127.** A client diagnosed with schizophrenia for the last two years tells the nurse who has brought the morning medications “That is not my pill! My pill is blue, not green.” The nurse should tell the client?

- 1. “Go ahead and take it. You can trust me. I am watching out for your safety and well being.”
- 2. “I know I took the correct medication out of the Pyxis. Don’t you trust me?”
- 3. “Don’t worry, your medication is generic and sometimes the manufacturers change the color of the pills without letting us know.”
- 4. “I will go back and check the drawer as well as telephone the pharmacy to check about any possible changes in the medication color.”

**128.** A client who took an overdose of Tylenol in a suicide attempt is transferred overnight to the psychiatric inpatient unit from the intensive care unit. The night shift nurse called the physician on call to obtain initial orders. The physician ordered the typical routine medications for clients on this unit: Milk of Magnesia, Maalox and Tylenol as needed. Prior to implementing the orders, the nurse should?

- 1. Ask the physician about holding all the client’s PM orders.
- 2. Question the physician about the Tylenol order.
- 3. Request an order for a medication to relieve agitation.
- 4. Suggest the physician write an order for intravenous fluids.

**129.** When developing appropriate assignments for the staff, which of the following clients should the nurse manager judge to be at highest risk for suicide completion?

- 1. An 85-year-old Caucasian man who lives alone after his wife’s death.
- 2. A 34-year-old single Hispanic woman who has recently been diagnosed with cancer.
- 3. A 15-year-old African American woman whose boyfriend broke up with her.
- 4. A 52-year-old Asian man who was terminated from his job because of downsizing.



**130.** When developing staff assignments for the unit, the nurse manager should determine that which of the following clients needs one-to-one staff supervision?

- 1. The client who is sometimes preoccupied with death.
- 2. The client who tries to elope from the unit but is ambivalent about suicide.
- 3. The client who is impulsive and holds her breath until she faints.
- 4. The client who cannot sign a no-harm contract because of hallucinations.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Major Depression

**1. 4.** Including the root healer gives credibility and respect to the client's cultural beliefs. Avoiding talking about the healer demonstrates either ignorance or disregard for the client's cultural values. Negative comparison of root healing with Western medicine not only denigrate the client's beliefs, but are likely to alienate him or her and cause them to end treatment.

🔑 CN: Psychosocial adaptation; CL: Create

**2. 3.** Cheese and yeast products contain tyramine which the client should avoid to prevent a negative interaction with Parnate, a monoamine oxidase (MAO) inhibitor. Sodium will not interact with Parnate and neither exercise nor sugar needs to be limited.

🔑 CN: Pharmacological and parenteral therapies; CL: Evaluate

**3.**

1. Sit quietly with the client.

4. Discuss specific concerns.

3. Offer use of MP3 player with relaxing music.

2. Encourage the use of Restoril.

The client is likely anxious about the procedure. The nurse should first spend time with the client and then discuss the client's concerns about the procedure. Next, the nurse could suggest the client listen to relaxing music. The use of the sleeping medication would only be considered as a last resort since it might interfere with the effectiveness of the seizure required for the treatment.

🔑 CN: Psychosocial adaptation; CL: Synthesize

**4. 1.** Selegiline transdermal system is the first transdermal monoamine oxidase inhibitor. The client on Emsam needs to avoid exposing the application site to external sources of direct heat, such as saunas, heating lamps, electric blankets, heating pads, heated water beds, and prolonged direct sunlight because heat increases the amount of selegiline that is absorbed, resulting in elevated serum levels of selegiline. Cutting the patch and using a smaller piece will result in a decreased amount of medication absorption, most likely leading to a worsening of the symptoms of depression. The client should apply a new patch as soon as possible if one falls off to ensure an adequate amount of medication absorption. Emsam is not associated with significant weight gain, although a weight gain of 1 to 2 lb (2.2 to 4.4 kg) is possible.

🔑 CN: Pharmacological and parenteral therapies; CL: Evaluate

**5. 3.** The nurse should report the client's beer consumption to the physician. Duloxetine should not be administered to a client with renal or hepatic insufficiency because the medication can elevate liver enzymes and, together with substantial alcohol use, can cause liver injury. Referring the client to the dual diagnosis program, sharing information at the next interdisciplinary treatment conference, and teaching the client relaxation exercises are helpful interventions for the nurse to implement. However, reporting the findings to the physician is most important.

🔑 CN: Pharmacological and parenteral therapies; CL: Synthesize

**6. 2.** The client's sudden improvement and decrease in anxiety most likely indicates that the client is relieved because he has made the decision to kill himself and may now have the energy to complete the suicide. Symptoms of severe depression do not suddenly abate because most antidepressants work slowly and take 2 to 4 weeks to provide a maximum benefit. The client will improve slowly due to the medication. The sudden improvement in symptoms does not mean the client is nearing discharge and decreasing observation of the client compromises the client's safety.

🔑 CN: Psychosocial adaptation; CL: Analyze


**7. 1, 2, 5.** It is important for the nurse to obtain information about the client's use of tea, herbal medicine, and a folk healer because the information is critical to the safe prescription of psychotropic medication. Breathing exercises, massage, and acupuncture are also traditional therapies used by the Asian American population, but do not interfere with the use of medications.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**8. 1.** The nurse should immediately report the rash to the physician because lamotrigine can cause Stevens-Johnson syndrome, a toxic epidermal necrolysis. The rash is not a temporary adverse effect. Giving the client an ice pack and questioning the client about recent sun exposure are irresponsible nursing actions because of the possible seriousness of the rash.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**9. 2.** The nurse should hold the 5 p.m. dose of lithium because a level of 1.8 mEq/L can cause adverse reactions, including diarrhea, vomiting, drowsiness, muscle weakness, and lack of coordination, which are early signs of lithium toxicity. The nurse should report the lithium level to the physician, including any symptoms of toxicity. Administering the 5 p.m. dose of lithium, giving the client the lithium with 8 oz (236 mL) of water, or giving it after supper would result in an increase of the lithium level, thus increasing the risk of lithium toxicity.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**10. 3.** Additional teaching is needed for the family member who states her son will only need to attend outpatient appointments when he starts to feel depressed again. Compliance with medication and outpatient follow-up are key in preventing relapse and rehospitalization. The statements expressing expectations of feeling better as medication takes effect, needing medicine and group therapy to stay well, and needing help with grocery shopping, cooking, and cleaning for a while indicate the families' understanding of depression, medication, and follow-up care.

 CN: Psychosocial adaptation; CL: Evaluate

**11. 4.** Delusions occurring in schizophrenia tend to be more mood incongruent and more bizarre than delusions experienced with depression. Schizophrenic delusions clear up less quickly and are more likely to require depot antipsychotic medication, which are administered intramuscularly. Delusions in major depression match the client's mood, are somewhat more reality based, and tend to resolve once the client is properly medicated.

 CN: Psychosocial adaptation; CL: Analyze

**12. 4.** The nurse closely monitors the client taking paroxetine for the development of agitation, which could lead to self-harm in the form of a suicide attempt. Headache, nausea, and fatigue are transient adverse effects of paroxetine.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**13.**

2. Sleep.

4. Appetite.


3. Energy level.

1. Self-esteem.

When beginning medication treatment, the client will initially notice an improvement in sleep, followed by an improvement in appetite which leads to an increase in energy level. Behavioral treatment is most likely to affect self-esteem and since the decline in self-esteem generally occurs over months or years, it will likely take longer than a few days to improve.


 CN: Physiological adaptation; CL: Analyze

**14. 3.** Endogenous depression (depression coming from within the person) is biochemical in nature. The biologic theory of depression indicates a neurotransmitter imbalance involving serotonin, norepinephrine, and possibly dopamine. Reactive depression is caused by the occurrence of something happening outside the body, such as the death of a loved one or another significant loss. Stating that the client will improve with the right medication or that family members seem supportive does not address the client's immediate concerns of not knowing the cause of the depression. Discussing possible reasons for the client's depression is nontherapeutic because the depression is endogenous and biochemically based.


 CN: Psychosocial adaptation; CL: Synthesize

**15. 2.** The nurse should initiate brief, frequent contacts throughout the day to let the client know that he is important to the nurse. This will positively affect the client's self-esteem. The nurse's action conveys acceptance of the client as a worthwhile person and provides some structure to the seemingly monotonous day. Waiting for the client to begin the conversation with the nurse is not helpful because the depressed client resists interaction and involvement with others. Sitting outside of the client's room is not productive and not necessary in this situation. If the client were actively suicidal,


then a one-on-one client-to-staff assignment would be necessary. Questioning the client until he responds would overwhelm him because he could not meet the nurse's expectations to interact.

 CN: Psychosocial adaptation;  
CL: Synthesize

**16. 1.** The most appropriate action is for the nurse to remain with the client even if the client does not engage in conversation with the nurse. A client with severe depression may be unable to engage in an interaction with the nurse because the client feels worthless and lacks the necessary energy to do so. However, the nurse's presence conveys acceptance and caring, thus helping to increase the client's self-worth. Telling the client that the nurse will come back later, stating that the nurse will find someone else for the client to talk with, or telling the client that the nurse will get her something to read conveys to the client that she is not important, reinforcing the client's negative view of herself. Additionally, such statements interfere with the client's development of a sense of security and trust in the nurse.


 CN: Psychosocial adaptation;  
CL: Synthesize

**17. 4.** The nurse tells the client that the nurse is interested in her to increase the client's sense of importance, worth, and self-esteem. Also, stating that the nurse wants to help conveys to the client that she is worthwhile and important. Telling the client that the nurse is assigned to care for her is impersonal and implies that the client is being uncooperative. Telling the client that the nurse is there because the client has potential for improvement will not help the client with low self-esteem because most people develop a sense of self-worth through accomplishment. Simply saying that the client has a lot of potential will not convince her that she is worthwhile. Telling the client that the nurse will talk to someone else later is not client-focused and does not address the client's question or concern.


 CN: Psychosocial adaptation;  
CL: Synthesize

**18. 2.** Nausea and gastrointestinal upset is a common, but usually temporary, side effect of paroxetine (Paxil). Therefore, the nurse would instruct the client to take the medication with food to minimize nausea and stomach upset. Other more common side effects are dry mouth, constipation, headache, dizziness, sweating, loss of appetite, ejaculatory problems in men, and decreased orgasms in women. Taking the medication an hour before breakfast would most likely lead to further gastrointestinal upset. Taking the medication at bedtime is not recommended because Paxil can cause nervousness and interfere with sleep. Because orange juice is acidic, taking the medication with it, especially on


an empty stomach, may lead to nausea or increase the client's gastrointestinal upset.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**19. 2.** The presence of dizziness could indicate orthostatic hypotension, which may cause injury to the client from falling. Nausea, sedation, and dry mouth do not require immediate intervention by the nurse.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**20. 3.** Symptom relief can occur during the 1st week of therapy, with optimal effects possible within 2 weeks. For some clients, 2 to 4 weeks is needed for optimal effects. The client's statement that the depression will be gone in 5 to 7 days indicates to the nurse that clarification and further teaching is needed. Trazodone should be taken after a meal or light snack to enhance its absorption. Trazodone can cause drowsiness, and therefore the major portion of the drug should be taken at bedtime. The depressant effects of central nervous system depressants and alcohol may be potentiated by this drug.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**21. 3.** The nurse should explain that ECT is a safe treatment and that the client is given an ultra-short-acting anesthetic to induce sleep before ECT and a muscle relaxant to prevent musculoskeletal complications during the convulsion, which typically lasts 30 to 60 seconds to be therapeutic. Atropine is given before ECT to inhibit salivation and respiratory tract secretions and thereby minimize the risk of aspiration. Medication for pain is not necessary and is not given before or during the treatment. Some clients experience a headache after the treatment and may request and be given an analgesic such as acetaminophen (Tylenol). Telling the daughter that the physician will ensure that the client does not suffer needlessly would not provide accurate information about ECT. This statement also implies that the client will have pain during the treatment, which is untrue.

 CN: Reduction of risk potential;  
CL: Synthesize

**22. 2.** Option 1 casts doubt on the client's perception, which is likely to increase the client's anxiety and make the client feel defensive. Options 3 & 4 further the client's unrealistic perception of the situation. Option 2 focuses on the client and her feelings which is the most effective approach to help her realistically consider her situation and decrease the anxiety that led the client to use the defense mechanism of reaction formation.

 CN: Psychosocial adaptation;  
CL: Synthesize


**23. 1.** By stating, “It must have been very upsetting for you,” the nurse conveys empathy to the client by recognizing the underlying meaning of a painful occurrence. The nurse’s statement invites the client to verbalize feelings and thoughts and lets the client know that the nurse is listening to and respects the client. Telling the client to talk about the job disregards the client’s feelings and is nontherapeutic for the depressed client because of underlying feelings of worthlessness and guilt that are commonly present. Telling the client that he will find another job when he is better or that he was probably too depressed to work is inappropriate because it disregards the client’s feelings and may promote additional feelings of failure and inadequacy in the client.

 CN: Psychosocial adaptation;  
CL: Synthesize

**24. 2.** The client’s negative thinking and statements are directly related to the psychopathology of depression. The client’s views and feelings about herself reflect low self-esteem. Although *Impaired social interaction*, *Risk for self-directed violence*, and *Ineffective coping* are possible nursing diagnoses, there are insufficient data to support these diagnoses. Further assessment is needed to identify supportive data.


 CN: Psychosocial adaptation; CL: Analyze

**25. 4.** The client with depression is preoccupied, has decreased energy, and cannot make decisions, even simple ones. Therefore, the nurse presents the situation, “It’s time for a shower,” and assists the client with personal hygiene to preserve his dignity and self-esteem. Explaining the importance of good hygiene to the client is inappropriate because the client may know the benefits of hygiene but is too fatigued and preoccupied to pay attention to self-care. Asking the client if he is ready for a shower is not helpful because the client with depression commonly cannot make even simple decisions. This action also reinforces the client’s feeling about not caring about showering. Waiting for the family to visit to help with the client’s hygiene is inappropriate and irresponsible on the part of the nurse. The nurse is responsible for making basic decisions for the client until the client can make decisions for himself.

 CN: Psychosocial adaptation;  
CL: Synthesize

**26. 4.** By saying, “You were able to bathe today,” the nurse is pointing out a visible accomplishment or strength, thereby increasing the client’s feelings of self-worth and self-esteem. Stating that “everybody around here likes you” or discussing what the client has done correctly is inappropriate because


although the client may agree with the nurse, the client still may be depressed. Stating that the nurse sees many good qualities in the client is not helpful because a person’s feeling of self-worth is generally determined by accomplishments. Intellectual understanding does not help the client with severe depression. Additionally, the nurse cannot talk a client out of depression because major depression is endogenous and biochemical in nature. Medication should restore the neurotransmitter balance and relieve the depression.

 CN: Psychosocial adaptation;  
CL: Synthesize

**27. 1.** The family needs to be informed that some confusion and disorientation will occur as the client emerges from anesthesia immediately after ECT, to lessen their fear and anxiety about the procedure. The nurse will assist the client with reorientation (time, person, and place) and will give clear, simple instructions. The client may need to lie down after ECT because of the effects of the anesthesia. Informing the family that there is a danger of aspiration during ECT is inappropriate and unnecessary. The risk of aspiration occurring during ECT is minimal because food and fluids are withheld for 6 to 8 hours before the treatment. In addition, the client receives atropine to inhibit salivation and respiratory tract secretions. Telling the family that the client will not be able to breathe independently during ECT may frighten them unnecessarily. If asked, the nurse should inform the family that the anesthesiologist mechanically ventilates the client with 100% oxygen immediately before the treatment. The client with severe depression responds to ECT. Usually, ECT is used for those who are severely depressed and not responding to pharmacotherapy and for those who are highly suicidal.

 CN: Psychosocial adaptation; CL: Create

**28. 2.** Sertraline, like other selective serotonin reuptake inhibitors (SSRIs), can cause decreased libido and sexual dysfunction such as delayed ejaculation in men and an inability to achieve orgasm in women. SSRIs do not typically cause weight gain but may cause loss of appetite and weight loss. Dry mouth is a possible side effect, but it is temporary. The client should be told to take sips of water, suck on ice chips, or use sugarless gum or candy. St. John’s wort should not be taken with SSRIs because a severe reaction could occur.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**29. 3.** It is best to involve the client in usual at-home activities as much as the client can tolerate them. Discouraging visitors may not be in the client’s best interest because visits with supportive significant others will help reinforce supportive

relationships, which are important to the client's self-worth and self-esteem. Providing for a schedule of activities outside the home may be overwhelming for the client initially. Involving the client in planning for outside activities would be appropriate. Encouraging the client to sleep as much as possible is nontherapeutic and promotes withdrawal from others.

 CN: Psychosocial adaptation;  
CL: Synthesize

**30. 4.** Medication management with outpatient follow-up is of vital importance to discuss with the client before discharge. The nurse teaches and clarifies any questions related to medication and outpatient treatment. The client also has the opportunity to voice feelings related to medication and treatment. The goal is to assist the client in making a successful transition from hospital to home with optimal functioning outside the hospital for as long as possible. The nurse may also need to assist with decreasing any anxiety the client may have related to discharge. Discussing future plans for returning to work or employment is not as immediate a concern as assisting with medication and treatment compliance. Noncompliance with medication is a primary cause of relapse in a client with a psychiatric disorder. Reviewing a conflict the client had encountered with another client is not appropriate or therapeutic at this time unless the client brings it to the nurse's attention. The conflict should have been dealt with and resolved when it occurred. Reviewing the results of psychological testing is the responsibility of the physician if he chooses.


 CN: Psychosocial adaptation; CL: Create

**31. 2.** Criteria for commitment include being gravely disabled and posing a harm to self or others. This client is not threatening to harm himself in the form of suicide or to harm others. The client is gravely disabled because of his inability to care for himself—namely, not eating because of his delusion. Evidence of psychosis or psychotic symptoms or diagnosis of a mental illness alone does not make the client legally eligible for commitment.


 CN: Management of care; CL: Apply

**32. 3.** The client needs to be informed of the time lag involved with antidepressant therapy. Although improvement in the client's symptoms will occur gradually over the course of 1 to 2 weeks, typically it takes 2 to 4 weeks to get the full effects of the medication. This information will help the client be compliant with medication and will also help in decreasing any anxiety the client has about not feeling better. The client's dose may not need to be increased; it is too early to determine the full effectiveness of the drug. Additionally, such a statement may increase the client's anxiety and diminish


self-worth. Telling the client to wait a few days discounts the client's feelings and is inappropriate. Although it is too soon to tell whether the medication will be effective, telling this to the client may cause the client undue distress. This statement is somewhat negative because it is possible that the medication will not be effective, possibly further compounding the client's anxiety about not feeling better.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**33. 1, 2, 3, 5, 6.** Serotonin syndrome can occur if a selective serotonin reuptake inhibitor is combined with a monoamine oxidase inhibitor, a tryptophan-serotonin precursor, or St. John's wort. Signs and symptoms of serotonin syndrome include mental status changes, such as confusion, restlessness or agitation, headache, diaphoresis, ataxia, myoclonus, shivering, tremor, diarrhea, nausea, abdominal cramps, and hyperreflexia. Constipation is not associated with serotonin syndrome.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**34. 2.** Phenelzine is a monoamine oxidase inhibitor (MAOI). MAOIs block the enzyme monoamine oxidase, which is involved in the decomposition and inactivation of norepinephrine, serotonin, dopamine, and tyramine (a precursor to the previously stated neurotransmitters). Foods high in tyramine—those that are fermented, pickled, aged, or smoked—must be avoided because, when they are ingested in combination with MAOIs, a hypertensive crisis occurs. Some examples include salami, bologna, dried fish, sour cream, yogurt, aged cheese, bananas, pickled herring, caffeinated beverages, chocolate, licorice, beer, Chianti, and alcohol-free beer.

 CN: Pharmacological and parenteral therapies; CL: Apply


**35. 4.** The nurse should first take the client's vital signs because the client could be experiencing a hypertensive crisis, which requires prompt intervention. Signs and symptoms of a hypertensive crisis include occipital headache, a stiff or sore neck, nausea, vomiting, sweating, dilated pupils and photophobia, nosebleed, tachycardia, bradycardia, and constricting chest pain. Giving this client an analgesic without taking his vital signs first is inappropriate. After the client's vital signs have been obtained, then the nurse would call the physician to report the client's complaints and vital signs. Administering the client's next dose of phenelzine before taking his vital signs could result in a dangerous situation if the client is experiencing a hypertensive crisis.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**36. 2.** A depressed client commonly is not interested in eating because of the psychopathology of the disorder. Therefore, the nurse must take responsibility to ensure that the client eats, including spoon-feeding the client (placing the food on the spoon, putting the food near the client's mouth, and asking her to eat) if necessary. Serving the client her tray in her room does not ensure that she will eat. Calling the family to bring the client food from home usually is allowed, but it is still the nurse's responsibility to ensure that the client eats. Explaining the importance of nutrition in recovery is not helpful. The client may intellectually know that eating is important but may not be interested in eating or want to eat.

 CN: Psychosocial adaptation;  
CL: Synthesize

**37. 1.** To promote adequate rest (6 to 8 hours per night) and to eliminate hyposomnia, the nurse should sit with the client at the bedside until the medication takes effect. The presence of a caring nurse provides the client with comfort and security and helps to decrease the client's anxiety. Engaging the client in interaction until the client falls asleep, reading to the client, or encouraging the client to watch television may be too stimulating for the client, consequently increasing rather than decreasing the client's restlessness.


 CN: Psychosocial adaptation;  
CL: Synthesize

**38. 3.** The client who verbalizes feeling in control of self and situations no longer feels powerless to affect an outcome but realizes that one's actions can have an impact on self and situations. It is common for the client with depression to feel powerless to affect an outcome and to feel a lack of control over a situation. Although interacting with staff and peers is a positive action, the client could be conversing in a negative or nontherapeutic manner. Sleeping 4 hours in the afternoon and 4 hours at night is evidence of symptomatology and does not indicate improvement or recovery. Verbalizing dissatisfaction over not being able to perform at work indicates that the client is most likely focusing on shortcomings and powerlessness.


 CN: Psychosocial adaptation;  
CL: Analyze

**39. 2.** The nurse must monitor the client for a suicide attempt at this time when the client is starting to feel better because the depressed client may now have enough energy to carry out an attempt. Bupropion inhibits dopamine reuptake; it is an activating antidepressant and could cause agitation. Although bupropion lowers the seizure threshold, especially at doses greater than 450 mg/day,


and visual disturbances and increased libido are possible adverse effects, the nurse must closely monitor the client for suicide attempt. As the client with major depression begins to feel better, the client may have enough energy to carry out an attempt.

 CN: Psychosocial adaptation;  
CL: Analyze

**40. 4.** In the initial plan of care, the most appropriate outcome would be that the client will interact with the nurse. First, the client would begin interacting with one individual, the nurse. The nurse would gradually assist the client to engage in interactions with other clients in one-on-one contacts, progressing toward informal group gatherings and eventually taking part in structured group activities. The client needs to experience success according to the client's level of tolerance. Initiating interactions with peers occurs when the client can gain a measure of confidence and self-esteem instead of feeling intimidated or unduly anxious. Discussing adaptive coping techniques is an outcome the client may be able to reach when symptoms are not as severe and the client can concentrate on improving coping skills.


 CN: Psychosocial adaptation;  
CL: Synthesize

**41. 3.** Imipramine, a tricyclic antidepressant, in combination with alcohol will produce additive central nervous system depression. Although caffeinated coffee is safe to use when the client is taking imipramine, it is not recommended for a client with depression who may be experiencing sleep disturbances. Imipramine may cause photosensitivity so the client would be instructed to use sunscreen and protective clothing when exposed to the sun. Reduced lacrimation may occur as a side effect of imipramine. Therefore, the use of artificial tears may be recommended.


 CN: Pharmacological and parenteral therapies; CL: Create

**42. 1.** Telling the client that ECGs are done routinely for all clients taking imipramine, a tricyclic antidepressant, is an honest and direct response. Additionally, it provides some reassurance for the client. Commonly, a client with depression will ruminate, leading needlessly to increased anxiety. Tricyclic antidepressants may cause tachycardia, ECG changes, and cardiotoxicity. Telling the client that it's probably a precautionary measure because the nurse is not aware of a cardiac condition instills doubt and may cause undue anxiety for the client. Telling the client not to worry because the doctor is very thorough dismisses the client's concern and does not give the client adequate information. Explaining that the client had an ECG


before initiating therapy with imipramine and that the procedure will be the same does not answer the client's question.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**43. 4.** Anticholinergic effects, which result from blockage of the parasympathetic (craniosacral) nervous system, include urine retention, blurred vision, dry mouth, and constipation. Tremors, cardiac arrhythmias, and sexual dysfunction are possible side effects, but they are caused by increased norepinephrine availability. Sedation and delirium are not anticholinergic effects. Sedation may be a therapeutic effect because many clients with depression experience agitation and insomnia. Delirium, typically not a side effect, would indicate toxicity, especially in elderly clients. Respiratory depression, convulsions, ataxia, agitation, stupor, and coma indicate tricyclic antidepressant toxicity.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**44. 2.** Doxepin and other tricyclic antidepressants may cause postural hypotension, especially in the morning. Postural hypotension occurs because the tricyclic antidepressant inhibits the body's natural vasoconstrictive reaction when a person stands. The nurse regularly monitors the client's vital signs, both lying and standing. The nurse should instruct the client to rise slowly and dangle his feet before standing. Advising the client to take a hot shower is detrimental to the client's safety. Heat causes vasodilation, which could further exacerbate the dizziness, placing the client at risk for falls and subsequent injury. Telling the client to stay in bed until he is feeling better is not helpful and is impractical. The client with depression would rather stay in bed and withdraw from others. Placing the client on fluid restriction is detrimental to the client with depression whose fluid and food intake may be inadequate.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**45. 1.** The nurse should give the medication as ordered. Mirtazapine is given once daily, preferably at bedtime to minimize the risk of injury resulting from postural hypotension and sedative effects. The usual dosage ranges from 15 to 45 mg. There is no reason to question the physician's order. The nurse should administer the medication as ordered. Requesting to give the medication in three divided doses is inappropriate and demonstrates the nurse's lack of knowledge about the drug.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**46. 4.** The nurse should express concern for the client and offer to help the client speak with the physician which will lend support to the client's concerns. The client who has stopped the medication must be taken seriously because medication non-compliance could result in a recurrence of symptoms of depression. Telling the client to focus on diet and exercise ignores the client's feelings and subtly implies the weight gain is the client's fault. Pointing out that the medication has helped and that positive things have happened since the depression lifted may be true, but it does not address the client's current feelings or needs.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**47. 3.** Compliance with medication therapy is crucial for the client with depression. Medication noncompliance is the primary cause of relapse among psychiatric clients. Therefore, the nurse needs to teach the client about managing common adverse effects to promote compliance with medication. Teaching the client about the medication's pharmacokinetics may help the client to understand the reason for the drug. However, teaching about how to manage common adverse effects to promote compliance is crucial. Current research about the medication is more important to the nurse than to the client. Teaching about dosage regulation and adjustment of medication may be helpful, but typically the physician, not the client, is the person in charge of this aspect.

 CN: Pharmacological and parenteral therapies; CL: Create

**48. 1.** After about 2 weeks of medication therapy, the nurse should expect improvements in sleep, appetite and energy though mood may not have improved significantly yet. The increased energy related to better sleep and food intake gives the client the ability to act on thoughts to harm self (suicide) since the depressed mood has not completely lifted.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**49. 4.** Dry mouth is a common, temporary side effect of paroxetine. The nurse needs to further assess the client's water intake when the client states she is drinking lots of water. Excessive intake of water could be harmful to the client and could lead to electrolyte imbalance. Dry mouth is caused by the medication, and drinking a lot of water will not eliminate it. Sucking on ice chips or using sugarless gum or candy is appropriate to ease the discomfort of dry mouth associated with paroxetine.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**50. 2, 3, 5.** Symptoms of depression include depressed mood, anhedonia, appetite disturbance, sleep disturbance, psychomotor disturbance, fatigue, feelings of worthlessness, excessive or inappropriate guilt, decreased concentration, and recurrent thoughts of death or suicide. Paroxetine is a selective serotonin reuptake inhibitor antidepressant that also can be used to treat anxiety. Improved concentration, verbalization of feelings, and decreased agitation or pacing are signs of improvement. Taking 2-hour evening naps daily is still a sign of fatigue or lack of energy, and the increased use of somatization (bodily complaints) could be signs of continued symptoms of depression.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**51. 3.** The most important behavior to report to the next shift is that the client was able to sleep from 11 p.m. to 6 a.m. This indicates that improvement in the symptoms of depression is occurring as a result of pharmacologic therapy. The nurse would expect to observe improvement in sleep, appetite, and psychomotor behavior first before improvement in cognitive symptoms. The client's flat affect is still a symptom of depression. The fact that the client had a visitor is not as important as changes in the client's behavior. Spending the evening in the room is a continuation of the client's withdrawn behavior and is important to report but not as important as the improvement in sleep.

 CN: Psychosocial adaptation; CL: Analyze

**52. 4.** A favorable response by a family member to a medication and a previous response to medication are good predictors of a favorable client response to a medication because the illness is genetic and hereditary. Although the side effects of the drug, the client's age at diagnosis, and the cost of the medication are important factors to consider when choosing antidepressant therapy, this information does not necessarily predict how a client will respond to a specific drug.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**53. 3.** Dysthymia is a milder, persistent type of depression in which sufferers are able to minimally carry on their work (Option 3). Options 1 and 2 are treatments used for occurrences of major depression with ECT being used as a last resort when several medications fail. Psychoanalysis is a very involved, long-term treatment rarely used now due to its cost and the long period of treatment required for results.

 CN: Psychosocial adaptation; CL: Synthesize

## The Client with Bipolar Disorder, Manic Phase

**54. 3.** The only right the client loses because of her involuntary admission is the right to leave the hospital whenever she wishes. Forcing the client to take medication and revoking privileges are punitive and coercive. Lithium is not given intramuscularly.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**55. 2.** The use of prednisone or other steroids can initiate a manic state in a bipolar client even if he is well controlled on medication. The other medications would decrease the client's depression, mood swings, and anxiety, making him calmer rather than more agitated.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**56. 3.** The nurse should concisely explain the benefit of the medication to the client to increase the possibility of compliance. The client has the right to refuse treatment, which in this instance is the medication. If the client was under involuntary commitment and the hospital had received a court order to treat, the client would have to comply with taking the medication and the physician would usually order the medication to be given intramuscularly if the oral medication was refused. The nurse would not threaten the client by stating that a shot will be given when there is no physician order and court order to treat. Giving written medication information to a client with acute mania is poor nursing judgment because a client with acute mania cannot benefit from written information due to his impaired ability to focus and concentrate.

 CN: Management of care; CL: Synthesize

**57. 2.** The nurse clearly informs the client about behavior that is unacceptable on the unit, such as voicing jokes with sexual content and touching others. Setting limits on behavior provides safety and security to the client and conveys to the client that he is worthy of help. Saying "she will not want to be around you with that kind of talk" and "you need to be careful about what you say to others" does not clearly inform the client about behaviors that are unacceptable and implies that the client can control behaviors if he chooses. A time-out in the client's room does not inform the client about the inappropriateness of his behaviors and could be interpreted by the client as punitive as well as diminishing his self-esteem.

 CN: Psychosocial adaptation; CL: Synthesize



**58. 3.** The nurse states her identity and purpose for being on the unit to clarify any misperception by the client. Saying “thank you for being so kind,” “I know you are only teasing me,” or “I am not here to receive compliments from clients” are nontherapeutic statements and do not clarify the nurse’s identity and purpose.

 CN: Psychosocial adaptation;  
CL: Synthesize

**59. 3.** The nurse should medicate the client who does not respond to verbal interventions and whose anxiety is escalating. This will reduce the client’s anxiety and agitation and prevent harm or injury to the client and others. Seclusion, restraint, and controlling the client are a last resort and require a physician’s order and close assessment for when the orders can be discontinued.

 CN: Psychosocial adaptation;  
CL: Synthesize


**60. 4.** The nurse should help the nursing assistant understand the client’s behavior by stating that his irritable mood is a symptom of mania. Not all clients with mania are euphoric or have an expansive mood. Saying, “It’s our responsibility to listen to him even though we might not like what he’s saying” does not help the nursing assistant understand the client with mania. Reprimanding the client for his behavior or asking him to control his behavior are inappropriate actions and show poor nursing judgment and a lack of understanding of the manic client.

 CN: Psychosocial adaptation;  
CL: Synthesize


**61. 1, 2, 3, 5.** Scheduled rest periods, relaxation exercises, and listening to soft music are activities that reduce environmental stimuli for the client who is hyperactive, talkative, easily distracted, irritable, and angry. Aerobic exercise is also beneficial to discharge some of the client’s need to be active. Watching television is not therapeutic because it would stimulate the client with acute mania.

 CN: Psychosocial adaptation; CL: Apply


**62. 3.** Reminding the client of past consequences of stopping the medication may help her realize the risks of stopping the medication again. Options 1 and 4 encourage the client’s misperception that she only needs medication when she feels depressed or manic rather than recognizing that her mood stabilizer can prevent her from experiencing those extreme highs and lows. Option 2 describes what will happen if she stops her medication, but if the client had recognized the consequences, she wouldn’t be contemplating stopping the medication.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**63. 1.** The nurse should administer the medication as ordered. Lithium has a clinical response lag time of 1 to 2 weeks. Haloperidol is prescribed temporarily to produce a neuroleptic effect until the lithium starts to produce a clinical response. Haldol is usually discontinued when the lithium starts to take effect.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**64. 4.** The client’s statement, “I’m the Queen of England. Bow before me,” is an example of a grandiose delusion and refers to thought content of the mental status examination. Examples of psychomotor behavior to be documented would include excited, typically exaggerated and repetitive physical movements and excessive talking and gesturing. Mood is a subjective state, and affect is an observable expression of emotion. Mood is what a client tells you she is feeling, and affect is what you see the client feeling. For example, the client may state that she feels sad or happy in reference to mood. Affect refers to the display of physical emotion, commonly described as “appropriate” or “flat.” Attitude toward the nurse refers to the client’s behavior in the presence of the nurse during the mental status examination (pleasant and cooperative, irritable and guarded).

 CN: Psychosocial adaptation;  
CL: Analyze


**65. 4.** Decreasing external stimuli is the intervention most likely to decrease the emotional lability and minimize its effect on other clients. While the client is displaying emotional lability, this behavior has not reached the level where involuntary isolation (seclusion) or physical restraint is needed. The client is not totally out of control or threatening others. However, ignoring the behavior will not result in a decrease in the lability.

 CN: Psychosocial adaptation;  
CL: Synthesize


**66. 1.** The nurse would excuse herself, showing respect and regard for the client, while telling the client to come to the dining room for lunch. Acutely manic clients need clear, concise comments and directions. Telling the client that he needs to stop talking because it’s lunchtime is disrespectful and does not give the client directions for what he needs to do. Using the familiar skill of waiting without interrupting until the person pauses would not be effective with the very talkative, manic client. Walking away and approaching the client after a few minutes before the food gets cold is not helpful because the client would probably continue talking.

 CN: Psychosocial adaptation;  
CL: Synthesize


**67. 3.** By stating to the client, “Swearing and profanity is unacceptable here,” the nurse is setting limits in a nonpunitive manner for behavior that is inappropriate or threatening to other clients and staff. Setting limits helps the client regain self-control, prevents alienation from others, and preserves self-esteem. It is common for the irritable manic client to misperceive the nurse’s and other’s statements and intentions, feel threatened, and respond in a manner that is out of character for the client when not in a manic phase. Stating that the client is acting very inappropriately, that the nurse will not tolerate the client’s swearing and profanity, or threatening to put the client in seclusion is threatening and punitive and thus nontherapeutic.

 CN: Psychosocial adaptation;  
CL: Synthesize

**68. 1.** Stating that this must be difficult for the husband conveys empathy and understanding and offers him the opportunity to voice his feelings to the nurse. Telling the husband that it is okay and that the nurse has heard worse is inappropriate and minimizes the impact of the wife’s illness on the husband. Asking about the length of the client’s illness or telling the husband that his wife needs some medication ignores the husband’s feelings, thereby minimizing his self-respect.


 CN: Psychosocial adaptation;  
CL: Synthesize

**69. 3.** Telling the client that others may not want to hear about sex and inviting him to play a game of ping-pong with the nurse informs the client that even though his behavior is unacceptable, the nurse considers him worthy of help. The client’s thoughts and actions are out of control, and directing him to an activity with the nurse is an appropriate way of regaining control. The nurse is responsible for providing safety and security to this client and others on the unit. Continuing to walk down the hall while ignoring the conversation does nothing to meet the needs of this or other clients. Doing so also diminishes trust in the nurse. Speaking to the client later in private while saying nothing at the time allows the client to continue his provocative behavior instead of focusing his energy toward productive activity. Informing the client that if he continues to talk about sex, no one will want to be around him is not helpful because his behavior is a symptom of his illness and the statement diminishes his self-worth.


 CN: Psychosocial adaptation;  
CL: Synthesize

**70. 4.** The nurse suggests an activity such as walking around the unit to distract the client from the paranoid grandiose delusion that could result in loss of control. This action interrupts the client’s anxious state and helps to redirect energy and focus

on an activity based in reality. The focus must be on the underlying need or feeling of the delusion and not on the content. Asking the client to describe the people who will come challenges the client and forces the client to cling to the delusion. Stating that the nurse and staff will protect the client conveys agreement with the client’s belief system, reinforcing the client’s delusion. Telling the client that he is not the prince of peace and repeating his name challenges the client and his present belief system. Doing so may lead to decreased trust in the nurse and an aggressive response, or it may force the client to defend his beliefs.

 CN: Psychosocial adaptation;  
CL: Synthesize

**71. 2.** The nurse needs to explain the procedure in simple terms because the client in a manic phase has difficulty concentrating, is easily distracted, and can misinterpret what the nurse states. Giving a thorough explanation of the procedure is not helpful and can confuse the client. Calling security to be on standby is inappropriate. If the nurse judges that the client might elope or become agitated, the nurse should schedule the appointment for another time. Canceling the appointment until the client can go unescorted is impractical and may not follow unit or hospital policy and the client’s treatment plan.


 CN: Psychosocial adaptation;  
CL: Synthesize

**72. 2.** The nurse needs to provide the client who cannot sit long enough to eat adequate amounts of “finger foods,” or food that can be held and eaten while moving. High-protein and high-carbohydrate foods, such as a cheeseburger or peanut butter sandwich, are best for the hyperactive client to help maintain body weight. A bacon, lettuce, and tomato sandwich would not provide the client with adequate protein and carbohydrates. Additionally, this type of sandwich is difficult to carry around and can be dropped easily. An ice cream cone, although high in calories, would not provide the client with adequate protein. Cut-up vegetables are a poor selection because, although they are high in vitamins, they are low in protein, which is necessary for building and repairing body cells and tissues, and low in carbohydrates, which are needed for energy.

 CN: Basic care and comfort; CL: Apply

**73. 4.** The nurse escorts the client to her room and assists with choosing appropriate attire to preserve the client’s dignity and self-esteem and prevent ridicule from others on the unit. It is common for a client with bipolar disorder, manic phase, to exhibit poor judgment, provocative behavior, and hyperactivity. The client in the manic phase commonly dresses inappropriately and changes clothes many times throughout the day. The nurse needs to


assist the client with hygiene, grooming, and proper attire until her judgment improves. Telling the client to dress appropriately while out of her room may be perceived by the client as an attack. Additionally, the client may be incapable of making that decision. Asking the client to put on hospital pajamas until she can dress appropriately is punitive and demeaning. Because of the client's cognitive difficulties, the client may not understand the instructions to go to her room to change clothes. Additionally, the client may become distracted by stimuli on the unit and may not reach her room.

 CN: Psychosocial adaptation;  
CL: Synthesize


**74. 3.** While the client who is psychotic can upset other clients, the nurse must respond to the second client with both empathy for his feelings and a general explanation that the behavior is out of the psychotic client's control. Agreeing with the second client or giving medication to the psychotic client does not help the complaining client gain empathy for his peer and only temporarily deals with the problem.

 CN: Psychosocial adaptation;  
CL: Synthesize

**75. 4.** The client with mania is very active and needs to have this energy channeled in a constructive task such as cleaning or tidying the dayroom. Because the client is distracted easily and can concentrate only for short periods, the successful completion of a helpful task would give the nurse the opportunity to thank the client for the help, thereby enhancing the client's self-esteem. Leading a group activity is too stimulating for the client. Participating in this type of activity also may cause the client to be disruptive. Watching television or reading the newspaper would be inappropriate for the client who cannot sit for a period of time.

 CN: Psychosocial adaptation;  
CL: Synthesize

**76. 1.** The client in the manic phase experiences insomnia, as evidenced by his sleeping only for about 4 hours a night for the past 5 days. The client experiencing an acute manic episode is not capable of judging the need for sleep. Therefore, the nurse should assess the amount of rest the client is receiving daily to prevent exhaustion. The development of vertigo, gastritis, or bradycardia typically does not result from acute mania.


 CN: Psychosocial adaptation;  
CL: Analyze

**77. 3.** Bipolar disorder is a biochemical disorder caused by an imbalance of neurotransmitters in the brain. Manic episodes seem to be related to excessive levels of norepinephrine, serotonin, and


dopamine. Psychopharmacologic therapy aims to restore the balance of neurotransmitters. In the past, it was thought that bipolar disorder may have been caused by early psychodynamics or disturbed families, but the current view emphasizes the role of biology. Bipolar disorder could be genetic or inherited from someone in the family, but it is best for the client and family to understand the disease concept related to neurotransmitter imbalance. This understanding also helps them to refrain from placing blame on anyone. Siblings and close relatives have a higher incidence of bipolar disorder and mood disorders in general when compared with the general population.

 CN: Psychosocial adaptation; CL: Apply


**78. 1.** A serum lithium level of 1.8 mEq/L is indicative of mild toxicity requiring temporary stoppage of further doses and fluids to flush the excess lithium out of the body. Starting an intravenous infusion and putting the client on bed rest is appropriate treatment for moderate toxicity requiring more involved flushing of lithium from the body related to the client's declining physical and mental status (client is less able to take oral fluids). Transferring a client to an intensive care unit is appropriate if the client has severe toxicity in which the client's physical and mental status are so compromised as to be life threatening. The client's lithium level is not within normal limits.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**79. 2.** The serum lithium level has nothing to do with the client's white blood cell count and the drug manufacturers have no specific requirement for blood testing. While a periodic serum lithium level could monitor whether or not a client was taking the prescribed medication, the most important reason for the blood test is to periodically assess the client's lithium level and prevent even mild toxicity on an ongoing basis.

 CN: Pharmacological and parenteral therapies; CL: Apply

**80. 3.** Because lithium reaches peak blood levels in 1 to 3 hours, blood specimens for serum lithium concentration determinations are usually drawn before the first dose of lithium in the morning (which is usually 8 to 12 hours after the previous dose) or before breakfast. Stat lithium levels can be drawn at any time, usually when toxicity is suspected.


 CN: Pharmacological and parenteral therapies; CL: Apply

**81. 2, 3, 5.** Serious side effects that may indicate lithium toxicity include muscle weakness, vertigo, vomiting, extreme hand tremor, and sedation. The prescribing health care provider should be notified


immediately when these symptoms occur. When lithium is initiated, mild or transient side effects can occur, such as nausea, fine hand tremor, anorexia, increased thirst and urination, and diarrhea or constipation.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**82. 2.** The therapeutic and toxic range of lithium is very narrow. If the client forgets to take a scheduled dose of lithium, the client needs to wait until the next scheduled time to take it, because taking twice the amount of lithium can cause lithium toxicity. The client needs to maintain a regular diet and regular salt intake. Lithium and sodium are eliminated from the body through the kidneys. An increase in salt intake leads to decreased plasma lithium levels because lithium is excreted more rapidly. A decrease in salt intake leads to increased plasma lithium levels. The client needs to drink 8 to 10 eight-ounce glasses of water daily to maintain fluid balance and decrease thirst. Decreased water intake can lead to an increase in the lithium level, and consequently a risk of toxicity. Lithium must be taken on a regular basis at the same time each day to ensure maximum therapeutic effect.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**83. 4.** Lithium commonly is combined with an antipsychotic agent, such as haloperidol, or a benzodiazepine such as lorazepam (Ativan). Antipsychotic agents, such as Haldol, are prescribed to produce a neuroleptic effect until the lithium, which has a clinical response lag time of 1 to 2 weeks, produces a clinical response. After a clinical response is achieved, the antipsychotic agent usually is discontinued. Additionally, the dosages of each drug listed are appropriate. Therefore, the nurse would administer the drugs as ordered.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**84. 4.** The client's statement, "I know I'm getting sick when I don't need much sleep and start buying things," indicates insight into her illness because the client recognizes symptoms that can lead to relapse. The statement, "I enjoy feeling high; I don't need much sleep then and get really creative," gives no indication that the client recognizes the detrimental effects of bipolar disorder. The statements about not needing medicine in another week or being cured indicate the client's lack of understanding about the chronic nature of the disorder. The client is not cured from bipolar disorder, but symptoms of the disorder are usually managed when she is stabilized on medication. Medication may be needed by the client for many years or throughout her life.

 CN: Psychosocial adaptation; CL: Evaluate

**85. 1.** For this client, the nurse needs to set limits on the client's intrusive, interruptive behavior by saying, "Please stop interrupting others; you can speak when it's your turn." This statement also clearly points out to the client the specific unacceptable behavior. The nurse helps the client to attain control and helps the other clients become more tolerant of the situation. Saying, "Stop talking; it's time for you to leave the meeting," is not helpful because it leaves the client unaware of what has happened or the behavior that is unacceptable. Also, such a statement may seem punitive. The statement, "If you can't control yourself, we'll have to take action," is threatening to the client and diminishes the client's self-worth. Using the statement, "Please behave like an adult. Your behavior is childish," is demeaning and scolding to the client, thereby diminishing the client's self-esteem.

 CN: Psychosocial adaptation; CL: Synthesize

**86. 3.** Depakene, an anticonvulsant agent, is used as a mood stabilizer in the client with bipolar disorder. Common side effects include drowsiness and gastrointestinal upset. The client needs to be cautioned not to drive or perform tasks requiring alertness and to take the medication with food or milk or eat frequent, small meals. Blood tests are required to evaluate the serum level (usually 50 to 100  $\mu\text{g}/\text{mL}$ ) and to check for possible hematologic effects. Depakene can cause changes in liver function and blood dyscrasias. The tablet must be swallowed whole and not chewed or crushed to prevent irritation of the mouth and throat. Alcohol as well as over-the-counter drugs and sleep-inducing agents must be avoided to prevent oversedation.


 CN: Pharmacological and parenteral therapies; CL: Create

**87. 1, 2, 5.** The therapeutic level of valproic acid is 50 to 100  $\mu\text{g}/\text{mL}$ . A level of 15  $\mu\text{g}/\text{mL}$  is not considered therapeutic. Therefore, the client would be manifesting symptoms of mania. Irritability, euphoria, grandiosity, pressured speech, flight of ideas, distractibility, and a decreased need for sleep are some characteristics of a manic episode. Anhedonia and hypersomnia are related to a depressive illness and not mania.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**88. 4.** The nurse should call the physician to report symptoms of a sore throat, fever, and chills because these symptoms may be signs of serious adverse effects of the medication, including potentially fatal hematologic, cardiovascular, and hepatic complications. Giving the dose of carbamazepine is contraindicated in this situation. Giving the acetaminophen ordered p.r.n. would be inappropriate

and potentially detrimental to the client's health. Waiting until morning to report the client's symptoms is a serious error in judgment.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**89. 2.** The nurse's most appropriate action is to give the wife information about a support group in her area. The National Alliance for the Mentally Ill (NAMI) has affiliates in every state and many locales. NAMI has separate groups for consumers and family members and offers a 12-week program for family members and caregivers called *Family to Family*. The program is psychoeducational in nature, and participants learn, share, and support each other. Family members need and want education and support. Suggesting that the wife see a physician is not necessary in this situation. She needs support and education. Recommending that she talk with her close friend may be helpful if she so chooses. However, this is not as helpful as attending a support group. Here the wife can learn, share, obtain support from, and provide support to others with similar situations. Having the wife share her feelings with her husband may or may not be appropriate or helpful to her or her husband. The husband may be unable to help his wife with adaptive coping, and therefore the client's self-esteem could be diminished.


 CN: Psychosocial adaptation; CL: Synthesize

**90. 2.** The nurse should encourage the husband to support and communicate openly with his wife to maintain effective family-client interactions. During any illness, open communication and support helps the relationship between husband and wife. It is unrealistic for any individual to be free from anxiety or worry and impossible for the husband to be able to control what his wife may think or feel. Relieving the client of all responsibilities is unrealistic and not helpful. The client needs to resume activities as soon as she can manage them. Reminding his wife to control her symptoms is not appropriate and indicates that the husband needs further teaching about this condition.


 CN: Psychosocial adaptation; CL: Create

**91. 1.** The statement, "I'm happy you realize that you started to get symptoms when you stopped your medication," praises the client for realistic self-appraisal and development of insight. Positive reinforcement by the nurse strengthens insight and promotes good judgment in the client. The statements, "Although it took a long time, you finally do understand that you need your medication" and "Why didn't you go to the community mental health center for help?" blame the client and diminish the client's self-worth. When clients begin to experience symptoms of relapse, they may not realize what is

happening to them and may not have the judgment to seek help. The statement, "Didn't your family tell you that you were getting sick again?" blames the family and makes an unfair assumption.

 CN: Psychosocial adaptation; CL: Synthesize

**92. 4.** The nurse should administer haloperidol ordered p.r.n. to the acutely manic and anxious client to help calm him and reduce the risk of violent or destructive behavior. The manic client is beginning to exhibit behaviors that may escalate and lead to loss of control, thereby causing the client to be a danger to self or others. Walking with the client is not helpful because his current anxiety is too high and his pacing is not helping him. Telling the client to go to his room is not helpful, because the client is exhibiting a high level of anxiety and hyperactivity and will be unable to stay in his room. Asking the client to sit in on a group therapy session is not helpful because the client cannot sit for a period of time. The client would be disruptive to the members of the group and his behavior could lead to increased anxiety in the other clients.

 CN: Psychosocial adaptation; CL: Synthesize

**93.**


**3.** Take client to a quiet area, such as his/her room, to decrease stimuli.

**1.** Use oral medication to decrease anxiety and increase appropriate social interaction.

**2.** Talk with the client about the anxiety and stress the client is feeling.

**4.** Teach the client coping strategies to deal with stressors.

None of the other interventions will be successful unless the stimuli that fuel the client's mania are removed or decreased. Once the client is in a quieter setting, oral medication will help calm the client so he/she can be calmer. Once the medication has taken effect, the nurse can help the client explore the client's feelings and problem. Finally, teaching coping techniques can be effective to address client problems after he/she has become calmer.


 CN: Psychosocial adaptation; CL: Synthesize

**94. 4.** The nurse should state her name and purpose on the unit to clarify her identity and to counteract other beliefs the client may have. Stating that the nurse doesn't want to or can't go out to dinner is not therapeutic because it fails to clarify the


client's misperceptions or erroneous beliefs, as is the statement, "It doesn't matter how I look, the answer is no."

 CN: Psychosocial adaptation;  
CL: Synthesize

**95. 3.** The client is visibly out of control, and other measures have not helped. Therefore, the nurse needs to seclude the client and use restraints if necessary to protect the client and others from harm. Following the client and asking her to calm down or telling the client to lie down on the sofa is not helpful because the client's level of anxiety is too high for her to attempt to calm down on her own and she cannot control her behavior. Telling the staff to ignore the client's remarks is not helpful because the client needs external means of control to protect the client, other clients on the unit, and the staff. Safety is the priority.

 CN: Safety and infection control;  
CL: Synthesize


**96. 3.** When the client in a manic state attempts to manipulate the nurse or demands privileges, the nurse must restate the unit rules in a calm and matter-of-fact manner. "The television hours are from 7 to 10 p.m. It is 10 p.m., and the television goes off so everyone can sleep," is the most therapeutic response because it restates the rules and is nonthreatening. During a manic phase, the client is impulsive and has difficulty concentrating. The client needs consistency and structure from the staff. The statement, "I'll let you watch television just this once; don't tell anyone about this," allows the client to manipulate the nurse, as does "I'll turn the television off when you get sleepy. Don't ask me to do this again." In addition, the last portion of the statement is a threat. The statement, "The television goes off at 10 p.m.; I've been telling you this for the past three evenings," is inappropriate because it is authoritative and demeaning to the client.

 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Suicidal Ideation and Suicide Attempt

**97. 3.** Assessing for suicide risk in the ED is important because suicidal clients can be discharged without being assessed for suicide potential. Many visitors to the ED are there for comprehensive health care needs and lack primary care providers. It is a myth that talking about suicide will cause young people to think about suicide, and evidence exists that they will talk about suicide if asked directly. Assessing adults only because they will be more honest is an incorrect assumption. Limiting the

assessment of suicide risk only to adolescents with psychiatric diagnoses falsely assumes that other young people are not at risk for suicide. Questioning the parents about their adolescent's suicide risk may be an unreliable method because the parents may not be aware that suicide risk is present.

 CN: Psychosocial adaptation;  
CL: Synthesize

**98. 2.** A crucial factor in determining the lethality of a method is the amount of time that occurs between initiating the method and the delivery of the lethal impact of the method. Lethal methods of suicide include using a gun, jumping from a high place, hanging, drowning, carbon monoxide poisoning, and overdose with certain drugs, such as central nervous system depressants, alcohol, and barbiturates. The more detailed the suicide plan, the more lethal and accessible the method, and the more effort exerted to block rescue, the greater the chance is for the suicide to be completed. Impulsive attempts at suicide even with rescuers in sight may be lethal depending on the method. Less lethal methods may include overdosing on aspirin and wrist cutting. Head-banging is a self-injurious behavior that requires intervention and is not to be taken lightly; however, it is not considered a lethal method of suicide.

 CN: Psychosocial adaptation; CL: Apply

**99. 4.** The statement, "No matter what the intent, all suicidal behavior is serious and deserves our serious consideration," is most appropriate because it provides accurate information for the staff. Superficial cuts may be termed *suicide gestures*. Nevertheless, they still are a cry for help and may indicate ambivalence about dying. Clients have accidentally and unintentionally killed themselves because previous attempts were not taken seriously, they acted on impulse, or rescue attempts were foiled. Stating, "It's our job to help her no matter how we feel about her or what she did; she'll be discharged soon," is inappropriate because it does not provide the staff members with accurate information. Stating, "I won't tolerate that kind of discussion from my staff; now it is time for you to go back to work," is authoritarian and punitive. Additionally, it does not help the staff members gain insight. Stating, "I know it's hard to understand, but we need to do the best we can even though she'll be back," voices agreement with the staff's bias and lack of knowledge. As such, this statement is inappropriate.


 CN: Management of care; CL: Synthesize

**100. 2.** On hearing the client's statement, the nurse must ask the client directly if she plans to kill herself. It is erroneous to think that talking to the client about suicide will drive her to it. Asking directly about suicidal intent is absolutely necessary.

Commonly, doing so provides the client with a sense of relief. In addition, the nurse conveys concern for and a sense of worth to the client, thus enabling appropriate planning for care. Asking “What do you mean?” is an indirect method of inquiry that provides the client with the opportunity to evade the nurse’s intent. Asking, “Doesn’t your family care about you?” shows poor judgment on the nurse’s part and is demeaning to the client. Asking, “What happened to make you think that?” conveys a lack of knowledge of psychopathology.

 CN: Psychosocial adaptation; CL: Analyze

**101. 4.** For the client with suicidal ideation, client safety is the priority. The nurse protects the client from self-harm or self-destruction. Although self-esteem, sleep, and hygiene are common areas that require intervention for a client with suicidal ideation, ensuring the client’s safety is the most immediate and serious concern.

 CN: Safety and infection control;  
CL: Synthesize


**102. 1.** To determine the seriousness of the suicidal ideation, the nurse must ask directly about the intent and the plan. The nurse needs to determine whether the client has a concrete plan and will act on his thoughts. Then the nurse assesses the lethality of the method, immediacy, means to complete suicide, and possibility of rescue. Asking the client, “Have you made out a will?” is not as important and does not necessarily imply that he is planning self-harm. Many individuals have made out wills without planning self-harm. Asking the client, “Does your family know you’re here?” provides no information about the client’s intent and plan. Asking the client, “How long have you been thinking about harming yourself?” does provide information that the client is thinking about self-harm. However, it does not provide information about the client’s immediate intent and plan.

 CN: Psychosocial adaptation; CL: Analyze


**103. 2.** The nurse’s best response is to teach the nursing assistant about the appropriate intervention and why it is important for the client. Staff members need to be client-focused and to understand why a specific intervention is important and appropriate. Telling the assistant that the assignment will be switched or not to worry about it is not appropriate because it does not teach the nursing assistant about the client’s illness and appropriate client care. The statement, “Clients who are depressed are hard to deal with, but don’t take what they say seriously,” does not help the staff member understand why listening is important and may jeopardize the client’s safety.

 CN: Management of care; CL: Synthesize

**104. 3.** The most therapeutic response is for the nurse to state, “You’re in a lot of pain now but you will feel better and I’m here to help you.” The client with active suicidal ideation believes that the solution to his problems is suicide. This statement by the nurse conveys empathy and hope to the client that he will get better and offers the nurse’s help in doing so. The statement, “I’ll walk with you to your room so that you can get some rest,” is inappropriate because it focuses only on the client’s use of the word tired, not the underlying feeling or intent of the statement. The statement about feeling better after the client’s son visits is inappropriate because the nurse does not recognize the client’s suicidal behavior and does not convey an understanding of the psychopathology of depression. The statement, “You are very depressed right now and want to die but you need to think about life,” is inappropriate because it will not change the way the client is thinking or feeling. It also minimizes the client’s feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**105. 2.** The immediate priority is to save the caller’s life. Therefore, the nurse should tell the caller that another nurse will telephone the police. The immediate goal is to rescue the caller because the suicide attempt has begun. Referring the caller to a 24-hour suicide hotline or instructing the caller to telephone her family for help may be appropriate as part of discharge planning. Asking the caller whether she has telephoned her physician is not appropriate. The nurse is responsible for notifying the physician.

 CN: Psychosocial adaptation;  
CL: Synthesize


**106. 4.** The statement refers to the suicidal client’s wish to use her own death to retaliate or get even with her boyfriend. If a client wishes to retaliate, discovering the specific plans would be important to maintaining her safety as well as possibly her boyfriend’s. Though sadness, escape, and loneliness can all be themes expressed by a suicidal client, they do not apply to the comment made by this client.

 CN: Psychosocial adaptation; CL: Analyze

**107. 2.** The statement, “I don’t think about killing myself as much as I used to,” indicates a lessening of suicidal ideation and improvement in the client’s condition. The statement, “I couldn’t kill myself because I don’t want to go to hell,” indicates that the client will not attempt suicide but could still be thinking about death. The statements, “I’m of no use to anyone anymore,” and “I know my kids don’t need me anymore since they’re on their own,” indicate that the client feels worthless and may be experiencing suicidal ideation.

 CN: Psychosocial adaptation; CL: Evaluate


**108. 4.** Based on the client's statement, the nurse must initiate plans for hospitalization immediately because the client has suicidal ideation with a definite plan, lethal method, and immediate access to the method.

 CN: Psychosocial adaptation;  
CL: Synthesize

**109. 1.** The survivor of suicide, in this situation, would be referred to a group for survivors of suicide to help her with her feelings and to work through the grief reaction. This group provides support and understanding of what the individual is experiencing by members who are experiencing similar reactions, including anger and guilt. Depression and unresolved grief can occur when the survivor does not receive appropriate help. Counseling by a chaplain or individual therapy by the nurse may be appropriate in addition to referral to the group. Giving the survivor the suicide hotline number would be appropriate if the survivor herself were thinking about suicide.

 CN: Psychosocial adaptation;  
CL: Synthesize


**110. 3.** The most appropriate response is to discuss the behavioral clues and resources because it provides the husband with important information that he needs to cope with his wife's condition. Family members are commonly afraid of future suicidal activity and need helpful information and resources to turn to in a crisis. Telling the husband not to worry minimizes the husband's concern and is not necessarily true. Additionally, past suicide attempts need to be considered when evaluating the client's future risk of suicide. The statement, "She told me she wants to live so I don't think she'll try again," ignores the husband's request and concerns. Additionally, there is no way for the nurse to know whether the client will attempt suicide again. The statement, "Tell her about your concern and just take care of her," is not helpful because the husband needs information and resources to turn to should a crisis develop.

 CN: Psychosocial adaptation;  
CL: Synthesize


**111. 4.** After the client identifies and shares her strengths, the nurse reinforces the client for her ability to evaluate herself in a positive manner. Doing so promotes self-esteem and offers hope for improvement. Asking the client to identify an additional three strengths or volunteering the client to lead the cooking group could be too overwhelming for the client at this time and may increase her anxiety and feelings of worthlessness. Although educating the client about the importance of medication is important, doing so at another time would be more appropriate.

 CN: Psychosocial adaptation;  
CL: Synthesize

**112. 2.** The best response would be for the nurse to advise the visitor to be caring and genuine to the client as a friend normally would. Family and friends are commonly afraid or at a loss about how to act or what to say to someone with a mental illness or to someone who may voice thoughts of self-harm. The statement, "Try to cheer her up," is inappropriate because the client may feel overwhelmed and thus become more despondent when she cannot meet or match the cheerful demeanor. The statement, "Control your expressions," is inappropriate because the client is not helped when interactions are not natural and genuine. The statement, "Avoid asking how she's feeling," is inappropriate because it conveys a lack of interest in and concern for the client.

 CN: Psychosocial adaptation;  
CL: Synthesize


**113. 2.** The client with feelings of self-doubt, inability to control her life, and dependency is manifesting problems evident in autonomy versus shame/doubt. Because of illness, regression has occurred and the client's behaviors affect how the nurse will intervene with the client. With trust versus mistrust, some behaviors reflecting problems include suspiciousness, projection of blame, and withdrawal from others. With initiative versus guilt, some behaviors reflecting problems include excessive guilt, reluctance to show emotions, and passivity. With industry versus inferiority, some behaviors reflecting problems include feelings of being unworthy, poor work history, and inadequate problem-solving skills.

 CN: Psychosocial adaptation;  
CL: Analyze

**114. 1.** The nurse should arrange for a psychiatric home care nurse to visit the client and follow her care. The psychiatric home care nurse will help the client manage her psychiatric disorder, medications for her mental illness and diabetes, diabetic care, and nutrition. A medical social worker may be involved with the client's care after discharge to help with interactions among agencies, and visits by clergy may be helpful, but a psychiatric home care nurse would be most important to help the client manage the many needs associated with her illness. An occupational therapist could help the client consider home management adjustments that might be needed after discharge but no ongoing disability is noted.


 CN: Management of care; CL: Apply

**115. 3.** Client safety is the priority to prevent further self-harm. Nutrition, sleep, and hygiene are important concerns, but they are secondary to safety.


 CN: Safety and infection control;  
CL: Analyze



**116. 4.** The nurse inspects the bag and its contents in the presence of the client and his wife so that they know what is allowed on the unit and what should be returned home and why. The nurse is responsible for the client's safety and that of the other clients and staff. Telling the wife to take her husband's things home because he is suicidal diminishes the client's self-worth and is inaccurate. Instructing the wife to unpack the bag and put her husband's things away is inappropriate because it is the nurse's responsibility to manage safety issues pertaining to the client and the unit. Asking the wife whether the bag contains anything dangerous would be poor judgment on the part of the nurse because the wife would not be knowledgeable about the safety factors.

 CN: Psychosocial adaptation;  
CL: Synthesize


**117. 2.** The nurse and staff should place the client in leather restraints to protect her from further self-harm. The client's behavior is out of control and necessitates external controls for her safety. Telling the client to stop and act like a responsible adult is ineffective and not therapeutic. Calling the physician for additional medication orders is not appropriate because the lorazepam (Ativan) given by the nurse may take effect if the client remains still. The nurse is responsible for judging whether additional medication is needed later. Instructing a staff member to sit in the room with the client is unsafe for the client and the staff member.

 CN: Safety and infection control;  
CL: Synthesize

**118. 2.** The nurse needs to ask the client whether he is going to hurt himself to determine the client's ability to cope with the voices and to assess the client's impulse control. The nurse's assessment will then determine the course of action to take regarding the client's safety. Asking when the client hears the voices and how long the client has heard them is important but not as important as determining whether the client will act on what the voices are saying. Asking "Why are the voices starting again?" would be inappropriate because the client may not know why and may not be able to answer the nurse.

 CN: Safety and infection control;  
CL: Analyze


**119. 4.** Though disturbed thoughts and sensory perceptions would be a concern to the nurse, as well as communication issues, the primary issue for this client in terms of his comments would be the potential for medication noncompliance and relapse. Most college students want to be like their peers and perceive themselves as capable and well. These beliefs can lead a young client with schizophrenia to stop taking medication which leads to relapse.

 CN: Psychosocial adaptation;  
CL: Synthesize


**120. 1.** Clients on 15-minute suicide checks must be observed by a staff member every 15 minutes. However, the staff member must stagger the timing of the check so that the client cannot predict the precise time. The staff member could check the client at 10 minutes and then at 8 minutes, and so on, to protect the client from self-harm. The nurse would further explain the necessity of this procedure to help the staff understand its importance. Documenting that suicide checks have been done is absolutely necessary. Clients on one-to-one suicide precautions can never be left alone. All clients using razors must be supervised by staff.

 CN: Management of care; CL: Evaluate

**121. 3.** Talking with a staff member when suicidal thoughts occur is an important part of contracting for safety. The nurse or another staff member can then assess whether the client will act on the thoughts and assist the client with methods of coping when suicidal ideation occurs. Writing in a journal, reading, or playing games with others does not allow the client to verbalize suicidal thoughts to the nurse.

 CN: Safety and infection control;  
CL: Synthesize

**122. 4.** Because the client has a history of recurring depression and suicidal ideation, the nurse would give the client a 7-day supply of imipramine to prevent possible overdose. Giving the client a 14-, 21-, or 30-day supply of medication would provide the client with enough medication to complete a suicide attempt. Tricyclic antidepressants are associated with a higher rate of death than are selective serotonin reuptake inhibitors.

 CN: Pharmacological and parenteral therapies; CL: Apply

**123. 2.** Because the client is in danger of noncompliance with the medication due to financial concerns, the nurse should contact the social worker to assist with locating available resources for the client to ensure continuation of the medication needed for the recurrent illness. The client needs to continue the medications with no interruptions to minimize the chance of decompensation. Although the physician is the person responsible for ordering the client's medication, routinely the physician is not involved in finding financial assistance for the client's medication needs. The client needs the medication at the present time. Three months is too long to wait for a follow-up appointment. The client could be severely depressed and could even attempt suicide. A family member's assistance may not be a sufficient or a permanent means of financial help for the client in terms of medication needs.

 CN: Management of care; CL: Synthesize

### Managing Care Quality and Safety

**124. 3.** As long as the client is not judged to be incompetent, he can refuse to sign the consent form. The only way to force treatment would be a court hearing in which a judge could order the treatment to proceed. The treatment cannot proceed merely on a verbal consent or the written consent of the spouse. The client's release cannot be held hostage to force him to sign the consent.

 CN: Management of care; CL: Synthesize


**125. 4.** The statement by the person who says "I have found a solution for this mess" contains suicidal ideation and that person is more of a safety risk than the angry, alienated client or the obsessed or helpless one. The other clients may need intervention as well, but the potentially suicidal client has the greatest need for nursing intervention.

 CN: Management of care; CL: Analyze


**126. 3.** The nurse communicates with consulting physicians and referral agencies as part of the client's continuity of care to which the client consented when admitted to the unit. The communication with family also has the client's consent. The communication with someone outside the care team without the client's permission (talking to a friend) is a breach of ethics by the nurse.

 CN: Management of care; CL: Apply

**127. 4.** It is important for the nurse to listen to the client and respect their knowledge about their medication. In the other options the nurse dismisses the client's concern or gives a possible explanation without checking out the specific situation. If the nurse has taken the wrong medication the client can prevent a medication error, and if there has been a color change, the nurse can let the client know that information. In either case, helping a psychotic client deal with reality appropriately is therapeutic.

 CN: Safety and infection control;  
CL: Synthesize

**128. 2.** The nurse should question the Tylenol order because the client overdosed on Tylenol, and that analgesic would be contraindicated as putting further stress on the liver. There is no need to hold the PM Milk of Magnesia or Maalox. There is no indication that the client is agitated or needs medication for agitation. There is little likelihood that the client needs an I.V. after being transferred out of an intensive care unit, as the client will be able to take oral fluids.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**129. 1.** High-risk factors that have been related to suicide include hopelessness, Caucasian race, male gender, advanced age, living alone, previous suicide attempts, family history of suicide attempts, family history of substance abuse, general medical illnesses, psychosis, and substance abuse. The highest suicide rate is among people over the age of 65, particularly Caucasian males age 85 and over. Psychiatric diagnosis is considered to be the most reliable factor for suicide, especially for those with depression, schizophrenia, and substance disorders. Therefore, an 85-year-old Caucasian male who lives alone after his wife's death is at high risk for suicide completion.

 CN: Management of care; CL: Analyze

**130. 4.** One-to-one staff supervision is needed for the client who is unwilling or cannot sign a no-harm contract because of an impairment in reality testing due to hallucinations, delusions, dementia, or delirium. Other high-risk clients include those with constant suicidal thoughts, past attempts with high lethality, high risk of elopement, available access to a planned method, and severe depression. The client who is sometimes preoccupied with death or who tries to elope but is ambivalent about suicide is not at high risk for suicide and therefore does not need one-to-one supervision, nor does the client who is impulsive and holds her breath until she faints. This client may be seeking attention and not intending self-harm in the form of suicide. Furthermore, fainting is not a lethal method of suicide.

 CN: Management of care; CL: Analyze

TEST  
2

# Schizophrenia, Other Psychoses, and Cognitive Disorders

- The Client with Paranoid Schizophrenia
- The Client with Other Types of Schizophrenia and Psychotic Disorders
- Clients and Families Affected by Chronic Mental Illnesses
- The Client with Cognitive Disorders
- The Client with Delirium
- The Client with Dementia
- The Client with Alzheimer's Disease
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with Paranoid Schizophrenia

**1.** A newly admitted client describes her mission in life as one of saving her son by eliminating the “provocative sluts” of the world. There are several attractive young women on the unit. What should the nurse do **first**?

- 1. Ask the client for her definition of “provocative sluts.”
- 2. Ask the young female clients on the unit to dress less provocatively.
- 3. Ask the client to discuss her concerns in the next group session.
- 4. Ask the client to inform the staff if she has negative thoughts about other clients.

**2.** A young client diagnosed with paranoid schizophrenia is talking with the nurse. “You know, when I thought everyone was out to get me, I was staying in my apartment all the time. Now, I’d like to get out and do things again.” What is the best initial response by the nurse?

- 1. “With whom do you want to do things?”
- 2. “What activities did you enjoy in the past?”
- 3. “What kind of transportation do you use?”
- 4. “How much money can you spend?”

**3.** A client is becoming agitated during a discussion group. She states, “I know that all of you hate me.” She leaves the group and goes to her room. Which action by the nurse is most therapeutic for the client?

- 1. After group, ask the client to talk to the nurse about her concerns.
- 2. Ask the client to return to group and share her feelings.
- 3. Explain to group members about the client’s problems.
- 4. Ask the group members to apologize to the client individually.

**4.** A client who was diagnosed with undifferentiated schizophrenia 8 years ago is admitted to a unit because of increasingly severe mood swings. His diagnosis is changed to schizoaffective disorder. He asks the nurse, “So now what? My risperidone (Risperdal) is just not doing the job.” How should the nurse respond?

- 1. “The doctor will probably increase the dosage of your Risperdal.”
- 2. “With your mood swings, you may need to take a mood stabilizer along with your Risperdal.”
- 3. “The doctor will have to see how severe your mood swings are before he decides what to do.”
- 4. “If you are not suicidal, no change will be made in your medicines.”

**5.** A client who is neatly dressed and clutching a leather briefcase tightly in his arms scans the adult inpatient unit on his arrival at the hospital and backs away from the window. The client requests that the nurse move away from the window. The nurse recognizes that doing as the client requested is contraindicated for which of the following reasons?

- 1. The action will make the client feel that the nurse is humoring him.
- 2. The action indicates nonverbal agreement with the client’s false ideas.
- 3. The client will then think that he will have his way when he wishes.
- 4. The nurse will be demonstrating a lack of composure over the situation.

**6.** A client reports having thoughts of being followed by foreign agents who are after his secret papers. Which response by the nurse is **most** appropriate when responding to the client's disturbed thought process?

- 1. "I don't see any foreign agents."
- 2. "I think these thoughts are frightening to you."
- 3. "I don't know what you mean."
- 4. "I'd like you to come to group with me right now."

**7.** Police bring a client to the emergency department after she threatens to kill her ex-husband. She states emphatically, "The police should bring him in, not me. He's paranoid about my dating and has been stalking me for weeks. He's probably off his medicines. His case manager and the police won't do anything." In which order should the following nursing actions be done from first to last?

1. Ask about the marital problems leading to the divorce.

2. Assess the client's risk for harm to self and others.

3. Obtain the name of her ex-husband's case manager.

4. Interview the client about her current needs and situation.

**8.** A client who has been stabilized on medications for several months is at the clinic for a medication check. During a conversation with the nurse, the client suddenly jumps up, begins pacing, and wrings her hands. In what order should the nurse do the following interventions from first to last?

1. Walk with the client to help decrease her anxiety.

2. Discuss productive ways to solve her problems causing anxiety.

3. Share observations about her anxiety-related behaviors.

4. Ask the client about the sources of her anxiety.

**9.** A client is receiving haloperidol decanoate (Haldol decanoate). He begins to complain of stiff muscles, restlessness, and internal jumpiness. The client has all of the following medications ordered as needed. Which one would be **most** appropriate for the nurse to administer to decrease the client's symptoms?

- 1. Lorazepam (Ativan)
- 2. Benztropine mesylate (Cogentin)
- 3. Trazodone (Desyrel)
- 4. Olanzapine (Zyprexa)

**10.** The parents of a 20-year-old female client diagnosed with paranoid schizophrenia admitted 4 days ago are attending a family psychoeducation group in the hospital. Which of the following statements by the mother indicates that she understands her daughter's illness and management?

- 1. "I know that I'll have to do everything for my daughter when she comes home."
- 2. "Tasks as simple as getting out of bed and showering in the morning may be difficult for her."
- 3. "I know that visits from her friends at home should be discouraged for a while."
- 4. "She won't experience a relapse as long as she takes her prescribed medication."

**11.** While conducting a home visit for a client diagnosed with paranoid schizophrenia discharged 1 week ago, the client's mother tearfully states, "I can hardly sleep because I'm so worried about my daughter. I'm afraid to leave her alone in the house. What if something should happen while I'm gone?" Which of the following problems related to the caregiver would be the **most** inclusive one for the nurse to incorporate into the client's plan of care?

- 1. Caregiver role strain.
- 2. Anxiety.
- 3. Fear.
- 4. Disturbed sleep pattern.

**12.** When conducting a mental status examination with a newly admitted client who has an Axis I diagnosis of paranoid schizophrenia, the client states, "I'm being followed; it's not safe. They're monitoring my every move." In which of the following areas of the mental status examination should the nurse document this information?

- 1. Thought content.
- 2. Quality of speech.
- 3. Insight.
- 4. Judgment.

**13.** The wife of a client diagnosed with paranoid schizophrenia visits 2 days after her husband's admission and states to the nurse, "Why isn't he eating? He's still talking about his food being poisoned." Which of the following appraisals by the nurse is **most** accurate?

- 1. The wife's inquiry is reasonable.
- 2. Education about her husband's medications is needed.
- 3. Her expectations of her husband are realistic.
- 4. An increase in the client's medication is indicated.

**14.** A client states that she hears God's voice telling her that she has sinned and needs to punish herself? Which response by the nurse is **most** important?

- 1. "How do you think you will be punished?"
- 2. "Please tell staff when you think you need to punish yourself."
- 3. "What exactly do you think you have done to be punished?"
- 4. "Let's talk about your strengths."

**15.** A client is complaining about blurred vision after 4 days of taking haloperidol (Haldol), benztropine (Cogentin), quetiapine (Seroquel), and bupirone (BuSpar). Which of the following medications should the nurse suspect as the most likely cause of this adverse effect?

- 1. Bupirone.
- 2. Quetiapine.
- 3. Haloperidol.
- 4. Benztropine.

**16.** When developing the plan of care for a client who is staying in his room because he perceives that staff want to harm him, which of the following outcomes of care planning is **most** realistic?

- 1. Within 2 days the client will complete his activities of daily living.
- 2. Within 3 days the client will participate in recreation with other clients.
- 3. Within 4 days the client will demonstrate an absence of verbal aggression.
- 4. Within 5 days the client will seek out staff to talk about feelings.

**17.** A client diagnosed with paranoid schizophrenia is still withdrawn, unkempt, and unmotivated to get out of bed. A mental health aide asks the nurse why he is this way after being on fluphenazine (Prolixin) 10 mg for 7 days. The nurse should tell the health aide:

- 1. "Prolixin is most effective with the positive symptoms of schizophrenia."
- 2. "He'll be less withdrawn and unmotivated when the Prolixin takes effect."
- 3. "His Prolixin dose probably needs to be increased again."
- 4. "His lack of motivation is a common side effect of the Prolixin."

**18.** A pregnant client in her third trimester is started on chlorpromazine (Thorazine) 25 mg four times daily. Which of the following instructions is **most** important for the nurse to include in the client's teaching plan?

- 1. "Don't drive because there's a possibility of seizures occurring."
- 2. "Avoid going out in the sun without a sunscreen with a sun protection factor of 25."
- 3. "Stop the medication immediately if constipation occurs."
- 4. "Tell your doctor if you experience an increase in blood pressure."

**19.** A client reports that men in blue clothes keep looking in her window and talking about her. Which of the following responses by the nurse is **most** appropriate?

- 1. "Those men are groundskeepers. They're talking about their work, not you."
- 2. "Don't take things so personally. Not everyone who is talking is talking about you."
- 3. "Let's not pay attention to the men. Let's play cards instead."
- 4. "I'll close the drapes so you can't see the men."

**20.** When preparing the teaching plan for a client who is to start clozapine (Clozaril), which of the following is crucial to include?

- 1. Description of akathisia and drug-induced parkinsonism.
- 2. Measures to relieve episodes of diarrhea.
- 3. The importance of reporting insomnia.
- 4. An emphasis on the need for weekly blood tests.

**21.** A client is sitting in the corner of the day-room cocking his head to one side as if he hears something, but no one is nearby. The nurse suspects he is having auditory hallucinations. Which of the following questions should the nurse ask **first**?

- 1. "Are you seeing someone other than me?"
- 2. "What are you hearing right now?"
- 3. "What is going on with you right now?"
- 4. "Do you want to go to the recreation room?"

**22.** A client who is newly diagnosed with paranoid schizophrenia tells the nurse, "The aliens are telling me that I'm defective and need to be eliminated." Which of the following responses by the nurse is **most** appropriate initially?

- 1. "I know those voices are real to you, but I don't hear them."
- 2. "You are having hallucinations as a result of your illness."
- 3. "I want you to agree to tell staff when you hear these voices."
- 4. "Your medications will help control these voices you are hearing."

**23.** When administering antipsychotics to a client with paranoid schizophrenia, the nurse understands that the newer atypical antipsychotics, such as olanzapine (Zyprexa) and risperidone (Risperdal), are more effective than the older medications in treating the negative symptoms of schizophrenia because of which of the following?

- 1. Serotonin and gamma-aminobutyric acid (GABA) levels are not affected.
- 2. Dopamine and serotonin receptors are blocked.
- 3. GABA and norepinephrine levels are increased.
- 4. Norepinephrine and dopamine receptors are blocked.

**24.** An outpatient client who has a history of paranoid schizophrenia and chronic alcohol dependency has been taking risperidone (Risperdal) for several months. She reports that she stopped drinking 4 days ago. The client is very frightened by the tactile hallucinations of bugs crawling under her skin. Which of the following factors should the nurse incorporate into the plan of care when explaining the tactile hallucinations?

- 1. Alcohol intoxication.
- 2. Ineffectiveness of risperidone.
- 3. Alcohol withdrawal.
- 4. Interaction of alcohol and risperidone.

**25.** A client with a long history of paranoid schizophrenia is readmitted voluntarily after missing his last two injections of haloperidol decanoate (Haldol Decanoate). He reports, "I'm not sleeping much and my friend says I smell from not showering. God is telling me to protect myself from others. My parents are sick and tired of me and my illness. They wish I were dead." Which of the following admission notes by the nurse contains assumptions and potentially false accusations? Select all that apply.

- 1. Client has been noncompliant with his medications, causing decreased sleep and activities of daily living, increased auditory hallucinations, and paranoid delusions about his parents harming him.
- 2. Client has missed two injections of Haldol Decanoate and was admitted voluntarily. He reports he has decreased sleep and showering and that he hears God's voice telling him to protect himself from others. He stated, "My parents are sick and tired of me and my illness. They wish I were dead."
- 3. Client has missed two doses of Haldol Decanoate. He's not sleeping and showering. Has a strained relationship with his parents and delusions that they want him dead. Voluntary admission to restart Haldol Decanoate.
- 4. Client admitted for noncompliance with Haldol Decanoate injections, sleep disturbance, poor hygiene, auditory hallucinations, and suspiciousness of his parents. Needs to be monitored for suicidal and homicidal ideation.
- 5. Client admitted because of hallucinations and delusions. His parents may be abusing him. He states he has not taken his medications for 2 days.

**26.** A newly admitted client diagnosed with paranoid schizophrenia is pacing rapidly and wringing his hands. He states that another client is out to get him. Then he says, "Protect me, select me, reject me." The nurse should next:

- 1. Administer his oral PRN lorazepam (Ativan) and haloperidol (Haldol).
- 2. Place the client in temporary seclusion before he has a chance to hurt others.
- 3. Call the physician for an order for restraints.
- 4. Ask the other clients to leave the immediate area.

**27.** When a client who exhibits feelings of inferiority is asked to attend group activities, she gets more anxious. Within 10 minutes, she begins ridiculing others in the group and receives negative attention. Which of the following statements best reflects the nurse's interpretation of the client's behavior? Select all that apply.

- 1. Increased anxiety levels can cause defensive coping.
- 2. Negative attention reinforces acting-out behaviors.
- 3. Negative attention is better than no attention at all.
- 4. Increased anxiety is a reason to exclude the client from groups.
- 5. The client needs medication to control her anxiety.

**28.** In a family education group for those who have relatives with paranoid schizophrenia, which of the following comments indicates the need for further teaching about symptom management?

- 1. "When the clients get overwhelmed, it's best if they spend some time in their room."
- 2. "The more we push the clients to spend time with friends, the more their voices decrease."
- 3. "Until we get the clients up and going, they seem to have no motivation to do anything."
- 4. "We still have to remind the clients that we don't hear the voices they do."

**29.** A client is being successfully treated with clozapine (Clozaril). Which of the following statements by the client reflects a need for further teaching about managing the drug's adverse effects?

- 1. "If I eat too many fruits, I'll get constipated."
- 2. "I need to take the medicine with food to avoid nausea."
- 3. "I have to get up slowly so I don't get dizzy."
- 4. "Sometimes I have to push myself because I'm sleepy."

**30.** Which of the following statements indicates increased insight by the client about her newly diagnosed paranoid schizophrenia being stabilized on medications?

- 1. "Now that the voices are gone, I can decrease my medicines."
- 2. "I would feel better if I knew there wasn't poison in my food."
- 3. "Since I feel better, I know I can restart school next week."
- 4. "The voices go away when I tell them to, except if I'm really nervous."

**31.** A client is aware that he is experiencing auditory hallucinations as a result of his paranoid schizophrenia. At this point, which of the following is **most** appropriate response for the nurse to make?

- 1. "I know you hear voices, but I don't hear them."
- 2. "Time and medicines will make the voices go away."
- 3. "What seems to help make the voices less bothersome?"
- 4. "The only voices I hear right now are yours and mine."

**32.** A client who is suspicious of others including staff is brought to the hospital wearing a wrinkled dress with stains on the front. Assessment also reveals a flat affect, confusion and slow movements. Which goal should the nurse identify as the initial priority when planning this client's care?

- 1. Helping the client feel safe and accepted.
- 2. Introducing the client to other clients.
- 3. Giving the client information about the program.
- 4. Providing the client with clean, comfortable clothes.

**33.** A suspicious client states, "I know you nurses are spraying my food with poison as you take it out of the cart." Which of the following actions would **most** likely be successful?

- 1. Serving only foods that come in sealed packages.
- 2. Asking what kind of poison the client suspects is being used.
- 3. Giving the client canned supplements until the delusion subsides.
- 4. Allowing the client to be the first to open the cart and get a tray.

**34.** The parent of a young adult client diagnosed with paranoid schizophrenia is asking questions about his son's antipsychotic medication, ziprasidone (Geodon). Which of the following statements by the father reflects a need for further teaching?

- 1. "If he experiences restlessness or muscle stiffness, he should tell the doctor."
- 2. "I should give him benztropine to help prevent constipation from the ziprasidone."
- 3. "If he becomes dizzy, I'll make sure he doesn't drive."
- 4. "The ziprasidone should help him be more motivated and less withdrawn."

### The Client Experiencing Other Types of Schizophrenia and Psychotic Disorders

**35.** The nurse is assessing a client who is taking an antipsychotic medication. Which of the following symptoms is uniquely indicative of Neuroleptic Malignant Syndrome (NMS) and requires immediate attention?

- 1. Very high temperature.
- 2. Muscular rigidity.
- 3. Tremors.
- 4. Altered consciousness.

**36.** A client diagnosed with Undifferentiated Schizophrenia gained 50 lb in 6 months while taking olanzapine (Zyprexa). After seeing her psychiatrist who changed the medication to ziprasidone (Geodon), the client tells the nurse, "I don't want to take this Geodon either. I can't gain any more weight." Which response by the nurse is **most** appropriate for this client?

- 1. "Geodon causes less weight gain than the other atypical antipsychotics."
- 2. "We can give it to you as an injection rather than in capsule form."
- 3. "Abnormal movements are not as common with Geodon."
- 4. "You can take it just before bedtime, so you won't need a snack."

**37.** As hospital-based care has become more oriented to crisis intervention, criteria for admission to the hospital have also changed. Which clients have priority for admission to an acute care facility? Select all that apply.

- 1. Clients who live alone.
- 2. Clients who are acutely psychotic.
- 3. Clients who are acutely depressed.
- 4. Clients who are dangerous to self or others.
- 5. Clients who are not sleeping and have a lack of appetite.
- 6. Clients who are not complying with medication regimens.

**38.** A 79-year-old woman is brought to the outpatient clinic by her daughter for a routine medication evaluation. The daughter reports that her mother is quite stable and has no adverse effects from the risperidone (Risperdal) she is taking. Then the daughter says, "I just think my mother could be even better if she was on a larger dosage. My son takes 1 mg of Risperdal every day and my mother is only on 0.5 mg." What is the **most** helpful response by the nurse?

- 1. "Maybe your son is sicker than your mother is."
- 2. "We could increase your mother's dosage if you want."
- 3. "Older clients generally need only one-third to one-half the dose of younger people."
- 4. "I'm not seeing any symptoms of illness in your mother. Let's wait until the next visit."

**39.** At an outpatient visit 3 months after discharge from the hospital, a client says he has stopped his olanzapine (Zyprexa) even though it controls his symptoms of schizophrenia better than other medications. "I have gained 20 lb already. I can't stand any more." Which response by the nurse is **most** appropriate?

- 1. "I don't think you look fat, why do you think so?"
- 2. "I can help you with a diet and exercise plan to keep your weight down."
- 3. "You can be switched to another medicine."
- 4. "Your weight gain will level off if you stay on the medication 3 more months."

**40.** A client diagnosed with schizophrenia is being switched to risperidone long-acting injection (Risperdal Consta). He is told that he will remain on his oral dose of risperidone (Risperdal) daily for approximately 1 month. The client says, "I didn't have to take pills when I was on fluphenazine decanoate (Prolixin Decanoate) shots in the past." The nurse should tell the client:

- 1. "Taking fluphenazine orally and by injection would not be as effective as the injection alone."
- 2. "Risperdal Consta is less potent than Prolixin Decanoate."
- 3. "The doctor didn't believe you would take both the pills and Prolixin Decanoate."
- 4. "Risperdal Consta initially takes a little longer to reach the ideal blood level."

**41.** One of the important aspects of the client's rights is the right to treatment in the least restrictive environment. The nurse observes this principle when making which decisions? Select all that apply.

- 1. Referring a client to a group home or supervised apartment living.
- 2. Releasing client information to a primary care physician or a relative.
- 3. Placing a client in seclusion or restraints.
- 4. Respecting the client's right to accept or refuse treatment.
- 5. Placing a committed client in a daily outpatient group or a weekly self-help group.

**42.** A client has been perceiving her roommate's stuffed animal as her own dog at home. The nurse determines that this misperception of reality (illusion) is improving when the client makes which of the following statements?

- 1. "Jan's stuffed dog looks somewhat like my dog, Trixie."
- 2. "Jan's dog and my dog could be twins."
- 3. "I wish Jan hadn't had my dog stuffed."
- 4. "I guess Jan needs a dog as much as I do."



**43.** When asked about her stresses before admission, an anxious client stares blankly at the nurse and mutters unintelligibly. Which of the following descriptions of the client's behaviors should the nurse document in the client's chart?

- 1. "Client cannot answer any questions asked at this time."
- 2. "Client is uncooperative during admission procedure, refusing to answer any questions."
- 3. "Client responded to questions with a blank look and incomprehensible mumble."
- 4. "Client stared at wall when asked questions and was disoriented and incoherent."

**44.** The nurse identifies a nursing diagnosis of *Dressing or grooming self-care deficit* related to apathy, as evidenced by an inability to shower and dress herself for a female client diagnosed with schizophrenia. When planning care for this client, which of the following outcomes should the nurse expect the client to achieve by the end of 4 days?

- 1. Verbalize the need to shower and dress herself.
- 2. Recognize the need to shower and dress herself.
- 3. Explain reasons for showering and dressing herself.
- 4. Perform showering and dressing for herself.

**45.** A client diagnosed with schizophrenia is brought to the hospital from a group home where he became agitated, threw a chair at another client, and has been refusing medication for 8 weeks. The client exhibits a flat affect, is not caring for his hygiene, and has become increasingly withdrawn and asocial. The physician orders treatment with risperidone (Risperdal) to improve the client's negative and positive symptoms of schizophrenia. When evaluating the drug's effectiveness on the client's negative symptoms, the nurse should expect improvement in which of the following?

- 1. Apathy, affect, social isolation.
- 2. Agitation, delusions, hallucinations.
- 3. Hostility, ideas of reference, tangential speech.
- 4. Aggression, bizarre behavior, illusions.

**46.** A 77-year-old client is brought to the emergency department by her son. The client is complaining of a severe headache and lack of sleep because, "I'm so worried about everything." Her son says that she has heart failure and chronic schizophrenia. "In addition to all of her heart medicines, she is on aripiprazole (Abilify), which was increased to 30 mg by her family doctor 3 days ago." In addition to documenting all of the client's medications and exact dosages, the nurse should particularly investigate which of the following? Select all that apply.

- 1. The qualifications of the client's family doctor.
- 2. The client's symptoms of schizophrenia.
- 3. The dose of aripiprazole.
- 4. The client's symptoms of heart failure.
- 5. The client's relationship with her son.

**47.** A client with schizophrenia comes to the outpatient mental health clinic 5 days after being discharged from the hospital. The client was given a 1-week supply of clozapine (Clozaril). The client tells the nurse that she has too much saliva and frequently needs to spit. The nurse interprets the client's statement as indicating which of the following?

- 1. Delusion, requiring further assessment.
- 2. Unusual reaction to clozapine.
- 3. Expected adverse effect of clozapine.
- 4. Unresolved symptom of schizophrenia.

**48.** The client with an Axis I diagnosis of schizophrenia, undifferentiated type, is acutely psychotic and exhibits religious delusions and hallucinations, loose associations, and concrete thinking. When the nurse offers the client her medication, the client states, "I don't need that. God will heal me." The nurse should respond to the client by saying:

- 1. "God helps those who help themselves."
- 2. "God wants you to take your medicine."
- 3. "God is important in your life, but the medicine will help you too."
- 4. "This medicine will help clear your thoughts and decrease anxiety."

**49.** The nurse hands the medication cup to a client who is psychotic and exhibiting concrete thinking, and tells the client to take his medicine. The client takes the cup, holds it in his hand, and stares at it. Which of the following should the nurse do next?

- 1. Tell the client to put the medicine in his mouth and swallow it with some water.
- 2. Instruct the client to sit in the dayroom and wait for the nurse to assist him.
- 3. Ask another staff member to stay with the client until he takes the medication.
- 4. Say nothing and wait for the client to put the medication in his mouth and swallow it.

**50.** A client is admitted to the unit with a diagnosis of Axis I delusional disorder, persecutory type. The nurse includes the nursing diagnosis *Defensive coping* secondary to suspiciousness as evidenced by the statement, "My wife and coworker are conspiring against me," in the client's plan of care. Which statement about the client is an expected outcome for this nursing diagnosis?

- 1. Demonstrate an absence of hostile behavior.
- 2. Express own needs using assertive communication.
- 3. Use adaptive coping strategies appropriately.
- 4. Accurately interpret the behaviors of his wife and coworker.

**51.** Which action by the nurse is likely to increase the anxiety and suspiciousness of a client who is delusional?

- 1. Informing the client of schedule changes.
- 2. Whispering with others where the client can observe.
- 3. Telling the client gently that the nurse does not share the client's view.
- 4. Inviting the client to join in leisure activities.

**52.** A client with undifferentiated schizophrenia tells the nurse that he doesn't go out much because he doesn't have anywhere to go and he doesn't know anyone in the apartment where he's staying. Which of the following actions is **most** beneficial for the client at this time?

- 1. Encouraging him to call his family to visit more often.
- 2. Making an appointment for the client to see the nurse daily for 2 weeks.
- 3. Thinking about the need for rehospitalization for the client.
- 4. Arranging for the client to attend day treatment at the clinic.

**53.** A client with chronic undifferentiated schizophrenia has positive and negative symptoms of schizophrenia but does not meet the criteria for paranoid, disorganized, or catatonic schizophrenia. Based on the interpretation of this information, the nurse should expect the client to exhibit which of the following as the **most** likely symptoms?

- 1. Auditory hallucinations and asocial behaviors.
- 2. Preoccupation with persecutory delusions and hallucinations.
- 3. Grossly disorganized behaviors and speech.
- 4. Immobility and waxy flexibility.

**54.** The plan of care for an outpatient client with chronic undifferentiated schizophrenia (CUS) includes risperidone (Risperdal) therapy. The nurse prepares to administer this drug based on the understanding of which of the following?

- 1. The positive symptoms of CUS are usually more prominent than the negative symptoms.
- 2. Agranulocytosis is less of a risk with risperidone therapy.
- 3. Traditional antipsychotics help with negative symptoms, but not as well as Risperdal does.
- 4. Risperidone is less expensive than traditional antipsychotics.

**55.** A client diagnosed with undifferentiated schizophrenia is being discharged on aripiprazole (Abilify) 5 mg every night. When developing the teaching plan about the most common adverse effects, which of the following should the nurse include? Select all that apply.

- 1. Headaches that will subside in a few weeks.
- 2. Transient mild anxiety.
- 3. Insomnia.
- 4. Torticollis.
- 5. Pill rolling movements.

**56.** A newly admitted client with an acute exacerbation of psychotic symptoms of chronic undifferentiated schizophrenia is having trouble deciding whether to live in a group home or a supervised apartment. When caring for this client, which of the following activities is **most** appropriate for the nurse to ask the client to do initially?

- 1. List the pros and cons of each housing option.
- 2. Choose between apple and orange juice for breakfast.
- 3. Identify why the client cannot live in an unsupervised apartment.
- 4. Decide which staff member the client would like to have today.

**57.** An outpatient client who has been receiving haloperidol (Haldol) for 2 days develops muscular rigidity, altered consciousness, a temperature of 103° F (39.4° C), and trouble breathing on day 3. The nurse interprets these findings as indicating which of the following?

- 1. Neuroleptic malignant syndrome.
- 2. Tardive dyskinesia.
- 3. Extrapyrimal adverse effects.
- 4. Drug-induced parkinsonism.

**58.** A client with chronic undifferentiated schizophrenia reports to the nurse that he does very little all day except sleep and eat. The nurse should:

- 1. Have three meals per day brought in to increase the amount of time the client spends out of bed.
- 2. Ask a relative to call the client at least 10 times a day to decrease the sleeping.
- 3. Help the client set up a daily activity schedule to include setting a wake-up alarm.
- 4. Arrange for the client to move to a group home with structured activities.

**59.** The nurse notes that a client sitting in a chair has not gotten up in 1 hour. The client does not respond to verbal directions, and her arm has been extended over the armrest for 30 minutes. Which of the following should the nurse do next?

- 1. Assist the client out of the chair to lead her back to bed.
- 2. Give p.r.n.-ordered doses of haloperidol (Haldol) and lorazepam (Ativan).
- 3. Ask the client to describe what is being experienced right now.
- 4. Sit quietly with the client until she begins to respond.

**60.** What is the most appropriate long-term goal for an outpatient client with chronic undifferentiated schizophrenia who has been withdrawn from friends and family for 3 weeks?

- 1. Calling his mother once a day.
- 2. Attending day therapy three times a week.
- 3. Allowing two friends to visit every day.
- 4. Remaining out of bed for 10 hours a day.

**61.** For the client with catatonic behaviors, which of the following should the nurse use to determine that the medication administered as needed has been most effective in the long term?

- 1. The client can move all extremities occasionally.
- 2. The client walks with the nurse to her room.
- 3. The client responds to verbal directions to eat.
- 4. The client initiates simple activities without directions.

**62.** The mother of a client with chronic undifferentiated schizophrenia calls the nurse in the outpatient clinic to report that her daughter has not answered the phone in 10 days. "She was doing so well for months. I don't know what's wrong. I'm worried." Which of the following responses by the nurse is **most** appropriate?

- 1. "Maybe she's just mad at you. Did you have an argument?"
- 2. "She may have stopped taking her medications. I'll check on her."
- 3. "Don't worry about this. It happens sometimes."
- 4. "Go over to her apartment and see what's going on."

**63.** During a home visit, the nurse discovers that the client is less verbal, less active, less responsive to directions, severely anxious, and more stuporous. The nurse interprets these findings to indicate that the client needs?

- 1. A sleep aid.
- 2. A clinic appointment.
- 3. An increase in medication.
- 4. Hospitalization.

**64.** A client diagnosed with disorganized schizophrenia has been well maintained on olanzapine (Zyprexa) for 1 year. Two days ago, the client was found in the backyard without any clothes on and unable to communicate well because of loose associations. His mother died 2 weeks ago. Which intervention will be most helpful to the client **first**?

- 1. Addition of a short course of haloperidol (Haldol).
- 2. A significant increase in the dose of olanzapine.
- 3. Grief counseling.
- 4. A switch to risperidone (Risperdal) instead of olanzapine.

**65.** A client admitted with a diagnosis of schizoaffective disorder, manic phase, who is currently taking fluoxetine (Prozac), valproic acid (Depakote), and olanzapine (Zyprexa) as ordered has had an increase in manic symptoms in the past week. The psychiatrist orders a valproic acid blood level to be drawn at once. The nurse understands the rationale for this order as which of the following?

- 1. All clients taking valproic acid need periodic valproic acid levels drawn.
- 2. Fluoxetine can decrease the effectiveness of the valproic acid.
- 3. A decrease in the level of valproic acid could explain the increase in manic symptoms.
- 4. The valproic acid level is needed before a short course of lorazepam (Ativan) for agitation is ordered.

**66.** A 22-year-old client is being admitted with a diagnosis of brief psychotic disorder. Two weeks ago, his girlfriend broke off their engagement and canceled the wedding. Given the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*, text revised, criteria for this disorder, the nurse should expect to find which data during the interview with the client?

- 1. Current treatment for pneumonia.
- 2. Regular use of alcohol or marijuana.
- 3. Evidence of delusions or hallucinations.
- 4. A history of chronic depression.

**67.** A successful real estate agent brought to the clinic after being arrested for harassing and stalking his ex-wife denies any other symptoms or problems except anger about being arrested. The ex-wife reports to the police, "He is fine except for this irrational belief that we will remarry." When collaborating with the health care provider about a plan of care, which of the following will be most effective for the client at this time?

- 1. An order for olanzapine (Zyprexa) 10 mg daily.
- 2. A joint session with the client and his ex-wife.
- 3. An order for fluoxetine (Prozac) 20 mg every morning.
- 4. Referral to an outpatient therapist.

### Clients and Families Affected by Chronic Mental Illnesses

**68.** When working with clients who are experiencing chronic mental illnesses, which of the following should the nurse expect to be generally the **least** necessary for this client population?

- 1. Community-based treatment programs.
- 2. Psychosocial rehabilitation.
- 3. Employment opportunities.
- 4. Custodial care in long-term hospitals.

**69.** The nurse planning care for a group of clients who are chronically mentally ill. Which of the following strategies is likely to be the **least** beneficial for the client population?

- 1. Teaching independent living skills.
- 2. Assisting clients with living arrangements.
- 3. Helping clients in insight-oriented therapy.
- 4. Linking clients with community resources.

**70.** A nurse working at an outpatient mental health center primarily with chronically mentally ill clients receives a telephone call from the mother of a client who lives at home. The mother reports that the client has not been taking her medication and now is refusing to go to the sheltered workshop where she has worked for the past year. What should the nurse do **first**?

- 1. Call the director of the workshop for information about the client.
- 2. Reserve an inpatient bed in preparation for the client's admission.
- 3. Ask to speak to the client directly on the phone.
- 4. Make an appointment for the client to see the doctor.

**71.** The nurse invites a new client's parents to attend the psychoeducational program for families of the chronically mentally ill. The program is most likely to help the family with which of the following issues?

- 1. Feeling guilty about the client's illness.
- 2. Developing a support network with other families.
- 3. Managing financial concerns and problems.
- 4. Recognizing the client's weaknesses.

**72.** A nurse is teaching the families of clients with chronic mental illnesses about causes of relapse and rehospitalization. What should the nurse include as the primary cause?

- 1. Loss of family support.
- 2. Noncompliance with medications.
- 3. Sudden changes in medications.
- 4. Nonattendance at treatment programs.

**73.** The director of a workshop program tells the nurse that the client with schizophrenia had done well for 6 months until last week, when a new person started at the workshop. This new person worked faster than the client did and took his place as leader of the group. Based on this information, which of the following interventions is **most** appropriate?

- 1. Make a home visit and tell the client that if he does not return to the workshop, he will lose his place there.
- 2. Ask the director to assign the client to another work group when he returns to the workshop.
- 3. Make an appointment to meet the client at the mental health center and ask him about the situation.
- 4. Arrange for the placement of the client in a skill-training program.

**74.** A 25-year-old client diagnosed with chronic schizophrenia states, "I stopped my medications a week ago. I was just tired of not being able to drink with my friends. Besides, I feel fine without them." Which of the following responses by the nurse is **most** appropriate?

- 1. "It's important for you to go back on your medicines."
- 2. "I hear how difficult it must be to live with the changes caused by your illness."
- 3. "You will have to talk to your doctor about stopping your medications."
- 4. "Your buddies will understand that you can't drink anymore."

**75.** A 23-year-old client diagnosed with schizophrenia cheerfully announces, "My mom and I are so excited that I'm pregnant. She's willing to help us take care of the baby too." Which of the following reasons should cause the nurse to be concerned about this situation?

- 1. The client did not say that the father of the baby was excited about this.
- 2. The mother is not likely to provide enough help for what the client needs.
- 3. Symptom management will be difficult in early pregnancy without medications.
- 4. The client will have difficulty financially supporting the baby.

**76.** Mental health professionals are concerned about the care of chronically ill clients who have aging parents. The primary reason for this concern is associated with which of the following?

- 1. Clients will have to face grieving issues when one or both parents die.
- 2. Parents experience much guilt about abandoning their child.
- 3. Clients will lose a source of emotional support.
- 4. Parents are commonly providing financial support and/or housing.

**77.** The discovery of the biochemical hypothesis for the cause of schizophrenia has helped families of ill clients in many ways. Which new information should the nurse understand to be **most** significant when planning care for a client with schizophrenia and his family?

- 1. Family dysfunction, if it exists, is viewed as an effect rather than a cause of the disorder.
- 2. Professionals are more likely to view families as allies than as villains.
- 3. Families are less likely to participate in “families of schizophrenics” studies.
- 4. Families are less likely to be involved in providing care to their ill relatives.

**78.** Which of the following clients has the **least** priority for admission to a psychiatric health care facility? A client with a:

- 1. Potential for self-harm.
- 2. Potential for harm to others.
- 3. Grave disability (cannot care for self).
- 4. Decline in functioning at work.

**79.** A client is being discharged before complete stabilization of symptoms. When developing a discharge plan for this client, the nurse should ensure that the client will have:

- 1. More medical consultations after discharge.
- 2. Monthly outpatient visits.
- 3. Many coordinated services.
- 4. A caring and supportive family.

**80.** Clients with chronic mental illnesses need to develop trust in their care providers and learn about their illness and its treatment. The nurse should develop a care plan that also includes:

- 1. Family support.
- 2. Advocacy for improved mental health statutes.
- 3. Diligent monitoring for medication compliance.
- 4. Support groups.

**81.** When developing a community-based service program for clients with chronic mental illnesses, which of the following is the **least** important?

- 1. Partial programs.
- 2. Psychiatric home care.
- 3. Residential services.
- 4. Long-term hospitals.

**82.** Crisis intervention plays a major role in the management of care for clients with chronic mental illnesses. Although the safety of the client and others is always a priority, these clients typically need crisis intervention in which of the following situations? Select all that apply.

- 1. Inability to keep outpatient appointments.
- 2. Signs of relapse and decompensation.
- 3. Threat of eviction from housing.
- 4. Unpaid bills and lack of food.
- 5. Occasionally missing a dose of medication.

**83.** The most common reason given by mentally ill clients for noncompliance with medications is their uncomfortable adverse effects. When teaching the families, what need should the nurse identify as the **greatest**?

- 1. Alternative ways to manage the adverse effects.
- 2. Home visits to set up a week’s supply of medications.
- 3. Family monitoring of the administration of medication.
- 4. Outpatient monitoring of medication compliance.

**84.** The stigma related to having a mental illness, especially a chronic illness, persists despite improvements in the management of illnesses and an increase in public education. Which of the following views **most** perpetuates the stigma?

- 1. Mental illness is hereditary.
- 2. Mental illnesses have biochemical bases.
- 3. Clients cannot prevent mental illness if they want to do so.
- 4. Clients can recover from mental illness if they have willpower.

## The Client with Cognitive Disorders

**85.** An elderly woman’s husband died. When her brother arrives for the funeral, he notices her short-term memory problems and occasional disorientation. A few weeks later, she calls him to say that her husband just died. She says, “I didn’t know he was so sick. Why did he die now?” She also complains of not sleeping, urinary frequency and burning, and seeing rats in the kitchen. A home care nurse is sent to evaluate her situation and finds the woman reclusive and passive, but pleasant. The nurse calls the woman’s primary care physician to discuss the client’s situation and background, and give his assessment and recommendations. The nurse concludes that the woman:

- 1. Is experiencing the onset of Alzheimer’s disease.
- 2. Is having trouble adjusting to living alone without her husband.
- 3. Is having delayed grieving related to her Alzheimer’s disease.
- 4. Is experiencing delirium and a urinary tract infection.

**86.** In planning for the discharge of a client with a cognitive disorder, it is important to assess the client's caregiver support system. Which aspects are the most crucial to assess? Select all that apply.

- 1. Availability of resources for caregiver support.
- 2. Ability to provide the level of care and supervision needed by the client.
- 3. Willingness to transport the client to medical and psychiatric services.
- 4. Interest in engaging the cognitively disordered family member in reminiscence and games.
- 5. Willingness to install door alarms and make other safety changes.
- 6. Understanding the client's abilities and limitations.

**87.** The son of an elderly client who has cognitive impairments approaches the nurse and says, "I'm so upset. The physician says I have 4 days to decide on where my dad is going to live." The nurse responds to the son's concerns, gives him a list of types of living arrangements, and discusses the needs, abilities, and limitations of the client. The nurse should intervene further if the son makes which comment?

- 1. "Boy, I have a lot to think about before I see the social worker tomorrow."
- 2. "I think I can handle most of Dad's needs with the help of some home health care."
- 3. "I'm so afraid of making the wrong decision, but I can move him later if I need to."
- 4. "I want the social worker to make this decision so Dad won't blame me."

**88.** Transfer data for a client brought by ambulance to the hospital's psychiatric unit from a nursing home indicate that the client has become increasingly confused and disoriented. The client's behavior is found to be the result of cerebral arteriosclerosis. Which of the following behaviors of the nursing staff should positively influence the client's behavior? Select all that apply.

- 1. Limiting the client's choices.
- 2. Accepting the client as he is.
- 3. Allowing the client to do as he wishes.
- 4. Acting nonchalantly.
- 5. Explaining to the client what he needs to do step-by-step.

**89.** The nurse observes a client in a group who is reminiscing about his past. Which effect should the nurse expect reminiscing to have on the client's functioning in the hospital?

- 1. Increase the client's confusion and disorientation.
- 2. Cause the client to become sad.
- 3. Decrease the client's feelings of isolation and loneliness.
- 4. Keep the client from participating in therapeutic activities.

## The Client with Delirium

**90.** A 69-year-old client is admitted and diagnosed with delirium. Later in the day, he tries to get out of the locked unit. He yells, "Unlock this door. I've got to go see my doctor. I just can't miss my monthly Friday appointment." Which of the following responses by the nurse is **most** appropriate?

- 1. "Please come away from the door. I'll show you your room."
- 2. "It's Tuesday and you are in the hospital. I'm Anne, a nurse."
- 3. "The door is locked to keep you from getting lost."
- 4. "I want you to come eat your lunch before you go the doctor."

**91.** An 83-year-old woman is admitted to the unit after being examined in the emergency department (ED) and diagnosed with delirium. After the admission interviews with the client and her grandson, the nurse explains that there will be more laboratory tests and X-rays done that day. The grandson says, "She has already been stuck several times and had a brain scan or something. Just give her some medicine and let her rest." The nurse should tell the grandson which of the following? Select all that apply.

- 1. "I agree she needs to rest, but there is no one specific medicine for your grandmother's condition."
- 2. "The doctor will look at the results of those tests in the ED and decide what other tests are needed."
- 3. "Delirium commonly results from underlying medical causes that we need to identify and correct."
- 4. "Tell me about your grandmother's behaviors and maybe I could figure out what medicine she needs."
- 5. "I'll ask the doctor to postpone more tests until tomorrow."

**92.** The nurse is attempting to draw blood from a woman with a diagnosis of delirium who was admitted last evening. The client yells out, "Stop; leave me alone. What are you trying to do to me? What's happening to me?" Which response by the nurse is **most** appropriate?

- 1. "The tests of your blood will help us figure out what is happening to you."
- 2. "Please hold still so I don't have to stick you a second time."
- 3. "After I get your blood, I'll get some medicine to help you calm down."
- 4. "I'll tell you everything after I get your blood tests to the laboratory."

**93.** A 90-year-old client diagnosed with major depression is suddenly experiencing sleep disturbances, inability to focus, poor recent memory, altered perceptions, and disorientation to time and place. Lab results indicate the client has a urinary tract infection and dehydration. After explaining the situation and giving the background and assessment data, the nurse should make which of the following recommendations to the client's physician?

- 1. An order to place the client in restraints.
- 2. A reevaluation of the client's mental status.
- 3. The transfer of the client to a medical unit.
- 4. A transfer of the client to a nursing home.

**94.** When caring for the client diagnosed with delirium, which condition is the **most** important for the nurse to investigate?

- 1. Cancer of any kind.
- 2. Impaired hearing.
- 3. Prescription drug intoxication.
- 4. Heart failure.

**95.** In addition to developing over a period of hours or days, the nurse should assess delirium as distinguishable by which of the following characteristics?

- 1. Disturbances in cognition and consciousness that fluctuate during the day.
- 2. The failure to identify objects despite intact sensory functions.
- 3. Significant impairment in social or occupational functioning over time.
- 4. Memory impairment to the degree of being called amnesia.

**96.** Which of the following is essential when caring for a client who is experiencing delirium?

- 1. Controlling behavioral symptoms with low-dose psychotropics.
- 2. Identifying the underlying causative condition or illness.
- 3. Manipulating the environment to increase orientation.
- 4. Decreasing or discontinuing all previously prescribed medications.

**97.** Which of the following is a realistic short-term goal to be accomplished in 2 to 3 days for a client with delirium?

- 1. Explain the experience of having delirium.
- 2. Resume a normal sleep-wake cycle.
- 3. Regain orientation to time and place.
- 4. Establish normal bowel and bladder function.

**98.** Which of the following should the nurse expect to include as a priority in the plan of care for a client with delirium based on the nurse's understanding about the disturbances in orientation associated with this disorder?

- 1. Identifying self and making sure that the nurse has the client's attention.
- 2. Eliminating the client's napping in the daytime as much as possible.
- 3. Engaging the client in reminiscing with relatives or visitors.
- 4. Avoiding arguing with a suspicious client about his perceptions of reality.

**99.** A client has been in the critical care unit for 3 days following a severe myocardial infarction. Although he is medically stable, he has begun to have fluctuating episodes of consciousness, illogical thinking, and anxiety. He is picking at the air to "catch these baby angels flying around my head." While waiting for medical and psychiatric consults, the nurse must intervene with the client's needs. Which of the following needs have the highest priority? Select all that apply.

- 1. Decreasing as much "foreign" stimuli as possible.
- 2. Avoiding challenging the client's perceptions about "baby angels."
- 3. Orienting the client about his medical condition.
- 4. Gently presenting reality as needed.
- 5. Calling the client's family to report his onset of dementia.

## The Client with Dementia

**100.** A nurse on the Geropsychiatric unit receives a call from the son of a recently discharged client. He reports that his father just got a prescription for memantine (Namenda) to take "on top of his donepezil (Aricept)." The son then asks, "Why does he have to take extra medicines?" The nurse should tell the son:

- 1. "Maybe the Aricept alone isn't improving his dementia fast enough or well enough."
- 2. "Namenda and Aricept are commonly used together to slow the progression of dementia."
- 3. "Namenda is more effective than Aricept. Your father will be tapered off the Aricept."
- 4. "Aricept has a short half-life and Namenda has a long half-life. They work well together."

**101.** A client diagnosed with dementia wanders the halls of the locked nursing unit during the day. To ensure the client's safety while walking in the halls, the nurse should do which of the following?

- 1. Administer PRN haloperidol (Haldol) to decrease the need to walk.
- 2. Assess the client's gait for steadiness.
- 3. Restrain the client in a geriatric chair.
- 4. Administer PRN lorazepam (Ativan) to provide sedation.

**102.** A client with dementia who prefers to stay in his room has been brought to the dayroom. After 10 minutes, the client becomes agitated and retreats to his room again. The nurse decides to assess the conditions in the dayroom. Which is the most likely occurrence that is disturbing to this client?

- 1. There is only one other client in the dayroom; the rest are in a group session in another room.
- 2. There are three staff members and one physician in the nurse's station working on charting.
- 3. A relaxation tape is playing in one corner of the room, and a television airing a special on crime is playing in the opposite corner.
- 4. A housekeeping staff member is washing off the countertops in the kitchen, which is on the far side of the dayroom.

**103.** Nursing staff are trying to provide for the safety of an elderly female client with moderate dementia. She is wandering at night and has trouble keeping her balance. She has fallen twice but has had no resulting injuries. The nurse should:

- 1. Move the client to a room near the nurse's station and install a bed alarm.
- 2. Have the client sleep in a reclining chair across from the nurse's station.
- 3. Help the client to bed and raise all four bedrails.
- 4. Ask a family member to stay with the client at night.

**104.** During a home visit to an elderly client with mild dementia, the client's daughter reports that she has one major problem with her mother. She says, "She sleeps most of the day and is up most of the night. I can't get a decent night's sleep anymore." Which suggestions should the nurse make to the daughter? Select all that apply.

- 1. Ask the client's physician for a strong sleep medicine.
- 2. Establish a set routine for rising, hygiene, meals, short rest periods, and bedtime.
- 3. Engage the client in simple, brief exercises or a short walk when she gets drowsy during the day.
- 4. Promote relaxation before bedtime with a warm bath or relaxing music.
- 5. Have the daughter encourage the use of caffeinated beverages during the day to keep her mother awake.

**105.** A client is experiencing agnosia as a result of vascular dementia. She is staring at dinner and utensils without trying to eat. Which intervention should the nurse attempt **first**?

- 1. Pick up the fork and feed the client slowly.
- 2. Say, "It's time for you to start eating your dinner."
- 3. Hand the fork to the client and say, "Use this fork to eat your green beans."
- 4. Save the client's dinner until her family comes in to feed her.

**106.** A client with early dementia exhibits disturbances in her mental awareness and orientation to reality. The nurse should expect to assess a loss of ability in which of the following other areas?

- 1. Speech.
- 2. Judgment.
- 3. Endurance.
- 4. Balance.

**107.** The client with dementia states to the nurse, "I know you. You're Margaret, the girl who lives down the street from me." Which of the following responses by the nurse is **most** therapeutic?

- 1. "Mrs. Jones, I'm Rachel, a nurse here at the hospital."
- 2. "Now Mrs. Jones, you know who I am."
- 3. "Mrs. Jones, I told you already, I'm Rachel and I don't live down the street."
- 4. "I think you forgot that I'm Rachel, Mrs. Jones."

**108.** While assessing a client diagnosed with dementia, the nurse notes that her husband is concerned about what he should do when she uses vulgar language with him. The nurse should:

- 1. Tell her that she is very rude.
- 2. Ignore the vulgarity and distract her.
- 3. Tell her to stop swearing immediately.
- 4. Say nothing and leave the room.

**109.** The term motor apraxia relates to a decline in motor patterns essential for complex motor tasks. However, the client with severe dementia may be able to perform which of the following actions?

- 1. Balance a checkbook accurately.
- 2. Brush the teeth when handed a toothbrush.
- 3. Use confabulation when telling a story.
- 4. Find misplaced car keys.

**110.** When communicating with the client who is experiencing dementia and exhibiting decreased attention and increased confusion, which of the following interventions should the nurse employ as the **first** step?

- 1. Using gentle touch to convey empathy.
- 2. Rephrasing questions the client doesn't understand.
- 3. Eliminating distracting stimuli such as turning off the television.
- 4. Asking the client to go for a walk while talking.

**111.** While educating the daughter of a client with dementia about the illness, the daughter complains to the nurse that her mother distorts things. The nurse understands that the daughter needs further teaching about dementia when she makes which statement?

- 1. "I tell her reality, such as, "That noise is the wind in the trees.""
- 2. "I understand the misperceptions are part of the disease."
- 3. "I turn off the radio when we're in another room."
- 4. "I tell her she is wrong and then I tell her what's right."



### The Client with Alzheimer's Disease

**112.** The client in the early stage of Alzheimer's disease and his adult son attend an appointment at the community mental health center. While conversing with the nurse, the son states, "I'm tired of hearing about how things were 30 years ago. Why does Dad always talk about the past?" The nurse should tell the son:

- 1. "Your dad lost his short-term memory, but he still has his long-term memory."
- 2. "You need to be more accepting of your dad's behavior."
- 3. "I want you to understand your dad's level of anxiety."
- 4. "Telling your dad that you are tired of hearing about the past will help him stop."

**113.** The nurse discusses the possibility of a client's attending day treatment for clients with early Alzheimer's disease. Which of the following is the best rationale for encouraging day treatment?

- 1. The client would have more structure to his day.
- 2. Staff are excellent in the treatment they offer clients.
- 3. The client would benefit from increased social interaction.
- 4. The family would have more time to engage in their daily activities.

**114.** When developing the plan of care for a client with Alzheimer's disease who is experiencing moderate impairment, which of the following types of care should the nurse expect to include?

- 1. Prompting and guiding activities of daily living.
- 2. Managing a medication schedule.
- 3. Constant supervision and total care.
- 4. Supervision of risky activities such as shaving.

**115.** The family of a client, diagnosed with Alzheimer's disease, wants to keep the client at home. They say that they have the most difficulty in managing his wandering. The nurse should instruct the family to do which of the following? (Select all that apply).

- 1. Ask the physician for a sleeping medication.
- 2. Install motion and sound detectors.
- 3. Have a relative sit with the client all night.
- 4. Have the client wear a Medical Alert bracelet.
- 5. Install door alarms and high door locks.

**116.** Which of the following is a priority to include in the plan of care for a client with Alzheimer's disease who is experiencing difficulty processing and completing complex tasks?

- 1. Repeating the directions until the client follows them.
- 2. Asking the client to do one step of the task at a time.
- 3. Demonstrating for the client how to do the task.
- 4. Maintaining routine and structure for the client.

**117.** The client with Alzheimer's disease may have delusions about being harmed by staff and others. When the client expresses fear of being killed by staff, which of the following responses is most appropriate?

- 1. "What makes you think we want to kill you?"
- 2. "We like you too much to want to kill you."
- 3. "You are in the hospital. We are nurses trying to help you."
- 4. "Oh, don't be so silly. No one wants to kill you here."

**118.** When helping the families of clients with Alzheimer's disease cope with vulgar or sexual behaviors, which of the following suggestions is most helpful?

- 1. Ignore the behaviors, but try to identify the underlying need for the behaviors.
- 2. Give feedback on the inappropriateness of the behaviors.
- 3. Employ anger management strategies.
- 4. Administer the prescribed risperidone (Risperdal).

**119.** The nurse determines that the son of a client with Alzheimer's disease needs further education about the disease when he makes which of the following statements?

- 1. "I didn't realize the deterioration would be so incapacitating."
- 2. "The Alzheimer's support group has so much good information."
- 3. "I get tired of the same old stories, but I know it's important for Dad."
- 4. "I woke up this morning expecting that my old Dad would be back."

**120.** The husband of a client with Alzheimer's disease that was diagnosed 6 years ago approaches the nurse and says, "I'm so excited that my wife is starting to use donepezil (Aricept) for her illness." The nurse should tell the husband:

- 1. The medication is effective mostly in the early stages of the illness.
- 2. The adverse effects of the drug are numerous.
- 3. The client will attain a functional level of that of 6 years ago.
- 4. Effectiveness in the terminal phase of the illness is scientifically proven.

**121.** The physician orders risperidone (Risperdal) for a client with Alzheimer's disease. The nurse anticipates administering this medication to help decrease which of the following behaviors?

- 1. Sleep disturbances.
- 2. Concomitant depression.
- 3. Agitation and assaultiveness.
- 4. Confusion and withdrawal.

**122.** The nurse is making a home visit with a client diagnosed with Alzheimer's disease. The client recently started on lorazepam (Ativan) due to increased anxiety. The nurse is cautioning the family about the use of lorazepam (Ativan). The nurse should instruct the family to report which of the following significant side effects to the health care provider?

- 1. Paradoxical excitement.
- 2. Headache.
- 3. Slowing of reflexes.
- 4. Fatigue.

**123.** When providing family education for those who have a relative with Alzheimer's disease about minimizing stress, which of the following suggestions is **most** relevant?

- 1. Allow the client to go to bed four to five times during the day.
- 2. Test the cognitive functioning of the client several times a day.
- 3. Provide reality orientation even if the memory loss is severe.
- 4. Maintain consistency in environment, routine, and caregivers.

### Managing Care Quality and Safety

**124.** A client reports having blurred vision after 4 days of taking haloperidol (Haldol) 1 mg. BID, and benztropine (Cogentin) 2 mg BID. The nurse contacts the physician to explain the situation, background, assessment and make a recommendation. Which information reported to the physician is the assessment of the situation?

- 1. "Mr. Roberts is taking 1 mg of Haldol BID and Cogentin 2 mg BID."
- 2. "I think Mr. Roberts might need a lower dose of Cogentin."
- 3. "Mr. Roberts reports having blurred vision since this morning."
- 4. "The higher dose of Cogentin could be causing Mr. Roberts' blurred vision."

**125.** When developing a teaching plan for the community about managed care models and their effect on clients with chronic mental illnesses, which of the following factors should the nurse include as detrimental to this population? Select all that apply.

- 1. Restriction in the range and quantity of services.
- 2. Hospitalization reserved for emergency services.
- 3. Nonshifting funding to outpatient services when clients are moved to these services.
- 4. Loss of the principle of "least restrictive alternative for care."
- 5. Lack of sufficient numbers of group homes and supervised apartments.

**126.** When assessing an aggressive client, which of the following behaviors warrants the nurse's prompt reporting and use of safety precautions?

- 1. Crying when talking about his divorce.
- 2. Starting a petition to delay bedtime.
- 3. Declining attendance at a daily group therapy session.
- 4. Naming another client as his adversary.


**127.** A nurse is planning care for an elderly client with cognitive impairment who is still living at home. Which action should the nurse identify as a priority for safety in planning care for this client?

- 1. Having two people accompany the client whenever the client is up and about.
- 2. Ensuring the removal of objects in the client's path that may cause him to trip.
- 3. Putting the client's favorite belongings in a safe place so that he will not lose them.
- 4. Giving the client his medications in liquid form to make certain that he swallows them.

**128.** The nurse manager of a psychiatric unit notices that one of the nurses commonly avoids a 75-year-old client's company. Which of the following factors should the nurse manager identify as being the most likely cause of this nurse's discomfort with older clients?


- 1. Fears and conflicts about aging.
- 2. Dislike of physical contact with older people.
- 3. A desire to be surrounded by beauty and youth.
- 4. Recent experiences with her mother's elderly friends.

## Answers, Rationales, and Test Taking Strategies


The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with Paranoid Schizophrenia


**1. 4.** It is critical for the nurse to ensure the safety of others by knowing who the client might think needs elimination. Asking the client to explain what she means or discuss her concerns at the group session are possible interventions for later in the client's hospital stay. Wearing appropriate clothing while hospitalized is generally a unit expectation for all clients.

 CN: Psychosocial adaptation;  
CL: Synthesize

**2. 2.** Knowing the client's interests is the best place to begin to help the client resocialize. Knowing with whom the client wishes to socialize, what transportation she has, or how much spending money she has may be relevant questions, but should be asked after the question concerning what activities the client enjoyed in the past.


 CN: Psychosocial adaptation;  
CL: Synthesize

**3. 1.** It is appropriate to talk alone with this client about her feelings. A suspicious client is unlikely to agree to talk about feelings in a group. It is a violation of the client's privacy to reveal a client's problems to group members. The other clients in the group have no reason to apologize, and the nurse should not ask them to do so.


 CN: Psychosocial adaptation;  
CL: Synthesize

**4. 2.** Schizoaffective disorder is commonly treated with a combination of antipsychotic and mood stabilizing medications. Risperdal alone will not manage the mood symptoms even in large doses. The severity of the mood symptoms is not a factor in selecting treatments. The mood swings are upsetting


to the client and need to be treated whether or not there are suicidal thoughts.

 CN: Psychosocial adaptation;  
CL: Synthesize

**5. 2.** The nurse's nonverbal behavior, moving away from the window as the client requests, indicates agreement with the client's false ideas. The client's behavior is likely to be reinforced if the nurse takes steps to agree with the false ideas he holds.

 CN: Psychosocial adaptation;  
CL: Synthesize

**6. 2.** The client's *disturbed thought process* likely reflect this client's paranoid delusions. The nurse should acknowledge that the thoughts are frightening the client. Telling the client the nurse does not see any foreign agents is an appropriate nursing response if the client is having *disturbed visual sensory perception* and is having visual hallucinations. Telling the client the nurse does not understand what the client means is an appropriate response if the client has *impaired verbal communication*. Suggesting that a client participate in group activities would be appropriate if the client had a nursing diagnosis of social isolation and was staying in his room.

 CN: Psychosocial adaptation;  
CL: Synthesize

**7.**


**2. Assess the client's risk for harm to self and others.**

**4. Interview the client about her current needs and situation.**

**3. Obtain the name of her ex-husband's case manager.**

**1. Ask about the marital problems leading to the divorce.**

The nurse should first assess the client's risk for harm, especially because the client could direct her anger to her ex-husband or the nurse. Then it is important to know more about her current situation and her immediate needs. Obtaining information from the ex-husband's case manager might help clarify the risk of harm to the client. Problems leading to the divorce are less important than the situation following the divorce.

 CN: Psychosocial adaptation;  
CL: Synthesize

## 8.


1. Walk with the client to help decrease her anxiety.

3. Share observations about her anxiety-related behaviors.


4. Ask the client about the sources of her anxiety.

2. Discuss productive ways to solve her problems causing anxiety.


The nurse should first walk with the client to reduce her anxiety because the client must be at a mild level of anxiety before learning can occur. Sharing observations with the client conveys a sense of caring. Later, the nurse can help the client connect the anxiety-related behaviors to her feelings of anxiety. Once the client can identify the source of her anxiety, she can talk about solutions.

 CN: Psychosocial adaptation;  
CL: Synthesize

**9. 2.** The reported symptoms are signs of extrapyramidal side effects (EPSE). The medication of choice is benztropine, an antiparkinson medicine. Lorazepam is an antianxiety agent. Trazodone is an antidepressant used to enhance sleep. Olanzapine is an antipsychotic medication which could aggravate the extrapyramidal side effects.


 CN: Psychosocial adaptation;  
CL: Synthesize

**10. 2.** Clients with paranoid schizophrenia experience alterations in thought resulting in introspection, confusion, and distraction from external reality. Simple tasks that require concentration and effort, including activities involving self-care, may be difficult for the client, especially during the acute phase of the illness. However, the mother should not need to do everything for her daughter. Rather, the mother should encourage the daughter to do things for herself with guidance. Visits from friends should be discussed with the client, and the client should be encouraged to visit with friends to minimize the risk of social isolation. Although relapse typically occurs with medication noncompliance, vulnerability to stress, a low threshold for stress, the number of stresses, and the client's lack of adaptive coping behaviors contribute to relapse.


 CN: Psychosocial adaptation;  
CL: Evaluate

**11. 1.** The nurse recognizes the mother's feelings of being overwhelmed with the issues concerning the management of her daughter at home as caregiver role strain. Anxiety, fear, and sleep disturbances all contribute to caregiver role strain.


The nurse should help the mother elicit the support of other family members or friends, continue with psychoeducation, and help the family connect with the Alliance for the Mentally Ill for support, reassurance, and education.

 CN: Psychosocial adaptation;  
CL: Analyze


**12. 1.** The client is voicing paranoid delusions of being followed and monitored. Presence of delusions is described in the area of thought content in the mental status examination. The speech section would typically include documentation of disturbances in speech or pressured speech. In the insight section, the nurse would document information reflecting a lack of insight—for example, statements such as “I don't have a problem.” In the judgment section, the nurse would document information reflecting a lack of judgment—for example, poor choices such as buying a gun for self protection.

 CN: Psychosocial adaptation;  
CL: Analyze

**13. 2.** For the client with paranoid schizophrenia, 2 days on medication is too short a time for improvement to be seen. Therefore, the nurse evaluates the client's wife as needing education or knowledge about paranoid schizophrenia, the course of the illness, and medications. Expecting an absence of delusions by the end of the client's second day of hospitalization is unrealistic. Rather, the nurse would reasonably expect delusions to decrease, disappearing by 5 to 9 days of hospitalization. The wife's inquiry is not reasonable because not enough time has elapsed to evaluate the effectiveness of treatment. An increase in the client's medication would be unreasonable because not enough time has elapsed to evaluate the effectiveness of the medication. Generally, a time frame of 5 to 7 days is needed before the effectiveness of medications can be determined.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**14. 2.** The client is at risk for harming herself because of the command auditory hallucinations. It is most important for the staff to know if she currently thinks she needs to punish herself. Then it is important to know how she thinks she might punish herself. Knowing what she thinks she has done is relevant for changing her negative thinking. Focusing on her strengths would help improve her self-esteem.

 CN: Psychosocial adaptation;  
CL: Synthesize

**15. 4.** Benztropine commonly causes the adverse effect of blurred vision. Quetiapine, an atypical antipsychotic, and buspirone, an antianxiety agent,

are not likely to produce blurred vision. Although haloperidol, a high-potency antipsychotic, may cause blurred vision, this adverse effect is more common with benztropine.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**16. 4.** The client is exhibiting suspiciousness of and a lack of trust in the staff, not aggression. Seeking out staff indicates the development of trust and decreased suspiciousness. Although completing activities of daily living and participating in recreation with other clients are important, the major problem presented is related to the client's isolation and perception of being harmed—not, for example, showering, hygiene, or other clients.

 CN: Psychosocial adaptation; CL: Create


**17. 1.** Haldol is most effective with the positive symptoms of schizophrenia. The client's symptoms reflect the negative symptoms. Haldol generally is effective in 3 to 7 days for the positive symptoms. An increased dose or longer time on Haldol will not help the negative symptoms of being withdrawn and unmotivated.

 CN: Psychosocial adaptation; CL: Apply

**18. 2.** Chlorpromazine is a low-potency antipsychotic that is likely to cause sun-sensitive skin. Therefore the client needs instructions about using sunscreen with a sun protection factor of 25 or higher. Typically, chlorpromazine is not associated with an increased risk of seizures. Although constipation is a common adverse effect of this drug, it can be managed with diet, fluids, and exercise. The drug does not need to be discontinued. Chlorpromazine is associated with postural hypotension, not hypertension. Additionally, if postural hypotension occurs, safety measures, such as changing positions slowly and dangling the feet before arising, not stopping the drug, are instituted.

 CN: Pharmacological and parenteral therapies; CL: Create


**19. 1.** The nurse needs to present the reality of the situation. By explaining that the men are groundskeepers and probably talking about work, the nurse is reinforcing reality to counter the client's illusion (misinterpretation of reality). Additionally, this response voices doubt in the client's paranoid interpretation. Telling the client not to take things personally is flippant and judgmental. Telling the client to not pay attention to the men fails to address the client's misinterpretations and misperceptions. Closing the drapes so that the client doesn't see the men ignores the client's misperceptions and misinterpretation.

 CN: Psychosocial adaptation; CL: Synthesize


**20. 4.** Clozapine is associated with agranulocytosis. Therefore, the nurse must instruct the client about the need for weekly blood tests to monitor for this adverse effect. Akathisia and drug-induced parkinsonism are associated with high-potency antipsychotics. These effects are not common with this atypical antipsychotic agent. Constipation and sedation may occur with this drug.

 CN: Pharmacological and parenteral therapies; CL: Create


**21. 2.** Before intervening with the client experiencing hallucinations, the nurse must validate what the client is experiencing. Asking the client what he hears right now accomplishes this. Asking about seeing someone near the client would be appropriate to validate visual hallucinations. Asking the client about what is going on may be helpful. However, the question is too general to validate that the client is experiencing auditory hallucinations. Asking the client if he wants to go to the recreation room might be appropriate after the nurse has validated what the client is experiencing.

 CN: Psychosocial adaptation; CL: Synthesize

**22. 3.** The client may act on command hallucinations and harm himself or others. Therefore, the staff need to know when the client is hearing such commands, to ensure safety first. Telling the client that the voices are real but that the nurse doesn't hear them would be an appropriate response later in the client's hospitalization when the client's safety is no longer an issue because antipsychotics are beginning to take effect. Telling the client that the hallucinations are part of the illness or that medications will help control the voices would be appropriate once the client has developed some insight into the symptoms of the illness.

 CN: Safety and infection control; CL: Synthesize

**23. 2.** The newer antipsychotics block dopamine and serotonin receptors. They do not block GABA acid and norepinephrine receptors. Antidepressants more commonly affect norepinephrine receptors and levels.

 CN: Pharmacological and parenteral therapies; CL: Apply


**24. 3.** Tactile hallucinations are more common in alcohol withdrawal than in schizophrenia. Therefore, the nurse should explain that these hallucinations are the result of withdrawal from alcohol. Because the client stopped drinking 4 days ago, the client is not intoxicated. Risperidone has little effect on symptoms of alcohol withdrawal. It is prescribed for symptoms of schizophrenia. Alcohol and risperidone have an additive effect, not one of causing hallucinations.

 CN: Psychosocial adaptation; CL: Analyze


**25. 1, 3, 4, 5.** Documentation provided in option 2 is the most factual and without conclusions or assumptions. Stating that the client was noncompliant with medications is not the only cause of decreased sleep and activities of daily living or increased delusions and hallucinations. Also, the client did not say that his parents wanted to harm him directly. Stating that the client's relationship with his parents is strained is an assumption, even if he did indeed state that they wanted him dead. The client does not state a wish to be dead or harm others, although further assessment would be necessary. Documenting that his parents may be abusing him makes an assumption, although the nurse should further assess for this possibility.

 CN: Management of care; CL: Evaluate


**26. 1.** The client's anxiety as reflected in rapid pacing and clang associations is rising as a result of his paranoid delusions. Administering the Ativan and Haldol will help the anxiety and delusions. He is not threatening others at this point, so seclusion, restraints, and asking clients to leave the area is not necessary.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**27. 1, 2, 3.** Ridiculing others is a defensive coping strategy in response to the client's feelings of increased anxiety. Negative attention does reinforce inappropriate behaviors. For many clients, negative attention is better than no attention. The client's increased level of anxiety is something that can be dealt with in the group. It is not a reason for excluding the client. There are not sufficient data to indicate a need for medication; behavioral approaches to anxiety management will be more effective.


 CN: Psychosocial adaptation;  
CL: Analyze

**28. 2.** Pushing a suspicious client into social situations is likely to increase anxiety, which increases, not decreases, the hallucinations. The statement about spending some time alone if the client is overwhelmed indicates awareness and understanding of how to intervene when the client is exposed to stress. The statement about lack of motivation indicates awareness and understanding of avolition. The statement about reminding the client that the family doesn't hear the voices indicates awareness and understanding of the client's hallucinations.


 CN: Psychosocial adaptation;  
CL: Evaluate

**29. 1.** Clozapine is the one atypical antipsychotic associated with severe anticholinergic adverse effects such as constipation. Consuming fruits


would not be the cause of the client's constipation. The client should take clozapine with food to avoid nausea. Getting up slowly indicates that the client understands that postural hypotension may occur with clozapine. The statement about sleepiness indicates that the client understands that sedation may occur with this drug.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**30. 4.** The statement about the voices occurring if the client is nervous reflects awareness that stress and anxiety can increase the positive symptoms of schizophrenia. Decreasing the medications because the voices are gone reveals a lack of awareness about the need for the medications to control the client's symptoms. Stating that there is still poison in her food demonstrates a lack of insight into the client's delusions. Restarting school in a week reflects an unrealistic expectation for a client who is newly diagnosed and being stabilized on medications.

 CN: Psychosocial adaptation;  
CL: Evaluate

**31. 3.** Because the client is aware that he is experiencing auditory hallucinations, he has some insight into his current problem. Therefore, the nurse should help the client take an active role in trying to control the hallucinations. Telling the client that the nurse doesn't hear voices even though the client does is appropriate to help the client gain insight and awareness of the problem. Although time and medications will make the voices go away, the focus is on helping the client to develop coping strategies to control the hallucinations. Telling the client that the nurse hears only the client's and the nurse's voices is appropriate when the client lacks insight and awareness of the problem.


 CN: Psychosocial adaptation;  
CL: Synthesize

**32. 1.** The initial priority for this client is to help her overcome suspiciousness of others, including staff, and thereby feel safe and accepted. Introducing the client to others, giving the client information about the program, and providing clean clothes are important, but these are of lower priority than helping the client feel safe and accepted.


 CN: Psychosocial adaptation; CL: Create

**33. 4.** Allowing the client to be the first to open the cart and take a tray presents the client with the reality that the nurses are not touching the food and tray, thereby dispelling the delusion. Serving foods in sealed packages is unrealistic because most hospital food does not arrive this way. Additionally, if this were possible, sealing the packages would further reinforce the client's delusion. Asking the client about the type of poison or giving the client

canned supplements confirms the reality of the client's suspicions, reinforcing the delusion.


 CN: Psychosocial adaptation;  
CL: Synthesize

**34. 2.** Constipation caused by medication is best managed by diet, fluids, and exercise. Benztropine (Cogentin) can increase constipation. However, it may be prescribed for restlessness and stiffness. Restlessness and stiffness should be reported to the physician. Drowsiness and dizziness are adverse effects of ziprasidone. Clients should not drive if they are experiencing dizziness. Ziprasidone does help improve the negative symptoms of schizophrenia such as avolition.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

### The Client with Other Types of Schizophrenia and Psychotic Disorders

**35. 1.** Muscular rigidity, tremors and altered consciousness are symptoms of other movement disorders as well as NMS, such as extrapyramidal side effects (dystonias and drug-induced Parkinsonism). High temperature is unique to NMS, particularly when seen with the other three symptoms. NMS is potentially fatal and needs immediate attention.

 CN: Psychosocial adaptation;  
CL: Analyze

**36. 1.** Most clients experience less weight gain when taking ziprasidone (Geodon). Although Geodon can be administered intramuscularly, it can be used only on an as needed basis by this route. Geodon has fewer extrapyramidal side effects (EPSE), but that is not this client's major concern. Geodon is better absorbed when taken with food, so a bedtime snack is needed.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**37. 2, 4.** Safety, including protection of the client and others, are the priorities for admission. Acute psychosis commonly involves issues of safety. Living alone is not a sufficient reason to be admitted to a health care facility. Depression, insomnia, lack of appetite, and noncompliance are important issues but not sufficient for admission unless combined with one of the other criteria.


 CN: Management of care; CL: Analyze

**38. 3.** Elderly clients are typically on lower dosages of antipsychotic medications due to the metabolic changes of aging. Comparing dosages is not relevant. Each client is unique in metabolizing


medications. Changing medication dosages is based on an assessment of illness symptoms and the adverse effect profile, not on family preferences. Urging the daughter to wait discounts her concerns and gives no rationale for waiting.

 CN: Psychosocial adaptation;  
CL: Synthesize

**39. 2.** Helping the client control his weight is the most appropriate approach. The nurse's contradiction of the client's complaint is inappropriate. Most atypical antipsychotics cause weight gain and are not a solution to the weight gain. There is little evidence that weight gain from taking olanzapine decreases with time.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**40. 4.** Achieving a therapeutic blood level is a slower process with risperidone long-acting injection. Oral fluphenazine (Prolixin) does not decrease the effectiveness of the intramuscular version and might increase the incidence of adverse effects. There is no evidence that the potency of the two medications is significantly different. Blaming the client for noncompliance with these two medications is inappropriate.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**41. 1, 3, 5.** Group homes, apartment programs, seclusion, restraints, day treatment programs, and self-help groups all involve degrees of restriction and supervision. Releasing information about the client is governed by rules of confidentiality and the Health Insurance Portability and Accountability Act of 1996. Accepting or refusing treatment is governed by laws related to informed consent.

 CN: Management of care; CL: Analyze

**42. 1.** Recognition by the client that there is a difference between the stuffed animal and her live dog indicates that the client perceives the reality of the situation. Stating that the stuffed animal and the client's dog could be twins reflects the client's continued misperception of reality, thinking that the stuffed animal and her dog are one and the same. Stating that she wishes her dog hadn't been stuffed reflects her continued misperception of reality. Stating that the roommate needs a dog as much as she does is unrelated to the client's perception or misperception of reality.

 CN: Psychosocial adaptation;  
CL: Evaluate

**43. 3.** The nurse must be objective in documenting the client's behavior, recording exactly what the client did or did not say or do in a particular situation. Recording that the client could not answer


any questions, was uncooperative and refused to answer questions, or was disoriented and incoherent is not described and is a subjective interpretation on the nurse's part.

 CN: Psychosocial adaptation; CL: Create


**44. 4.** By the end of 4 days, the client should be able to perform showering and dressing for herself. The client with schizophrenia commonly appears to be apathetic and lack initiative. Therefore, demonstrating the ability to complete the tasks indicates improvement. Although the client may be able to recognize, verbalize, or explain the need to shower and dress herself, she may be unable to do so because of the ambivalence associated with schizophrenia that impedes the client's ability to initiate and complete self-care. Therefore, evidence of improvement would be lacking.

 CN: Psychosocial adaptation; CL: Create


**45. 1.** When determining the effectiveness of risperidone, the nurse would expect improvement in the client's negative symptoms of apathy, flat affect, and social withdrawal. Delusions, hallucinations, illusions, and ideas of reference are positive symptoms of schizophrenia. Agitation, hostility, and aggression are the result of the positive symptoms.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**46. 2, 3, 4.** The client's symptoms are likely to be adverse effects of aripiprazole, especially at the reported dose. The normal adult dose is 5 to 10 mg. The elderly client commonly needs a lower dose compared with other adults. The anxiety and sleep disturbance could be symptoms of schizophrenia or medication adverse effects. A holistic approach would include assessing the client's heart failure. Questioning the qualifications of the family doctor is unproductive. There are no indications of problems in the client's relationship with her son.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**47. 3.** Sialorrhea, excessive salivation, is commonly associated with clozapine therapy. The client can use a washcloth to wipe the saliva instead of spitting. It is an expected adverse effect of the drug, not a delusion, an unusual reaction, or an unresolved symptom of schizophrenia.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**48. 3.** Stating that God is important in the client's life recognizes the client's cognitive and perceptual disturbances and level of anxiety and acknowledges the client's message in a respectful and neutral manner, while adding that the medicine also will help, clearly and directly states the need for medication.


Stating, "God helps those who help themselves" challenges the client. Stating, "God wants you to take your medicine" is deceitful. Stating, "Medicine will help clear your thinking and decrease anxiety" would be helpful to the client later when she is less acutely psychotic and anxious.

CN: Psychosocial adaptation; CL: Apply


**49. 1.** The nurse instructs the client clearly and directly to put the medication in his mouth and then to swallow it with some water. Clear, step-by-step directions assist the client to process what the nurse is saying. Telling the client to sit in the dayroom and wait, asking another staff member to stay with the client, or saying nothing is not helpful.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**50. 4.** Based on the nursing diagnosis of *Defensive coping* secondary to suspiciousness, the client's ability to accurately interpret the behaviors of his wife and coworker would be the expected outcome. The underlying problem is the client's suspiciousness. Therefore, improvement in this behavior would be the focus of the outcome. Although demonstrating an absence of hostile behavior, developing the ability to express one's own needs assertively, and using adaptive coping strategies are desirable, the focus of the outcome needs to address the client's underlying problem, which is interpreting the behaviors of others.

 CN: Psychosocial adaptation; CL: Evaluate

**51. 2.** Whispering and laughing with another person where the client can see or observe the nurse but not hear the conversation increases the client's anxiety and suspiciousness. Therefore, this action should be avoided. Informing the client of schedule changes, telling the client gently that the nurse does not share the client's interpretation of an event, and inviting the client to participate in leisure activities help the client to decrease anxiety and suspiciousness and to focus on actual or realistic events.


 CN: Psychosocial adaptation; CL: Synthesize

**52. 4.** Because the client can live in an apartment setting, further development of independent functioning and the skills to gain as much independence as he is capable of need to be fostered, including getting out and developing new friendships. Arranging for participation in day treatment is most beneficial at this time. Family visits and daily nursing visits do not encourage the client to do this. Making an appointment for 2 weeks later puts the client's needs off. Lack of social relationships is not a sufficient reason for rehospitalization.


 CN: Psychosocial adaptation; CL: Synthesize



**53. 1.** Hallucinations and asocial behaviors are typical symptoms of undifferentiated schizophrenia. Preoccupation with persecutory delusions and hallucinations are associated with paranoid schizophrenia. Grossly disorganized behaviors and speech are associated with disorganized schizophrenia. Immobility and waxy flexibility are associated with catatonic schizophrenia.

 CN: Psychosocial adaptation;  
CL: Analyze

**54. 2.** With CUS, negative symptoms are more prominent. Therefore, risperidone is given to help control negative symptoms. Negative symptoms do not respond to traditional antipsychotics such as Haldol or Thorazine. Agranulocytosis is commonly associated with clozapine (Clozaril). Because it is a newer drug, risperidone usually is more expensive than traditional antipsychotics.

 CN: Pharmacological and parenteral therapies; CL: Apply

**55. 1, 2, 3.** Headaches, transient anxiety, and insomnia are the most common adverse effects of aripiprazole. Torticollis and pill rolling are more common with the older antipsychotics.

 CN: Pharmacological and parenteral therapies; CL: Create

**56. 2.** The client is in an acute psychotic state and cannot process complex decisions or explain complex situations. Therefore, the nurse would focus on decision making involving simple choices. Listing the pros and cons of each housing option and identifying why the client cannot live in an unsupervised apartment involve complex decision-making skills. Deciding which staff member to have today is a difficult and threatening decision for a client who is psychotic.


CN: Psychosocial adaptation; CL: Synthesize

**57. 1.** The client is exhibiting hallmark signs and symptoms of life-threatening neuroleptic malignant syndrome induced by the haloperidol. Tardive dyskinesia usually occurs later in treatment, typically months to years later. Extrapyramidal adverse effects (dystonia, akathisia) and drug-induced parkinsonism, although common, are not life-threatening.


 CN: Reduction of risk potential;  
CL: Analyze

**58. 3.** The client with chronic undifferentiated schizophrenia needs more structure every day to improve functioning. Therefore, helping the client to set up a daily activity schedule is most appropriate. However, a group home is not necessary. The client is already eating. Having meals brought in would increase the client's dependence, not his

activity level. Asking a relative to call the client 10 times per day is unrealistic given the typical daily responsibilities of a healthy relative.

 CN: Psychosocial adaptation;  
CL: Synthesize


**59. 2.** The client is exhibiting catatonic behavior, an acutely serious result of severe anxiety and psychosis. In this situation, the nurse needs to administer the p.r.n.-ordered doses of haloperidol and lorazepam; they can be given together safely. Assisting the client out of the chair to go back to bed or sitting quietly until the client responds ignores the seriousness of the client's condition. It is unlikely that the client can describe what is being experienced.

 CN: Psychosocial adaptation;  
CL: Synthesize


**60. 2.** Attending day therapy three times per week is a long-term goal that will show the most progress in overcoming withdrawal. The client's calling his mother is a first step in getting out of a severe withdrawal. Allowing two friends to visit every day would be appropriate if the client is successful with calling his mother once a day. Insufficient information is presented in the scenario to indicate that excessive sleep is a problem.

 CN: Psychosocial adaptation; CL: Create

**61. 4.** Although all the actions indicate improvement, the ability to initiate simple activities without directions indicates the most improvement in the catatonic behaviors. Moving all extremities occasionally, walking with the nurse to the client's room, and responding to verbal directions to eat represent single steps toward the client initiating her own actions.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**62. 2.** Noncompliance with medications is common in the client with chronic undifferentiated schizophrenia. The nurse has the responsibility to assess this situation. Asking the mother if they've argued or if the client is mad at the mother or telling the mother to go over to the apartment and see what's going on places the blame and responsibility on the mother and therefore is inappropriate. Telling the mother not to worry ignores the seriousness of the client's symptoms.


 CN: Psychosocial adaptation;  
CL: Synthesize

**63. 4.** The client is exhibiting symptoms of becoming catatonic and unable to care for himself, and needs hospitalization. A sleep aid is not sufficient to treat this client. The client's worsening condition dictates action without waiting for a


clinic appointment. An increase in medication may be indicated, but hospitalization is required first for safety.

 CN: Psychosocial adaptation;  
CL: Analyze


**64. 1.** The client recently lost his mother, causing the client to experience increased stress. This increase in stress can decrease the effectiveness of medications. Therefore, a short course of a fast-acting medication, such as haloperidol, would be added to the client's drug therapy regimen. An increase in olanzapine is not likely to relieve the immediate symptoms quickly. Grief counseling would not be effective until the client's other symptoms are controlled. Changing to a new medication is premature. This would be done only if the client failed to respond to the addition of haloperidol to his drug regimen.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**65. 3.** Valproic acid is commonly used to treat manic symptoms. Therefore, a decrease in the valproic acid level could explain the increase in manic symptoms. Periodic determinations of the valproic acid level are necessary to determine the effectiveness of the drug. However, the stat nature of the specimen to be drawn indicates an immediate problem. Fluoxetine is not known to decrease the effectiveness of valproic acid. The valproic acid level is not needed before beginning a short course of therapy with lorazepam.

 CN: Pharmacological and parenteral therapies; CL: Apply

**66. 3.** According to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revised, a diagnosis of brief psychotic disorder is made when the client exhibits delusions, hallucinations, and disorganized speech or behaviors in the absence of a mood disorder, substance-induced disorder, or general medical condition.


 CN: Psychosocial adaptation;  
CL: Analyze

**67. 4.** Follow-up counseling is appropriate because of the client's anger and inappropriate behaviors. The goal is to help the client deal with the end of his marriage. A joint session might have been useful before the divorce and arrest, but not after. The client is exhibiting no signs or symptoms of schizophrenia or psychosis, so olanzapine is not indicated. The client is not exhibiting signs of depression, so fluoxetine is not indicated.


 CN: Psychosocial adaptation;  
CL: Synthesize

## Clients and Families Affected by Chronic Mental Illnesses


**68. 4.** During necessary periods of hospitalization, active treatment, rather than custodial care, is needed. Among the more common needs of the chronically mentally ill are community-based treatment programs, psychosocial rehabilitation programs, and employment opportunities.

 CN: Psychosocial adaptation; CL: Apply


**69. 3.** Insight-oriented therapy is less beneficial for this client population. The nurse's role in a psychosocial rehabilitation program involves teaching the client to live independently by using interpersonal skills and community resources.

 CN: Psychosocial adaptation; CL: Apply


**70. 3.** The first thing that the nurse should do is to speak with the client on the phone and question her about perceptions or reasons that are interfering with her going to the sheltered workshop. This conveys that the nurse is interested and willing to help the client. The nurse should call the director of the workshop for information only if the nurse receives the client's permission. Making preparations for the client's admission is inappropriate and would not be done until the client's needs have been assessed and it is determined that the client requires hospitalization. Making an appointment with the doctor is inappropriate until the nurse has assessed the client's needs.

 CN: Psychosocial adaptation;  
CL: Synthesize

**71. 2.** Psychoeducational groups for families primarily help them to develop a support network. They provide education about the biochemical etiology of psychiatric disease to reduce, not increase family guilt. Financial problems may or may not be addressed. The focus should be on client strengths, not weaknesses.


 CN: Psychosocial adaptation;  
CL: Evaluate

**72. 2.** Noncompliance with medications is documented as the primary cause of relapse. Although loss of family support, sudden changes in medications, and nonattendance at treatment programs may contribute to relapse, these factors are not as significant as medication noncompliance as causes of relapse.


 CN: Psychosocial adaptation;  
CL: Analyze

**73. 3.** The most therapeutic action at this time is for the nurse to make an appointment with the client at the mental health center to explore his feelings


and behavior. Doing so acknowledges the client's importance and makes him a partner in resolving the problem. The nurse needs to determine what is going on in the situation first, and then plan accordingly. Threatening the client with loss of the position, asking for a new assignment for the client, or arranging for the placement of the client in a skill-training program is inappropriate and premature.

 CN: Psychosocial adaptation;  
CL: Synthesize


**74. 2.** By acknowledging the difficulties of living with the illness, the nurse conveys empathy for the client's feelings and opens up the lines of communication. Although it is important for the client to maintain compliance with medication therapy, telling the client that it is important to start taking them again or to talk with the doctor about stopping the medications ignores the underlying feelings of the client's initial statements. Stating that the client's buddies will understand may or may not be true. Additionally, this statement ignores the underlying feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**75. 3.** Because antipsychotic agents cross the placental barrier and can be teratogenic, they are to be avoided during pregnancy, especially during the first trimester. Later in the pregnancy, low doses of medications may be given if necessary. Although the degree of excitement by the father, the mother's ability to provide help, and the client's financial situation may or may not be of concern, the priority in this situation is the safety of the fetus and risks associated with the need for antipsychotic therapy.

 CN: Psychosocial adaptation;  
CL: Analyze

**76. 4.** Although all of the options are commonly true, the primary reason for concern is that parents commonly provide financial support and housing for their chronically mentally ill children. The most critical needs after loss of the parents are the lack of financial support and housing, which are hard to replace.

 CN: Psychosocial adaptation;  
CL: Analyze


**77. 2.** Families are more likely to be seen as allies in the care of clients because they are no longer viewed as causing the illness. Although family dysfunction is viewed as an effect of rather than a cause of the disorder, the most significant aspect is that families are now viewed as allies by health care professionals. Families may or may not be less likely to participate in studies or to be involved in caring for the ill relatives.

 CN: Psychosocial adaptation; CL: Apply


**78. 4.** Although a decline in functioning is important, this situation would have the least priority when compared with other situations that put the client or others in danger of direct or indirect harm.

 CN: Safety and infection control;  
CL: Analyze

**79. 3.** Many coordinated services is needed, including medication management, more frequent outpatient visits, day treatment, or some combination of these, to decrease the risk of relapse, which is common among chronically ill clients. Medical consultations (if needed) would be included in the coordinated services provided. Chronically mentally ill clients who are discharged early, before becoming truly stable, typically require more than monthly outpatient visits because of the high risk of relapse. A caring and supportive family is ideal for all clients but not always available.

 CN: Psychosocial adaptation;  
CL: Create


**80. 3.** Noncompliance with medications is the most common cause of relapse and rehospitalization for chronically mentally ill persons. Preventing relapse is a daily goal. Support groups are not always appropriate for chronically ill clients. Family support is desirable but is less likely to be available for these clients. Advocacy is a long-term goal.

 CN: Psychosocial adaptation;  
CL: Create


**81. 4.** For a community-based program, the need for long-term hospitalization is least needed if the other services, such as partial programs, psychiatric home care, and residential services, are available and accessible.

 CN: Management of care; CL: Apply

**82. 2, 3, 4.** Although all of the situations require immediate attention, the inability to keep outpatient appointments is less critical than signs of relapse and decompensation, threat of eviction, and unpaid bills and lack of food. Occasionally missing a dose of medication usually will not precipitate a crisis for a client.

 CN: Psychosocial adaptation;  
CL: Analyze

**83. 1.** Ways to decrease or manage adverse effects without additional medications is crucial. Although home visits, family monitoring, and outpatient monitoring may help, if the adverse effects are not controlled, the client is less likely to take the drug, which would interfere with its effectiveness.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**84. 4.** Many Americans still believe that recovery from mental illness is a matter of willpower—for example, “pull yourself up by your bootstraps” or “just get over it.” This belief persists despite awareness that mental illness is hereditary and has a biochemical basis. Mental illness can be prevented only if there is early intervention. Clients cannot prevent it just by the desire to do so.

 CN: Psychosocial adaptation;  
CL: Evaluate

### The Client with Cognitive Disorders

**85. 4.** Delirium is commonly due to a medical condition such as a UTI in the elderly. Delirium often involves memory problems, disorientation, and hallucinations. It develops rather quickly. There is not enough data to suggest Alzheimer’s disease especially given the quick onset of symptoms. Delayed grieving and adjusting to being alone are unlikely to cause hallucinations.

 CN: Psychosocial adaptation;  
CL: Analyze


**86. 1, 2, 3, 5, 6.** It is important for a caregiver to have support for herself as well as be able to provide adequate safety, supervision, and medical care to the client. The caregiver must also have realistic expectations of the client, given his abilities and limitations. Reminiscing and engaging the client in games is desirable but not crucial to care.

 CN: Management of care; CL: Analyze

**87. 4.** Expecting the social worker to make the decision indicates that the son is avoiding participating in decisions about his father. The other responses convey that the son understands the importance of a careful decision, the availability of resources, and the ability to make new plans if needed.


 CN: Management of care; CL: Synthesize

**88. 1, 2, 5.** Confused clients need fewer choices, acceptance as a person, and step-by-step directions. Allowing the client to do as he wishes can lead to substandard care and the risk of harm. Acting nonchalantly conveys a lack of caring.

 CN: Psychosocial adaptation;  
CL: Synthesize


**89. 3.** Reminiscing can help reduce depression in an elderly client and lessens feelings of isolation and loneliness. Reminiscing encourages a focus on positive memories and accomplishments as well as shared memories with other clients. An increase in confusion and disorientation is most likely the result of other cognitive and situational factors, such

as loss of short-term memory, not reminiscing. The client will not likely become sad because reminiscing helps the client connect with positive memories. Keeping the client from participating in therapeutic activities is less likely with reminiscing.


 CN: Psychosocial adaptation;  
CL: Evaluate

### The Client with Delirium


**90. 2.** Loss of orientation, especially for time and place, is common in delirium. The nurse should orient the client by telling him the time, date, place, and who the client is with. Taking the client to his room and telling him why the door is locked does not address his disorientation. Telling the client to eat before going to the doctor reinforces his disorientation.

 CN: Psychosocial adaptation;  
CL: Synthesize


**91. 1, 2, 3.** The client does need rest and it is true that there is no specific medicine for delirium, but it is crucial to identify and treat the underlying causes of delirium. Other tests will be based on the results of already completed tests. Although some medications may be prescribed to help the client with her behaviors, this is not the primary basis for medication orders. Because the underlying medical causes of delirium could be fatal, treatment must be initiated as soon as possible. It is not the nurse’s role to determine medications for this client. Postponing tests until the next day is inappropriate.

 CN: Psychosocial adaptation;  
CL: Apply

**92. 1.** Explaining why blood is being taken responds to the client’s concerns or fears about what is happening to her. Threatening more pain or promising to explain later ignores or postpones meeting the client’s need for information. The client’s statements do not reflect loss of self control requiring medication intervention.

 CN: Psychosocial adaptation;  
CL: Synthesize


**93. 4.** The client is showing symptoms of delirium, a common outcome of UTI in older adults. The nurse can request a transfer to a medical unit for acute medical intervention. The client’s symptoms are not just due to a worsening of the depression. There are not indications that the client needs restraints or a transfer to a nursing home at this point.

 CN: Psychosocial adaptation;  
CL: Synthesize

**94. 3.** Polypharmacy is much more common in the elderly. Drug interactions increase the incidence of intoxication from prescribed medications, especially with combinations of analgesics, digoxin, diuretics, and anticholinergics. With drug intoxication, the onset of the delirium typically is quick. Although cancer, impaired hearing, and heart failure could lead to delirium in the elderly, the onset would be more gradual.

 CN: Reduction of risk potential;  
CL: Analyze


**95. 1.** Fluctuating symptoms are characteristic of delirium. The failure to identify objects despite intact sensory functions, significant impairment in social or occupational functioning over time, and memory impairment to the degree of being called amnesia all indicate dementia.

 CN: Physiological adaptation;  
CL: Analyze

**96. 2.** The most critical aspect when caring for the client with delirium is to institute measures to correct the underlying causative condition or illness. Controlling behavioral symptoms with low-dose psychotropics, manipulating the environment, and decreasing or discontinuing all medications may be dangerous to the client's health.

 CN: Reduction of risk potential;  
CL: Apply

**97. 3.** In approximately 2 to 3 days, the client should be able to regain orientation and thus become oriented to time and place. Being able to explain the experience of having delirium is something that the client is expected to achieve later in the course of the illness, but ultimately before discharge. Resuming a normal sleep-wake cycle and establishing normal bowel and bladder function probably will take longer, depending on how long it takes to resolve the underlying condition.


 CN: Psychosocial adaptation; CL: Create

**98. 1.** Identifying oneself and making sure that the nurse has the client's attention addresses the difficulties with focusing, orientation, and maintaining attention. Eliminating daytime napping is unrealistic until the cause of the delirium is determined and the client's ability to focus and maintain attention improves. Engaging the client in reminiscing and avoiding arguing are also unrealistic at this time.

 CN: Psychosocial adaptation; CL: Apply


**99. 1, 2, 4.** The abnormal stimuli of the critical care unit can aggravate the symptoms of delirium. Arguing with hallucinations is inappropriate. When a client has illogical thinking, gently presenting

reality is appropriate. Dementia is not the likely cause of the client's symptoms. The client is experiencing delirium, not dementia.


 CN: Psychosocial adaptation;  
CL: Synthesize

## The Client with Dementia

**100. 2.** The two medicines are commonly given together. Neither medicine will improve dementia, but may slow the progression. Neither medicine is more effective than the other; they act differently in the brain. Both medicines have a half-life of 60 or more hours.

 CN: Pharmacological and parenteral therapies; CL: Apply


**101. 2.** Elderly clients have increased risk for falls due to balance problems, medication use, and decreased eyesight. Haldol may cause extrapyramidal side effects (EPSE) which increase the risk for falls. The client is not agitated, so restraints are not indicated. Ativan may increase fall risk and cause paradoxical excitement.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**102. 3.** The tape and television are competing, even conflicting, stimuli. Crime events portrayed on television could be misperceived as a real threat to the client. A low number of clients and the presence of a few staff members quietly working are less intense stimuli for the client and not likely to be disturbing.

 CN: Management of care; CL: Analyze

**103. 1.** Using a bed alarm enables the staff to respond immediately if the client tries to get out of bed. Sleeping in a chair at the nurse's station interferes with the client's restful sleep and privacy. Using all four bedrails is considered a restraint and unsafe practice. It is not appropriate to expect a family member to stay all night with the client.

 CN: Safety and infection control;  
CL: Synthesize


**104. 2, 3, 4.** A set routine and brief exercises help decrease daytime sleeping. Decreasing caffeine and fluids and promoting relaxation at bedtime promote nighttime sleeping. A strong sleep medicine for an elderly client is contraindicated due to changes in metabolism, increased adverse effects, and the risk of falls. Using caffeinated beverages may stimulate metabolism but can also have long-lasting adverse effects and may prevent sleep at bedtime.

 CN: Management of care; CL: Synthesize


**105. 3.** Agnosia is the lack of recognition of objects and their purpose. The nurse should inform the client about the fork and what to do with it. Feeding the client does not address the agnosia or give the client specific directions. It should only be attempted if identifying the fork and explaining what to do with it is ineffective. Waiting for the family to care for the client is not appropriate unless identifying the fork and explaining or feeding the client are not successful.

 CN: Management of care; CL: **Synthesize**


**106. 2.** Clients with chronic cognitive disorders experience defects in memory orientation and intellectual functions, such as judgment and discrimination. Loss of other abilities, such as speech, endurance, and balance, is less typical.

 CN: Psychosocial adaptation;  
CL: Analyze


**107. 1.** Because of the client's short-term memory impairment, the nurse gently corrects the client by stating her name and who she is. This approach decreases anxiety, embarrassment, and shame and maintains the client's self-esteem. Telling the client that she knows who the nurse is or that she forgot can elicit feelings of embarrassment and shame. Saying, "I told you already" sounds condescending, as if blaming the client for not remembering.

 CN: Psychosocial adaptation;  
CL: Synthesize

**108. 2.** Vulgar language is common in clients with dementia when they are having trouble communicating about a topic. Ignoring the vulgarity and distracting her is appropriate. Telling the client she is rude or to stop swearing will have no lasting effect and may cause agitation. Just leaving the room is abandonment that the client will not understand.


 CN: Psychosocial adaptation;  
CL: Synthesize

**109. 2.** Highly conditioned motor skills, such as brushing the teeth, may be retained by the client who has dementia and motor apraxia. Balancing a checkbook involves calculations, a complex skill that is lost with severe dementia. Confabulation is fabrication of details to fill a memory gap. This is more common when the client is aware of a memory problem, not when dementia is severe. Finding keys is a memory factor, not a motor function.


 CN: Psychosocial adaptation;  
CL: Analyze

**110. 3.** Competing and excessive stimuli lead to sensory overload and confusion. Therefore, the nurse should first eliminate any distracting stimuli. After this is accomplished, then using touch and

rephrasing questions are appropriate. Going for a walk while talking has little benefit on attention and confusion.


 CN: Psychosocial adaptation;  
CL: Synthesize

**111. 4.** Telling the client that she is wrong and then telling her what is right is argumentative and challenging. Arguing with or challenging distortions is least effective because it increases defensiveness. Telling the client about reality indicates awareness of the issues and is appropriate. Acknowledging that misperceptions are part of the disease indicates an understanding of the disease and an awareness of the issues. Turning off the radio helps to limit environmental stimuli and indicates an awareness of the issues.

 CN: Psychosocial adaptation;  
CL: Evaluate

## The Client with Alzheimer's Disease


**112. 1.** The son's statements regarding his father's recalling past events is typical for family members of clients in the early stage of Alzheimer's disease, when recent memory is impaired. Telling the son to be more accepting is critical and not an attempt to educate. Understanding the client's level of anxiety is unrelated to the memory loss of Alzheimer's disease. The client cannot stop reminiscing at will.

 CN: Psychosocial adaptation; CL: Apply

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


 CN: Psychosocial adaptation; CL: Apply

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**115. 2, 4, 5.** Motion and sound detectors, a Medical Alert bracelet, and door alarms are all appropriate interventions for wandering. Sleep medications do not prevent wandering before and after the client


is asleep and may have negative effects. Having a relative sit with the client is usually an unrealistic burden.

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation; CL: Apply

**119. 4.** The statement about expecting that the old Dad would be back conveys a lack of acceptance of the irreversible nature of the disease. The statement about not realizing that the deterioration would be so incapacitating is based in reality. The statement about the Alzheimer's group is based in reality and demonstrates the son's involvement with managing


the disease. Stating that reminiscing is important reflects a realistic interpretation on the son's part.

 CN: Psychosocial adaptation;  
CL: Evaluate

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

 CN: Pharmacological and parenteral therapies; CL: Apply

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

 CN: Pharmacological and parenteral therapies; CL: Apply

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


 CN: Psychosocial adaptation; CL: Apply

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

 CN: Psychosocial adaptation; CL: Apply

## Managing Care Quality and Safety


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

 CN: Management of care; CL: Synthesize


**125. 1, 3.** Without a sufficient range and quantity of services, care is inadequate and hospitalization rates increase. Nonshifting of allocated funding to outpatient services has increased the problem with the range and quantity of services. Reserving hospitalization for emergency services was a practice before managed care. The principle of “least restrictive alternative” is still as relevant as it was before managed care. There are not enough group homes available.

 CN: Psychosocial adaptation; CL: Apply


**126. 4.** The client exhibits aggression against his perceived adversary when he names another client as his adversary. The staff will need to watch him carefully for signs of impending violent behavior that may injure others. Crying about a divorce would be appropriate, not pathologic, behavior demonstrating grief over a loss. A petition to delay bedtime would be a positive, direct action aimed at a bothersome situation. Although declining to attend group therapy needs follow-up, there may be any number of unknown reasons for this action.

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Safety and infection control;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Analyze



TEST  
3

# Personality Disorders, Substance-Related Disorders, Anxiety Disorders, and Anxiety-Related Disorders

- The Client with a Personality Disorder
- The Client with an Alcohol-Related Disorder
- The Client with Disorders Related to Other Addictive Substances
- The Client with Anxiety Disorders and Anxiety-Related Disorders
- The Client with a Somatoform Disorder
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client with a Personality Disorder

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

1. Teach the client anxiety management and social skills.

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

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

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

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

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

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

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

4. A client diagnosed with paranoid personality disorder is hospitalized for physically threatening his wife because he suspects her of having an affair with a coworker. Which of the following approaches should the nurse employ with this client?

- 1. Authoritarian.
- 2. Parental.
- 3. Matter-of-fact.
- 4. Controlling.

5. When planning care for a client diagnosed with schizotypal personality disorder, which of the following helps the client become involved with others?

- 1. Participating solely in group activities.
- 2. Being involved with primarily one-to-one activities.
- 3. Leading a sing-along in the afternoon.
- 4. Attending an activity with the nurse.

**6.** A client is complaining to other clients about not being allowed by staff to keep food in her room. The nurse should:

- 1. Ignore the client's behavior.
- 2. Set limits on the behavior.
- 3. Reprimand the client.
- 4. Allow the snack to be kept in her room.

**7.** A client with an Axis II diagnosis of antisocial personality disorder has a potential for violence and aggressive behavior. Which of the following client outcomes to be accomplished in the short term is **most** appropriate for the nurse to include in the plan of care?

- 1. Use humor when expressing anger.
- 2. Discuss feelings of anger with staff.
- 3. Ask the nurse for medication when upset.
- 4. Use indirect behaviors to express anger.

**8.** A client was admitted after making a suicidal gesture in a police car. He is diagnosed with Antisocial Personality Disorder and has been stealing equipment from his work. He states, "It's not a big deal. My boss can afford a few missing pieces. He picks on me anyway." Which of the following is the **most** appropriate response by the nurse?

- 1. "Have the police charged you with the thefts?"
- 2. "Stealing is a crime regardless of the reason."
- 3. "I bet your boss doesn't think he can afford the losses."
- 4. "Are you having any guilt feelings at all?"

**9.** Which of the following approaches should the nurse expect to include in the plan of care for a client diagnosed with antisocial personality disorder who has a history of stealing and jail time?

- 1. Helping the client develop a conscience.
- 2. Teaching the client consequences of her actions.
- 3. Assisting the client with understanding right from wrong.
- 4. Using strategies to help the client become passive.

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

- 1. "You're a 28-year-old adult now, not a child who needs to be cared for."
- 2. "Your parents won't be around forever. After all, they are getting older."
- 3. "Your parents need a break, and you need a break from them."
- 4. "Your parents have been supportive and will continue to be even if you live apart."

**11.** The client diagnosed with major depression and dependent personality disorder has made the decision to live independently in an apartment. The nurse and the client meet with his parents to discuss his decision. Which statement by the nurse is most helpful to foster the client's independence?

- 1. "You'll still be able to see your son and help him as much as you want."
- 2. "All of you will gain from his independent living; he needs our support."
- 3. "You'll need to help monitor his medication and clinic appointments."
- 4. "You'll live nearby and be able to help with meals and laundry."

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

1. Monitor for suicide and self-mutilation.

2. Discuss the issues of loneliness and emptiness.

3. Monitor sleeping and eating behaviors.

4. Discuss her housing options for after discharge.

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

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

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

- 1. “Thank you, you’re a good person.”
- 2. “All of the nurses here provide good care.”
- 3. “Other clients have told me that too.”
- 4. “Mary and Sam are good nurses too.”

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

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

**16.** The nurse assesses a client to be at risk for self-mutilation and implements a safety contract with the client. Which of the following client behaviors indicate that the contract is working?

- 1. The client withdraws to his room when feeling overwhelmed.
- 2. The client notifies staff when anxiety is increasing.
- 3. The client suppresses his feelings when angry.
- 4. The client displaces his feelings onto the physician.

**17.** The client diagnosed with borderline personality disorder who is to be discharged soon threatens to “do something” to herself if discharged. The nurse should **first**:

- 1. Request that the client’s discharge be cancelled.
- 2. Ignore the client’s statement because it’s a sign of manipulation.
- 3. Ask a family member to stay with the client at home temporarily.
- 4. Discuss the meaning of the client’s statement with her.

**18.** A 19-year-old client is admitted to a psychiatric unit with an Axis I diagnosis of alcohol abuse and an Axis II diagnosis of personality disorder not otherwise specified. The client’s mother states, “He’s always in trouble, just like when he was a boy. Now he’s just a bigger prankster and out of control.” In view of the client’s history, which of the following is **most** important initially?

- 1. Letting the client know the staff has the authority to subdue him if he gets unruly.
- 2. Keeping the client isolated from other clients until he is better known by the staff.
- 3. Emphasizing to the client that he will have to pay for any damage he causes.
- 4. Closely observing the client’s behavior to establish a baseline pattern of functioning.

**19.** The client tells the nurse at the outpatient clinic that she doesn’t need to attend groups because she’s “not a regular like these other people here.” The nurse should respond to the client by saying:

- 1. “Because you’re not a regular client, sit in the hall when the others are in group.”
- 2. “Your family wants you to attend, and they will be very disappointed if you don’t.”
- 3. “I’ll have to mark you absent from the clinic today and speak to the doctor about it.”
- 4. “You say you’re not a regular here, but you’re experiencing what others are experiencing.”

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

- 1. “You’re being very childish.”
- 2. “I’m sorry if you can’t wait.”
- 3. “I will not continue to talk with you if you curse.”
- 4. “Come back tomorrow and your medication will be ready.”

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

- 1. Interacting with two other clients.
- 2. Listening to music with headphones.
- 3. Sitting at a table and painting.
- 4. Talking on the telephone.

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

- 1. Warning the client that his telephone privileges will be taken away if he abuses them.
- 2. Offering to disregard the client’s plan if he does not go through with it.
- 3. Notifying the proper authorities after saying nothing until the client has actually completed the call.
- 4. Explaining to the client that this information will have to be shared immediately with the staff and the physician.

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

- 1. The clients are accepted although their behavior may not be.
- 2. Clients need limits on their behavior.
- 3. The staff members are the primary ones left to care about these clients.
- 4. The staff should use minimal humor when working with these clients.

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

- 1. Explaining the negative reactions of others toward his behavior.
- 2. Suggesting he apologize to others for his behavior.
- 3. Asking him to explain the reasons for his seductive behavior.
- 4. Discussing his relationship with his mother.

**25.** The client with an Axis II diagnosis of narcissistic personality disorder tells the nurse he can get an executive position with the best company around anytime he wants. The history reveals that the client, whose highest level of education completed is high school, has held only a series of short-term part-time jobs for the past 2 years. The nurse interprets the client’s statement to be an example of which of the following?

- 1. Grandiose delusion.
- 2. Blatant lie.
- 3. Grandiose self-importance.
- 4. Sense of entitlement.

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

- 1. Limit setting.
- 2. Supportive confrontation.
- 3. Consistency.
- 4. Rationalization.

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

- 1. Party planning.
- 2. Music group.
- 3. Cooking class.
- 4. Role-playing.

**28.** When assessing a hospitalized client diagnosed with Major Depression and Borderline Personality Disorder, the nurse should ask the client about which of the following **first**?

- 1. Access to pills and weapons.
- 2. Suicidal plans.
- 3. Suicidal thoughts.
- 4. Seriousness of the client’s intent to die.

### The Client with an Alcohol-Related Disorder

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

- 1. Inviting the client to play a board game with the nurse.
- 2. Allowing the client to sit in the community room until she feels sleepy.
- 3. Advising the client to sleep on the sofa in the dayroom.
- 4. Teaching the client relaxation exercises to use before bedtime.

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

1. Administer lorazepam (Ativan) 2 mg I.M.

2. Draw blood for a magnesium level.

3. Take vital signs every 15 minutes.

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

**31.** A client has been admitted to the emergency department with alcohol withdrawal delirium. The nurse is assessing the client for signs of withdrawal. At 9 a.m. on 10/25, the nurse notes that the client is confused. His vital signs are T = 99° F, P = 50, R = 10, and BP = 100/60. The nurse compares these findings to the nurses' progress notes from admission 24 hours ago (see below). What should the nurse do **first**?

- 1. Contact the physician.
- 2. Increase the rate of the I.V. infusion.
- 3. Attempt to arouse the client.
- 4. Administer magnesium sulfate.

**Progress Notes**

Date	Time	Progress Notes
10/24/07	09:00 pm	T = 99° F; P = 110; R = 18; BP = 140/90; Client has I.V. D <sub>5</sub> W keep open rate started; Valium administered as ordered. Client oriented x 3.
10/25/07	01:00 am	T = 99.2° F; P = 90; R = 14; BP = 130/80; Client resting.
10/25/07	05:00 am	T = 99° F; P = 70; R = 14; BP = 126/80; Client oriented x 3.

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

- 1. Give the client black coffee to drink.
- 2. Walk the client around the unit.
- 3. Have the client take a cold shower.
- 4. Provide the client with a quiet room to sleep in.

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

- 1. Taking vital signs.
- 2. Monitoring intake and output.
- 3. Placing the client in restraints as a safety measure.
- 4. Reinforcing reality if the client is disoriented or hallucinating.
- 5. Explaining to the client that the symptoms of withdrawal are temporary.

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

- 1. Has been drinking alcohol with the Klonopin.
- 2. Has developed tolerance to the Klonopin and needs to increase the dose.
- 3. Has stopped taking the Klonopin suddenly.
- 4. Is having a panic attack and needs to take an extra Klonopin.

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

- 1. Toothpaste.
- 2. Dental floss.
- 3. Shaving cream.
- 4. Antiseptic mouthwash.

**36.** A client is entering rehabilitation for alcohol dependency as an alternative to going to jail for multiple DUI's (driving under the influence). While obtaining the client's history, the nurse asks about the amount of alcohol he consumes daily. He responds, "I just have a few drinks with the guys after work." Which of the following responses by the nurse is **most** therapeutic?

- 1. "That's what all the clients here say at first."
- 2. "Then you should have had a designated driver for yourself."
- 3. "I guess you just can't handle a few drinks."
- 4. "You say you have a few drinks, but you have multiple arrests."

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

- 1. The severity of the disease.
- 2. The severity of withdrawal symptoms.
- 3. The possibility of alcoholic hallucinosis.
- 4. The occurrence of delirium tremens.

**38.** The client is feeling better as the symptoms of alcohol withdrawal abate. She refuses information about alcohol rehabilitation and states, "I don't have a problem. I'll never drink like that again. I learned my lesson this time. I guess I'll just have to switch to beer or wine." The nurse should respond by:

- 1. Discussing how alcohol has gotten her into trouble.
- 2. Explaining the effects of drinking on her family.
- 3. Urging her to attend Alcoholics Anonymous meetings.
- 4. Telling her about the physiologic damage that can result.

**39.** A client who is experiencing alcohol withdrawal exhibits tremors, diaphoresis, and hyperactivity. Blood pressure is 190/87 mm Hg and pulse is 92 bpm. Which of the following medications should the nurse expect to administer?

- 1. Haloperidol (Haldol).
- 2. Lorazepam (Ativan).
- 3. Benztropine (Cogentin).
- 4. Naloxone (Narcan).

**40.** Which of the following assessments provides the best information about the client's physiologic response and the effectiveness of the medication prescribed specifically for alcohol withdrawal?

- 1. Nutritional status.
- 2. Evidence of tremors.
- 3. Vital signs.
- 4. Sleep pattern.

**41.** A client who had been drinking heavily over the weekend could not remember specific events of where he had been or what he had done. The nurse interprets this information as indicating that the client experienced which of the following conditions?

- 1. Blackout.
- 2. Hangover.
- 3. Tolerance.
- 4. Delirium tremens.

**42.** A client is entering the alcohol treatment program for the fourth time in 5 years. Which of the following statements by the nurse will be **most** helpful to the client?

- 1. "I hope you are serious about maintaining your sobriety this time."
- 2. "I'm Maria, a nurse here. I don't know you from past attempts but you'll get it right this time."
- 3. "I know someone who was successful after the fifth program."
- 4. "I'm Maria, a nurse in the program. The staff and I will help you through the program."

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

- 1. Helpfulness.
- 2. Self-defeat.
- 3. Enabling.
- 4. Masochism.

**44.** Which of the following statements by the nurse participating in a group confrontation of a coworker is **most** helpful in reducing the coworker's denial about alcohol being a problem?

- 1. "Your behavior is unprofessional."
- 2. "As a nurse you should have sought help earlier."
- 3. "Nurses are the worst when it comes to asking for help."
- 4. "You have alcohol on your breath."

**45.** The husband of a nurse who is being confronted by a group about her problem with alcohol asks the nurse acting as the group leader what he should say to his wife during the meeting. The nurse leader directs the husband to use which of the following statements to facilitate his wife's entrance into treatment?

- 1. "The children and I want you to get help."
- 2. "If your parents were alive, they would be extremely disappointed in you."
- 3. "Either you get help or the kids and I will move out of the house."
- 4. "You need to enter treatment now or be a drunk if that's what you want."

**46.** A nurse working in an alcohol rehabilitation program is teaching staff how to give clients constructive feedback. Which of the following statements given as an example illustrates that the staff member understands the nurse's teaching regarding the use of constructive feedback?

- 1. "I think you're a real con artist."
- 2. "You're dominating the conversation."
- 3. "You interrupted Terry twice in 4 minutes."
- 4. "You don't give anyone a chance to finish talking."

**47.** A client ashamedly tells the nurse that he hit his wife while intoxicated and asks the nurse if his wife will ever forgive him. The nurse should reply to the client by saying:

- 1. "Perhaps you could ask her and find out."
- 2. "That's something you can explore in family therapy."
- 3. "It would depend on how much she really cares for you."
- 4. "You seem to have some feelings about hitting your wife."

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

- 1. Alateen.
- 2. Al-Anon.
- 3. Employee assistance program.
- 4. Alcoholics Anonymous.

**49.** Which of the following nursing actions is contraindicated for the client who is experiencing severe symptoms of alcohol withdrawal?

- 1. Helping the client walk.
- 2. Monitoring intake and output.
- 3. Assessing vital signs.
- 4. Using short, concrete statements.

**50.** Which of the following client statements indicates to the nurse that the client needs further teaching about disulfiram (Antabuse)?

- 1. "I can drink one or two beers and not get sick while on Antabuse."
- 2. "I can take Antabuse at bedtime if it makes me sleepy."
- 3. "A metallic or garlic taste in my mouth is normal when starting on Antabuse."
- 4. "I'll read the labels on cough syrup and mouthwash for possible alcohol content."

**51.** While receiving disulfiram (Antabuse) therapy, the client becomes nauseated and vomits severely. Which of the following questions should the nurse ask **first**?

- 1. "How long have you been taking Antabuse?"
- 2. "Do you feel like you have the flu?"
- 3. "How much alcohol did you drink today?"
- 4. "Have you eaten any foods cooked in wine?"

**52.** The expected outcome for using thiamine for a client being treated for an alcohol addiction is to:

- 1. Prevent the development of Wernicke's encephalopathy.
- 2. Decrease clients' withdrawal symptoms.
- 3. Aid clients in regaining their strength sooner.
- 4. Promote elimination of alcohol from the body faster.

**53.** Which of the following client statements indicates an understanding of the signs of alcohol relapse?

- 1. "I know I can stay dry if my wife keeps alcohol out of the house."
- 2. "Stopping Alcoholics Anonymous (AA) and not expressing feelings can lead to relapse."
- 3. "I'll have my sponsor at AA keep the list of symptoms for me."
- 4. "If someone tells me I'm about to relapse, I'll be sure to do something about it."

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

- 1. Denial.
- 2. Displacement.
- 3. Rationalization.
- 4. Reaction formation.

**55.** A client with alcohol dependency is prescribed a B-complex vitamin. The client states, "Why do I need a vitamin? My appetite is just fine." Which of the following responses by the nurse is **most** appropriate?

- 1. "Your doctor wants you to take it for at least 4 months."
- 2. "You've been drinking alcohol and eating very little."
- 3. "The vitamin is a nutritional supplement important to your health."
- 4. "The amount of vitamins in the alcohol you drink is very low."

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

- 1. Milk.
- 2. Regular coffee.
- 3. Orange juice.
- 4. Eggs.

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

- 1. Washing and drying the feet daily.
- 2. Massaging the feet with lotion.
- 3. Trimming the toenails carefully.
- 4. Avoiding use of an electric blanket.

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

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

2. Administer a dose of lorazepam (Ativan) depending on the severity of the withdrawal symptoms.

3. Assess the client for other withdrawal symptoms.

4. Take the client’s vital signs

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






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

- 1. Using restraints continuously.
- 2. Touching the client before saying anything.
- 3. Remaining with the client when she is confused or disoriented.
- 4. Informing the client about alcohol treatment programs.

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

- 1. “You must be sober for at least a month before joining.”
- 2. “AA is open to anyone who wants sobriety.”
- 3. “The members will interview you and decide if you can join the group.”
- 4. “AA requires daily attendance at meetings.”

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

- 1. Supportive friends.
- 2. A list of goals.
- 3. Family forgiveness.
- 4. Follow-up care.

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

- 1. The client states the need to cut down on his alcohol intake.
- 2. The client verbalizes the damaging effects of alcohol on his body.
- 3. The client plans to attend Alcoholics Anonymous meetings.
- 4. The client takes naltrexone (ReVia) daily.
- 5. The client says he is indestructible.

**63.** A client diagnosed with Major Depression and Substance Dependence is being admitted to the Dual Diagnosis Unit. In explaining the focus of this program, the nurse should tell the client?

- 1. The addiction will be treated first, then the depression.
- 2. The depression will be treated first, then the addiction.
- 3. There will be simultaneous treatment of the addiction and depression.
- 4. As the addiction is treated, the depression will clear up on its own.

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

- 1. Sleep pattern.
- 2. Mental status.
- 3. Eating habits.
- 4. Self-care ability.

**65.** A client diagnosed with schizophrenia and alcohol abuse decides to drink alcohol with his buddies. The nurse interprets this behavior, recognizing which of the following as an underlying dynamic of the client’s alcohol use?

- 1. The decision to use alcohol is a wish to feel accepted by others.
- 2. The decision to drink increases the client’s guilt and shame.
- 3. The client abused alcohol before developing a mental illness.
- 4. The client is compelled to drink because of cognitive difficulties.



### The Client with Disorders Related to Other Addictive Substances

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

- 1. "Once you are tapered off the Vicodin, you will find that non-addictive pain medicines will be enough to control your pain."
- 2. "You are going to be switched from the Vicodin to methadone (Dolophine) for long-term pain management."
- 3. The Vicodin will be stopped tomorrow, but you will have lorazepam (Ativan) to help you with the withdrawal symptoms."
- 4. Your pain will be controlled by tapering doses of propoxyphene (Darvon-N), with other pain management strategies and medicines."

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

- 1. Monitor for paper bags and rags that may have been used for breathing inhalants.
- 2. Brain damage is unlikely with the use of inhalants.
- 3. Use of inhalants by teens is on the decline.
- 4. Deaths from inhalants occur from asphyxiation, suffocation, and aspiration of vomit.
- 5. Inhalants usually cause depression of the central nervous system.
- 6. The basic groups of inhalants are hydrocarbon solvents such as glue, aerosol propellants from spray cans, and anesthetics/gases.

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

- 1. Respiratory rate of 9 breaths/minute.
- 2. Urinary retention.
- 3. Hypotension.
- 4. Reduced pupil size.

**69.** A client is brought to the emergency department by a friend who states, "He's been using a lot of heroin until he ran out of money about 2 days ago." The nurse judges the client to be in opioid withdrawal if he exhibits which of the following? Select all that apply.

- 1. Rhinorrhea.
- 2. Diaphoresis.
- 3. Piloerection.
- 4. Synesthesia.
- 5. Formication.

**70.** An unconscious client in the emergency department is given I.V. naloxone (Narcan) due to an overdose of heroin. Which of the following would indicate a therapeutic response to the Narcan? Select all that apply.

- 1. Decreased pulse rate.
- 2. Warm skin.
- 3. Dilated pupils.
- 4. Increased respirations.
- 5. Consciousness.

**71.** Which of the following should the nurse expect to assess for a client who is exhibiting late signs of heroin withdrawal?

- 1. Vomiting and diarrhea.
- 2. Yawning and diaphoresis.
- 3. Lacrimation and rhinorrhea.
- 4. Restlessness and irritability.

**72.** After administering naloxone (Narcan), an opioid antagonist, the nurse should monitor the client carefully for which of the following?

- 1. Cerebral edema.
- 2. Kidney failure.
- 3. Seizure activity.
- 4. Respiratory depression.

**73.** When teaching a client who is to receive methadone therapy for opioid addiction, the nurse should instruct the client that methadone is useful primarily for which of the following reasons?

- 1. It is not an addictive substance.
- 2. A maintenance dose is taken twice a day.
- 3. The client will no longer be addicted to opioids.
- 4. The client may work and live normally.

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

- 1. "Try attending a meeting at a different location; you may feel more comfortable there."
- 2. "Maybe it just wasn't a good day for you. Everybody has bad days now and then."
- 3. "Perhaps you weren't paying close enough attention to what they were saying."
- 4. "Sometimes the meetings can seem like a waste of time, but you need to attend to stay clean."

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

- 1. The kinds of friends he makes.
- 2. The number of drug-free days he has.
- 3. The way he gets along with his parents.
- 4. The amount of responsibility his job entails.

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

- 1. Hilarity.
- 2. Aggression.
- 3. Labile mood.
- 4. Hypoactivity.

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

- 1. Kidney failure.
- 2. Cerebrovascular accident.
- 3. Status epilepticus.
- 4. Respiratory failure.

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

- 1. "We can only wait and see. It's too soon to tell."
- 2. "Do you know her well? She's so young."
- 3. "She is very ill and may not live. Some don't pull through."
- 4. "Her condition is serious. You sound very worried about her."

**79.** Before his hospitalization, a client needed increasingly larger doses of barbiturates to achieve the same euphoric effect he initially realized from their use. From this information, the nurse develops a plan of care that takes into account that the client is likely suffering from which of the following?

- 1. Tolerance.
- 2. Addiction.
- 3. Abuse.
- 4. Dependence.

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

- 1. "I'm here to help you beat your drug habit. But it's you who will need to work hard."
- 2. "It's time to get straight and stay clean and put an end to your torture."
- 3. "I'm glad you pulled through; it was touch and go with you for a while."
- 4. "You're in the hospital because of a drug problem; I'm one of the nurses who will help you."

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

- 1. "It seems as if your self-esteem has been affected by all your losses."
- 2. "I know you took an overdose of barbiturates. Are you thinking of suicide now?"
- 3. "Helplessness is common after losing a job. Are you having trouble making decisions?"
- 4. "You sound hopeless about the future since your divorce."

**82.** The nurse identifies a nursing diagnosis of *Situational low self-esteem* for a client who has experienced the loss of her husband through divorce, the loss of her job and apartment, and the development of drug dependency. Which of the following outcomes is **most** appropriate initially?

- 1. The client will discuss her feelings related to her losses.
- 2. The client will identify two positive qualities.
- 3. The client will explore her strengths.
- 4. The client will prioritize problems.

**83.** The nurse notices that a client recovering from a barbiturate overdose spends most of his time with other young adults who have substance-related problems. This group of clients is a dominant force on the unit, keeping the non-drug users entertained with stories of their "highs." Which of the following methods is **best** to use when dealing with this problem?

- 1. Providing additional recreation.
- 2. Breaking up drug-oriented discussions.
- 3. Speaking with the clients individually about their behavior.
- 4. Discussing the behavior at the daily community meeting.

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

- 1. Allowing the client to continue with her stories.
- 2. Telling the client you've heard the stories before.
- 3. Questioning the client further about her exploits.
- 4. Directing the conversation to realistic concerns.

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

- 1. “Marijuana isn’t safe and it is illegal.”
- 2. “Do you really believe him?”
- 3. “That drug causes more damage to your body than regular cigarettes.”
- 4. “Marijuana usage can lead to using other chemicals.”

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

- 1. Using Ecstasy is similar to using speed.
- 2. Ecstasy is used at “raves.”
- 3. Candylike pacifiers are used for teeth grinding.
- 4. It can cause death.
- 5. It reduces self-consciousness.

**87.** A client in the emergency department tells the nurse that he “sees sounds and hears colors” as a result of using lysergic acid diethylamide (LSD). He also has elevated vital signs and mild paranoia. The nurse should do which of the following? Select all that apply.

- 1. Induce vomiting.
- 2. Decrease stimuli.
- 3. Apply restraints for safety.
- 4. Monitor vital signs every 30 minutes.
- 5. Talk reassuringly to help with relaxation.
- 6. Administer lorazepam (Ativan) if anxiety increases.

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

- 1. Induce vomiting.
- 2. Place seizure pads on the bed.
- 3. Administer PRN haloperidol (Haldol) as ordered.
- 4. Monitor for respiratory acidosis.
- 5. Encourage deep breathing.
- 6. Monitor for metabolic acidosis.

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

- 1. Suspiciousness.
- 2. Loss of appetite.
- 3. Drug craving.
- 4. Suicidal ideation.

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

1. Transfer the client to the psychiatric unit.

2. Monitor cardiac and respiratory status.

3. Place seizure pads on the bed.

4. Administer IM haloperidol (Haldol) as ordered.

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

- 1. “There will be an immediate discontinuation of the Xanax and haloperidol (Haldol) will be available if needed.”
- 2. “Instead of Xanax, you will take lorazepam (Ativan) in decreasing doses and frequency over a period of 3 to 4 days.”
- 3. “The Xanax will be tapered down over a period of 48 hours.”
- 4. “Xanax will be available on an as needed basis for 4 to 5 days.”

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

- 1. Refocusing attention.
- 2. Allowing ventilation.
- 3. Suggesting a time-out.
- 4. Giving intramuscular medication.
- 5. Assisting with problem solving.

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

- 1. Visual hallucinations.
- 2. Violent behavior.
- 3. Bizarre behavior.
- 4. Loud screaming.

**94.** Which of the following liquids should the nurse administer to a client who is intoxicated on phencyclidine (PCP) to hasten excretion of the chemical?

- 1. Water.
- 2. Milk.
- 3. Cranberry juice.
- 4. Grape juice.

**95.** When assessing a client with possible alcohol poisoning, the nurse should investigate the client's use of which of the following substances while drinking alcohol?

- 1. Marijuana.
- 2. Lysergic acid diethylamide.
- 3. Peyote.
- 4. Psilocybin.

**96.** A client with a cocaine dependency is irritable, anxious, highly sensitive to stimuli, and over-reactive to clients and staff on the unit. Which of the following actions is **most** therapeutic for this client?

- 1. Secluding and restraining the client as needed.
- 2. Telling the client to stay in his room until he can control himself.
- 3. Providing the client with frequent "time-outs."
- 4. Confronting the client about his behaviors.

**97.** A client with symptoms of amphetamine psychosis that are improving is anxious and still experiencing some delusions. When developing the client's plan of care, which of the following measures should the nurse include?

- 1. Assign the client to a group about the physiologic effects of drugs.
- 2. Advise the client to watch television.
- 3. Wait for the client to approach the nurse.
- 4. Invite the client to play a game of ping-pong with the nurse.

### The Client with Anxiety Disorders and Anxiety-Related Disorders

**98.** The nurse is to administer Xanax (alprazolam) to help a client of Japanese descent calm down. The order reads Xanax 0.25 to 1 mg by mouth as needed for agitation. What is the best dose for the nurse to give this client?

\_\_\_\_\_ mg.

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

- 1. To consult with his health care provider before he stops taking the drug.
- 2. To avoid eating cheese and other tyramine-rich foods.
- 3. To take the medication on an empty stomach.
- 4. Not to use alcohol while taking the drug.
- 5. To stop taking the drug if he experiences swelling of the lips and face and difficulty breathing.

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

- 1. Instruct the woman to avoid touching these foods.
- 2. Ask the woman why she becomes anxious in these situations.
- 3. Assist the woman to make a plan for her family to do the food shopping and preparation.
- 4. Teach the woman to use cognitive behavioral approaches to manage her anxiety.

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

- 1. "You need to sit down and relax."
- 2. "Are you feeling anxious?"
- 3. "Is something bothering you?"
- 4. "You must be experiencing a problem now."

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

- 1. "It was very frightening for you."
- 2. "We would not have let you die."
- 3. "I would have felt the same way."
- 4. "But you're okay now."

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

1. Teach problem solving strategies.

2. Ask the client to deep breathe for 2 minutes.

3. Discuss the client's feelings in more depth.

4. Reduce environmental stimuli.

**104.** Which of the following points should the nurse include when teaching a client about panic disorder?

- 1. Staying in the house will eliminate panic attacks.
- 2. Medication should be taken when symptoms start.
- 3. Symptoms of a panic attack are time limited and will abate.
- 4. Maintaining self-control will decrease symptoms of panic.

**105.** A client with panic disorder is taking alprazolam (Xanax) 1 mg P.O. three times daily. The nurse understands that this medication is effective in blocking the symptoms of panic because of its specific action on which of the following neurotransmitters?

- 1. Gamma-aminobutyrate.
- 2. Serotonin.
- 3. Dopamine.
- 4. Norepinephrine.

**106.** A client is diagnosed with Generalized Anxiety Disorder (GAD) and given a prescription for venlafaxine (Effexor). Which of the following information should the nurse include in a teaching plan for this client? Select all that apply.

- 1. Various strategies for reducing anxiety.
- 2. The benefits and mechanisms of actions of Effexor in treating GAD.
- 3. How Effexor will eliminate his anxiety at home and work.
- 4. The management of the common side effects of Effexor.
- 5. Substituting adaptive coping strategies for maladaptive ones.
- 6. The positive effects of Effexor being evident in 4 to 5 days.

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

- 1. Chocolate.
- 2. Cheese.
- 3. Alcohol.
- 4. Shellfish.

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

- 1. "This medication will help my tight, aching muscles."
- 2. "I may not feel better for 7 to 10 days."
- 3. "The drug does not cause physical dependence."
- 4. "I can take the medication with food."

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

- 1. Explain the effects of stress on the mind and body.
- 2. Reassure the client that her feelings are typical reactions to serious trauma.
- 3. Reassure the client that her symptoms are temporary.
- 4. Acknowledge the unfairness of the client's situation.

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

- 1. Recognizing when she is feeling anxious.
- 2. Understanding reasons for her anxiety.
- 3. Using adaptive and palliative methods to reduce anxiety.
- 4. Describing the situations preceding her feelings of anxiety.

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

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

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

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

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

- 1. Working on a puzzle.
- 2. Writing in a journal.
- 3. Meditating.
- 4. Listening to music.

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

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

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

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

2. Ask him to talk about his upsetting experiences in Iraq.

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

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





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

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

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

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

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

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

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

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

- 1. Trying relaxation techniques to help decrease her anxiety before bedtime.
- 2. Taking the quetiapine (Seroquel) 25 mg as needed as ordered by the physician.
- 3. Staying in the dayroom and trying to sleep in the recliner chair near staff.
- 4. Listening to calming music as she tries to fall asleep.
- 5. Processing the content of her flashbacks no less than hour before bedtime.
- 6. Leaving her door slightly open to decrease noise during the nightly checks.

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

- 1. A method of avoidance.
- 2. A detriment to progress.
- 3. The end of treatment.
- 4. A necessary break in treatment.

**120.** The nurse should warn a client who is taking a benzodiazepine about using which of the following medications in combination with his current medication?

- 1. Antacids.
- 2. Acetaminophen (Tylenol).
- 3. Vitamins.
- 4. Aspirin.

**121.** Which of the following client statements indicates the need for additional teaching about benzodiazepines?

- 1. “I can’t drink alcohol while taking diazepam (Valium).”
- 2. “I can stop taking the drug anytime I want.”
- 3. “Valium can make me drowsy, so I shouldn’t drive for a while.”
- 4. “Valium will help my tight muscles feel better.”

**122.** A client is diagnosed with agoraphobia without panic disorder. Which type of therapy is **most** effective for this illness?

- 1. Insight therapy.
- 2. Group therapy.
- 3. Behavior therapy.
- 4. Psychoanalysis.

**123.** The client diagnosed with a fear of eating in public places or in front of other people has finished eating lunch in the dining area in the nurse’s presence. Which of the following statements by the nurse should reinforce the client’s positive action?

- 1. “It wasn’t so hard, now was it?”
- 2. “At supper, I hope to see you eat with a group of people.”
- 3. “You must have been hungry today.”
- 4. “It is progress for you to eat in the dining room with me.”

**124.** The client diagnosed with agoraphobia refuses to walk down the hall to the group room. Which of the following responses by the nurse is appropriate?

- 1. “I know you can do it.”
- 2. “Try holding onto the wall as you walk.”
- 3. “You can miss group this one time.”
- 4. “I’ll walk with you.”

**125.** A client diagnosed with Obsessive-Compulsive Disorder has been taking sertraline (Zoloft) but would like to have more energy every day. At his monthly checkup, he reports that his massage therapist recommended he take St. John’s Wort to help his depression. The nurse should tell the client:

- 1. “St. John’s Wort is a harmless herb that might be helpful in this instance.”
- 2. “Combining St. John’s Wort with the Zoloft can cause a serious reaction called Serotonin Syndrome.”
- 3. “If you take St. John’s, we’ll have to decrease the dose of your Zoloft.”
- 4. “St. John’s Wort isn’t very effective for depression, but we can increase your Zoloft dose.”

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

- 1. “What do you mean when you say you think you’re going crazy?”
- 2. “Most people feel that way occasionally.”
- 3. “I don’t know you well enough to judge your mental state.”
- 4. “You sound perfectly sane to me.”

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

- 1. Relief from anxiety.
- 2. Control of his thoughts.
- 3. Attention from others.
- 4. Safe expression of hostility.

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

- 1. Tell the client to make his bed one time only.
- 2. Wake the client an hour earlier to perform his ritual.
- 3. Insist that the client stop his activity when it’s time for breakfast.
- 4. Advise the client to have breakfast first before making his bed.

**129.** The nurse notices that a client diagnosed with Major Depression and Social Phobia must get up and move to another area when someone sits next to her. Which of the following actions by the nurse is appropriate?

- 1. Ignore the client’s behavior.
- 2. Question the client about her avoidance of others.
- 3. Convey awareness of the client’s anxiety about being around others.
- 4. Tell the other clients to follow the client when she moves away.

**130.** The nurse is developing a long term care plan for an outpatient client diagnosed with Dissociative Identity Disorder. Which of the following should be included in this plan? Select all that apply.

- 1. Learning how to manage feelings, especially anger and rage.
- 2. Joining several outpatient support groups that are process-oriented.
- 3. Identifying resources to call when there is a risk of suicide or self-mutilation.
- 4. Selecting a method for alter personalities to communicate with each other, such as journaling.
- 5. Trying different medicines to find one that eliminates the dissociative process.
- 6. Helping each alter accept the goal of sharing and integrating all their memories.

**131.** A co-manager of a convenience store was taking the daily receipts to the bank when she was robbed at gun point. She did not report the robbery and could not be found for 2 days. In a city 100 miles away, a hotel manager called the police because the woman gave a false name and address. After learning that the robbery was confirmed by the bank cameras, she was admitted to the hospital with a diagnosis of Dissociative Fugue. The nurse should include which of the following in the client’s care plan? Select all that apply.

- 1. Develop trust and rapport to provide safety and support.
- 2. Rule out possible physical and neurological causes for the fugue.
- 3. Help the client discuss what she can remember about the trip to the bank.
- 4. Seclude the client from the other clients because of her lack of memory.
- 5. Question her repeatedly about the robbery and how she responded.
- 6. Encourage the client to talk about her feelings about what has been happening.

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

- 1. Explore Jason’s attitudes toward Jana more thoroughly.
- 2. Place Jana in restraints when Jason emerges.
- 3. Contract with Jason to tell the nurse when he has the urge to harm Jana and the body they both share.
- 4. Keep Jana in a stress-free environment so that the stronger Jason does not get a chance to emerge.

### The Client with a Somatoform Disorder

**133.** At 10 a.m., a client with an Axis I diagnosis of pain disorder demands that the nurse call the physician for more pain medication because she’s still in pain after the 9 a.m. analgesic. Which of the following should the nurse do next?

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



**134.** The nursing assistant tells the nurse that the client is sick and is not coming to the dining room for lunch. The nurse should direct the nursing assistant to do which of the following?

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

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

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

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

- 1. Asking the client to describe his problem with nausea.
- 2. Directing the client to describe his feelings about his impending divorce.
- 3. Allowing the client to talk about the physicians he has seen and the medications he has taken.
- 4. Informing the client about a different medication for his nausea.

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

- 1. Allow the client to talk about his pain.
- 2. Ask the client if he needs more pain medication.
- 3. Get up and leave the client.
- 4. Redirect the interaction back to fishing.

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

- 1. "I understand my pain will feel worse when I'm worried about my divorce."
- 2. "My stomach pain will go away once I get properly diagnosed."
- 3. "My headache feels better when I time my medication dose."
- 4. "I need to find a doctor who understands what my pain is like."

### Managing Care Quality and Safety

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

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

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

3. Page the ED physician and prepare to give diazepam (Valium) intravenously.

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

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

1. Ask the other clients to leave the room and meet with another nurse.
2. Ask Becky to talk about what happened to her during the group therapy session.
3. Get close to Annie and protect her from injury until she calms down.
4. Ask Annie about what happened to her during the group.

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

1. Having a sitter stay with the client to decrease her fear.
2. Placing the client next to the nursing desk.
3. Leaving the client alone until the “trip” is over.
4. Having the boyfriend check on the client frequently.

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

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

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

1. “Alcohol dependency affects the entire family.”
2. “The client is a weak individual and could stop if he desires.”
3. “Alcohol is a problem when it interferes with the client’s daily life.”
4. “The client who can’t stop drinking even though he wants to is alcohol dependent.”

- 144.** The nurse is serving on the hospital ethics committee which is considering the ethics of a proposal for the nursing staff to search the room of a client diagnosed with substance abuse while he is off the unit and without his knowledge. Which of the following should be considered concerning the relationship of ethical and legal standards of behavior?
- 1. Ethical standards are generally higher than those required by law.
  - 2. Ethical standards are equal to those required by law.
  - 3. Ethical standards bear no relationship to legal standards for behavior.
  - 4. Ethical standards are irrelevant when the health of a client is at risk.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client with a Personality Disorder

1.

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

1. Teach the client anxiety management and social skills.

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

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

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

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

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

🔑 CN: Reduction of risk potential;  
CL: Synthesize

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


🔑 CN: Psychosocial adaptation;  
CL: Synthesize

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


🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**5. 4.** Attending an activity with the nurse assists the client to become involved with others slowly. The client with a schizotypal personality disorder needs support, kindness, and gentle suggestion to improve social skills and interpersonal


relationships. The client commonly has problems in thinking, perceiving, and communicating and appears similar to clients with schizophrenia except that psychotic episodes are infrequent and less severe. Participation solely in group activities or leading a sing-along would be too overwhelming for the client, subsequently increasing the client's anxiety and withdrawal. Engaging primarily in one-to-one activities would not be helpful because of the client's difficulty with social skills and interpersonal relationships. However, activities with the nurse could be used to establish trust. Then the client could proceed to activities with others.

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**8. 4.** The client diagnosed with an antisocial personality disorder is manifesting behavior indicative of problems in Erikson's stage of initiative versus guilt. Typical behaviors of a client with an antisocial personality disorder are engaging in illegal activities, violating the rights of others, lack of guilt or remorse, recklessness, impulsiveness,

aggressive behavior, and irresponsibility in work and with finances, and the nurse should determine if the client is feeling any guilt. A lack of guilt or remorse for offenses, such as stealing, is typically present, as if the client does not have a conscience. Behaviors indicating problems in the stage of trust versus mistrust include suspiciousness, projection of blame and feelings, and withdrawal. Behaviors indicating problems in the stage of autonomy versus shame and doubt include self-doubt and self-consciousness, dependency on others for approval, and denial of problems. Behaviors indicating problems in the stage of industry versus inferiority include poor work history, inadequate problem-solving skills, and manipulation of others.

 CN: Health promotion and maintenance;  
CL: Synthesize


**9. 2.** The nurse should teach the client consequences of her actions to help the client understand that if she steals she will get into legal trouble and be put in jail. So, if she wants to avoid jail, she needs to not steal. Helping the client to develop a conscience or to understand right from wrong is impossible. However, the client needs to be taught that her actions do lead to consequences. Using strategies to help the client become passive is not helpful, is nontherapeutic, and does not help the client to understand the consequences of her actions.

 CN: Psychosocial adaptation; CL: Create

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

 CN: Psychosocial adaptation; CL: Apply

**11. 2.** Stating, "All of you will gain from his independent living; he needs our support," encourages the client's independent behaviors and fosters autonomous functioning for the entire family. The other statements minimize the son's independence and decrease his self-esteem.

 CN: Psychosocial adaptation;  
CL: Synthesize

**12.**


1. Monitor for suicide and self-mutilation.

3. Monitor sleeping and eating behaviors.

2. Discuss the issues of loneliness and emptiness.

4. Discuss her housing options for after discharge.

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

 CN: Safety and infection control;  
CL: Synthesize

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

 CN: Management of care; CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Apply

**15. 4.** The client with borderline personality disorder is usually in a crisis situation when hospitalized for self-mutilation and suicidal ideation or behavior. The statement, “Any attempt at self-harm is serious and safety is a priority,” is the best response because the misperception that self-mutilation is used to gain attention can result


in death of the client. The client can accidentally commit suicide. Any form of self-harm is an indication that the client needs treatment. The statement, “She’s here now and we have to do our best,” is not helpful and does not educate the staff member about the client’s needs. The statement, “She needs to be here until she can control her behavior,” may be true but does not provide information about the client’s priority needs. The statement, “I’m ashamed of you; you know better than to say that,” is punitive, diminishes self-worth, and may not be a correct assumption of the staff member’s knowledge.

 CN: Management of care; CL: Synthesize

**16. 2.** For the client who is at risk for self-mutilation, the nurse develops a contract to assist the client with assuming responsibility for his behavior and to help the client develop adaptive methods of coping with feelings. Self-mutilation is usually an expression of intense anxiety, anger, helplessness, or guilt or a means to block psychological pain by inducing physical pain. A typical contract helpful to the client would have the client notify staff when anxiety is increasing. Withdrawing to his room when feeling overwhelmed, suppressing feelings when angry, or displacing feelings onto the physician is not an adaptive method to help the client deal with his feelings and could still result in self-mutilation.


 CN: Safety and infection control;  
CL: Evaluate

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**18. 4.** The best initial course of action when admitting a client is to observe him to establish baseline information. This assessment provides valuable information about the client’s behavior and forms the basis for the plan of care. Telling the client that the staff has authority to subdue him if he gets unruly or that he will have to pay for any damage he causes is threatening and may incite or provoke

trouble. Isolating a client is not recommended unless there is a very good reason for it, such as a very active, combative client who is dangerous to himself and others.

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Analyze


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

 CN: Safety and infection control;  
CL: Synthesize


**23. 1.** The most basic and important idea to convey to a client is that, as a person, he or she is accepted, although his or her behavior may not be. Empathy is conveyed for emotional pain regardless of the client’s behavior. Although some clients need limits placed on their behavior, not all clients require limit setting. That the staff members are the primary ones left to care about these clients is not necessarily true, nor is it true that the staff should use very little humor with these clients. Clients who are rigid and perfectionists and who have a restricted affect may need help with displaying humor.

 CN: Management of care; CL: Apply

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

 CN: Psychosocial adaptation;  
CL: Synthesize


**25. 3.** The nurse judges the client’s statement to be an example of grandiose self-importance, which is not a lie but an overvaluing of oneself. The grandiosity of a client with a narcissistic personality disorder is not a delusion because it usually is based somewhat in reality. However, it can be distorted, embellished, or convoluted to meet the client’s need of self-importance. Sense of entitlement is a symptom of the narcissistic client but refers to deserving to be favored or given special treatment.

 CN: Psychosocial adaptation;  
CL: Analyze


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**28. 3.** The nurse should first determine if the client is suicidal. If the client is suicidal, it is crucial to know what the client plans to do. The seriousness of intent to die would determine the level of suicidal precautions required to maintain safety. Understanding about access to means for suicide is more important as the client is preparing for discharge.

 CN: Safety and infection control;  
CL: Analyze

### The Client with an Alcohol-Related Disorder

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

 CN: Basic care and comfort;  
CL: Synthesize

**30.**

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

**1.** Administer lorazepam (Ativan) 2 mg I.M.

**2.** Draw blood for a magnesium level.

**3.** Take vital signs every 15 minutes.


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

 CN: Management of care; CL: Synthesize

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

 CN: Safety and infection control;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**33. 1, 2, 4, 5.** For the client experiencing symptoms of alcohol withdrawal, the nurse monitors vital signs and intake and output, reinforces reality for the client who is confused, disoriented, or hallucinating, explains that the symptoms of withdrawal are temporary, reduces stimulation, and stays with the client if he is confused or agitated. The nurse administers medications to prevent the progression

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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Pharmacological and parenteral therapies; CL: Analyze

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


 CN: Safety and infection control;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**37. 2.** The client's response helps the nurse determine the severity of withdrawal symptoms because the length and extent of drinking alcohol has an effect on the severity of symptoms the client experiences during withdrawal. Decreased use of alcohol can also result in withdrawal symptoms in the client who has developed a high tolerance to alcohol and is physically dependent. The severity of the disease, the possibility of hallucinations, and the occurrence of delirium tremens are not determined by the information given. The Axis I diagnosis of alcohol dependency is just that—it is not classified as mild, moderate, or severe. Alcoholic hallucinosis is a state of auditory hallucinations that develops about 48 hours after the client has stopped drinking. The client hears voices or noises within the context of a clear sensorium, meaning that the auditory hallucination is the only symptom the client


experiences. Severe withdrawal symptoms that are not managed medically can progress to delirium tremens or a severe abstinence syndrome. Delirium tremens occurs about 3 to 5 days after the client's last drink and is characterized by confusion, agitation, severe psychomotor activity, hallucinations, sleeplessness, tachycardia, elevated blood pressure, elevated temperature, and possibly seizures.

 CN: Reduction of risk potential;  
CL: Analyze


**38. 1.** The most effective way to help decrease the client's denial is to point out how alcohol has gotten the client into trouble, using specific, concrete data based on fact, not opinion. Explaining the effects of drinking on family, urging the client to attend Alcoholics Anonymous meetings, and telling her about the physiologic damage that can result are important components of the treatment process but are not as effective in decreasing denial as discussing how alcohol has affected her life.

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Reduction of risk potential;  
CL: Analyze

**41. 1.** A client is suffering from a blackout when he cannot recall what he did while under the influence of alcohol. A hangover refers to symptoms experienced the day after a bout of heavy drinking.



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

 CN: Physiological adaptation;  
CL: Analyze

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Analyze

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**45. 3.** The nurse leader should direct the husband to say, “Either you get help or the kids and I will move out of the house.” This statement facilitates entrance into treatment because it is a direct statement of what the consequences are if


the alcohol abuse continues. The statement, “The children and I want you to get help,” is not effective. Most likely, the husband has already made a similar statement before the confrontation session. Saying, “If your parents were alive, they would be extremely disappointed in you,” or “You need to enter treatment now or be a drunk if that’s what you want,” shames the wife and further decreases her self-esteem.

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Evaluate

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Management of care; CL: Apply

**49. 1.** Having the client who is experiencing severe symptoms of alcohol withdrawal walk is contraindicated because increased activity and stimulation may confuse the client and promote hallucinations. The client may also sustain an injury if he has a seizure as part of the alcohol withdrawal process. The nurse should monitor intake and output to ensure fluid and electrolyte balance and hydration. The nurse should assess vital signs to assess the


physiologic status of the client and the response to medications. The nurse should use short, concrete statements to decrease confusion and ambiguity.

 CN: Reduction of risk potential;  
CL: Apply


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

 CN: Pharmacological and parenteral therapies; CL: Evaluate

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize


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

 CN: Pharmacological and parenteral therapies; CL: Apply


**53. 2.** The statement, "Stopping Alcoholics Anonymous and not expressing feelings can lead to relapse," indicates the client's understanding of signs of relapse. The client is responsible for sobriety and must understand the signs of relapse. Other antecedents to relapse include severe craving, being around users, and severe emotional crises. The other statements place the responsibility for the client's sobriety on someone else.

 CN: Reduction of risk potential;  
CL: Evaluate

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

 CN: Psychosocial adaptation;  
CL: Analyze

**55. 3.** Stating that the vitamin is a nutritional supplement important to the client's health is the best response. The client is nutritionally depleted, and the B-complex vitamins produce a calming effect on the irritated central nervous system and prevent anemia, peripheral neuropathy, and Wernicke's encephalopathy. Although the statements about drinking alcohol and eating very little and that there is a low amount of vitamins in the alcohol consumed may be true, they fail to address the client's concerns directly and fail to provide the necessary information, as does telling the client that the doctor wants the client to take the vitamin for 4 months.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

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

 CN: Reduction of risk potential;  
CL: Apply

**57. 4.** The nurse should teach the client with peripheral neuropathy to avoid using an electric blanket because the client is likely to have decreased sensitivity in the extremities owing to the damaging effects of alcohol on the nerve endings.

It is particularly important to guard against burns because the client may not be able to discern the appropriate degree of heat on the feet. Daily washing and drying, massaging with lotion, and trimming the toenails are appropriate foot care measures for any client.

 CN: Reduction of risk potential;  
CL: Create

### 58.

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

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

3. Assess the client for other withdrawal symptoms.


2. Administer a dose of lorazepam (Ativan)

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

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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Safety and infection control;  
CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Apply


**61. 4.** Follow-up care is essential to prevent relapse. Recovery has just begun when the treatment program ends. The first few months after program completion can be difficult and dangerous for the chemically dependent client. The nurse is responsible for discharge plans that include arrangements for counseling, self-help group meetings, and other forms of aftercare. Supportive friends, a list of goals, and family forgiveness may be important and helpful to the client, but follow-up care is essential.

 CN: Management of care; CL: Create

**62. 2, 3, 4.** The client who plans to attend Alcoholics Anonymous meetings, verbalizes the damaging effects of alcohol on his body, and takes naltrexone daily may be ready for alcohol rehabilitation. Other key outcomes include admitting that a problem with alcohol exists and realizing the negative effects of alcohol on his life. Stating that he needs to cut down on his alcohol intake and that he is indestructible are signs of denial of an alcohol problem.

 CN: Psychosocial adaptation;  
CL: Evaluate

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Management of care; CL: Analyze

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

 CN: Psychosocial adaptation; CL: Apply

### The Client with Disorders Related to Other Addictive Substances

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**67. 1, 4, 5, 6.** The nurse should instruct the parents to monitor their children for use of paper bags or rags. The nurse should present information about brain damage from inhalants including damage to the frontal lobe, cerebellum, and hippocampus, and that death is possible. Rather than use being on the decline, teenagers are experimenting even more with many types of inhalants, such as Freon, ground-up candy disks, and spray cleaners for computer and TV screens.

 CN: Health promotion and maintenance; CL: Create

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

 CN: Reduction of risk potential; CL: Analyze

**69. 1, 2, 3.** Symptoms of opioid withdrawal include yawning, rhinorrhea, sweating, chills, piloerection (goose bumps), tremors, restlessness, irritability, leg spasms, bone pain, diarrhea, and vomiting. Symptoms of withdrawal occur within 36 to 72 hours of usage and subside within a week. Withdrawal from heroin is seldom fatal and usually does not necessitate medical intervention. Synesthesia (a blending of senses) is associated with lysergic acid diethylamide use, and formication (feeling of bugs crawling beneath the skin) is associated with cocaine use.

 CN: Psychosocial adaptation; CL: Analyze


**70. 4, 5.** Naloxone is an opioid antagonist used to treat an opioid overdose. Within a few minutes, the client should have an increase of respirations to near normal and become conscious. With a heroin overdose, the pulse is not significantly affected, the skin becomes warm and wet and the pupils are dilated. With naloxone the skin would return to a normal temperature and become dry. The pupils also would react normally and the pulse would not be decreased.

 CN: Pharmacological and parenteral therapies; CL: Analyze

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

 CN: Reduction of risk potential; CL: Analyze


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

 CN: Pharmacological and parenteral therapies; CL: Analyze


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

 CN: Psychosocial adaptation; CL: Apply


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Evaluate


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

 CN: Psychosocial adaptation;  
CL: Analyze


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

 CN: Reduction of risk potential;  
CL: Analyze


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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Evaluate

**83. 4.** The best method to deal with the problem is to discuss observations with clients at the daily community meeting because the problem involves all of the clients and this provides them with the opportunity to offer their views. Peer pressure is

valuable in confronting self-defeating and destructive behaviors. Providing additional recreation avoids or ignores the problem and is damaging to all clients because it decreases trust in the nurse. Breaking up drug-oriented discussions would not be sufficient to stop the behavior. Speaking with the clients individually about their behavior is not as effective as dealing with the problem openly and directly with everyone.

 CN: Psychosocial adaptation;  
CL: Synthesize

**84. 4.** The nurse directs the conversation to realistic concerns or issues to decrease denial and focus on rebuilding a substance-free life. Allowing the client to continue with the stories or questioning the client further about her exploits reinforces the denial. Telling the client you've heard the stories before is nondirective. Additionally, these actions do nothing to help the client focus on rebuilding a substance-free life.

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Apply

**86. 1, 2, 3, 4, 5.** Ecstasy is chemically related to methamphetamine (speed) and is used at "raves" (all-night dance parties) to enhance dancing, closeness to others, affection, and the ability to communicate. Euphoria, heightened sexuality, disinhibition, and diminished self-consciousness can occur. Adverse effects include tachycardia, elevated blood pressure, anorexia, dry mouth, and teeth grinding. Pacifiers, including candy-shaped pacifiers and lollipops, are used to ease the discomfort associated with teeth grinding and jaw clenching. Hyperthermia, dehydration, renal failure, and death can occur.


 CN: Psychosocial adaptation; CL: Create

**87. 2, 4, 5, 6.** The client is experiencing "synesthesia", the blending of senses. At this point, the client needs decreased stimuli and reassurance that the "trip" effects will decrease. Monitoring the vital signs also provides frequent contact with the client

to see if Ativan will be needed to decrease anxiety. Inducing vomiting is not needed, nor are there any behaviors that warrant restraints.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**88. 2, 3, 4, 5, 6.** The cocaine was not swallowed so inducing vomiting is not indicated. A cocaine overdose can produce seizures, paranoia, and respiratory and/or metabolic acidosis. Deep breathing will help decrease the respiratory distress and pulse rate.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Analyze

**90.**

3. Place seizure pads on the bed.

2. Monitor cardiac and respiratory status.


4. Administer I.M. haloperidol (Haldol) as ordered.

1. Transfer the client to the psychiatric unit.

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**92. 1, 2, 5.** The client is exhibiting symptoms of moderate anxiety. At this level of anxiety, the nurse should help the client to decrease anxiety by allowing ventilation, crying, exercise, and relaxation techniques. The nurse would further assist the client by refocusing his attention, relating behaviors and feelings to anxiety, and then assisting with problem solving. Oral medication may be needed if the client's anxiety is prolonged or does not decrease with the nurse's interventions. Suggesting a time-out and giving intramuscular medication are possible interventions for a client whose anxiety level is severe.

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Safety and infection control;  
CL: Analyze

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

 CN: Reduction of risk potential;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Analyze

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

behaviors induced by chemicals. Confronting the client about his behaviors would most likely lead to aggression and possibly violent behavior.

 CN: Safety and infection control;  
CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Create

## The Client with Anxiety Disorders and Anxiety-Related Disorders


**98. 2 mg.** Asians have a greater sensitivity to psychotropic medication and generally require much less than other cultural groups to achieve positive results. The smallest dose is safest to start; the dosage can always be increased. However, a dose that is too high for the client is likely to cause unpleasant or even serious side effects. Those side effects likely would lead to distress and noncompliance in the future.

 CN: Pharmacological and parenteral therapies; CL: Apply


**99. 1, 4, 5.** The nurse should instruct the client who is taking diazepam to take the medication as prescribed; stopping the medication suddenly can cause withdrawal symptoms. This medication is used for a short term only. The drug dose can be potentiated by alcohol and the client should not drink alcoholic beverages while taking this drug. Swelling of the lips and face and difficulty breathing are signs and symptoms of an allergic reaction. The client should stop taking the drug and seek medical assistance immediately. The client does not need to avoid eating foods containing tyramine; tyramine interacts with monoamine oxidase inhibitors, not Valium. The client can take the medication with food.

 CN: Health promotion and maintenance;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

**103.**

4. Reduce environmental stimuli.

2. Ask the client to deep breathe for 2 minutes.

3. Discuss the client’s feelings in more depth.

1. Teach problem solving strategies.

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


 CN: Psychosocial adaptation;  
CL: Synthesize

**104. 3.** It is important for the nurse to teach the client that the symptoms of a panic attack are time limited and will abate. This helps decrease the

client’s fear about what is occurring. Clients benefit from learning about their illness, what symptoms to expect, and the helpful use of medication. A simple biologic explanation of the disorder can convince clients to take their medication. Telling the client to stay in the house to eliminate panic attacks is not correct or helpful. Panic attacks can occur “out of the blue,” and clients with panic disorder can become agoraphobic because of fear of having a panic attack where help is not available or escape is impossible. Medication should be taken on a scheduled basis to block the symptoms of panic before they start. Taking medication when symptoms start is not helpful. Telling the client to maintain self-control to decrease symptoms of panic is false information because the brain and biochemicals may account for its development. Therefore, the client cannot control when a panic attack will occur.

 CN: Psychosocial adaptation; CL: Create


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

 CN: Pharmacological and parenteral therapies; CL: Apply

**106. 1, 2, 4, 5.** It is appropriate to provide education on medication mechanisms, benefits, and managing side effects. No medication will eliminate all anxiety, so teaching about anxiety reduction and adaptive coping is needed. Effexor is a serotonin-norepinephrine reuptake inhibitor antidepressant and it will take 2 to 4 weeks to feel the effects.

 CN: Pharmacological and parenteral therapies; CL: Create


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

 CN: Pharmacological and parenteral therapies; CL: Apply

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



can be taken with food or small meals to reduce gastrointestinal upset.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


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

 CN: Psychosocial adaptation; CL: Synthesize


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

 CN: Psychosocial adaptation; CL: Synthesize

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


 CN: Psychosocial adaptation; CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Synthesize

**113. 2.** Writing in a journal can help the client safely express feelings, particularly anger, when the client cannot verbalize them. Safely externalizing

anger by writing in a journal helps the client to maintain control over her feelings.

 CN: Psychosocial adaptation; CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Create

**115.**

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

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


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

2. Ask him to talk about his upsetting experiences in Iraq.

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

 CN: Safety and infection control; CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Synthesize

## 117.

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

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

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

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


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

 CN: Reduction of risk potential;  
CL: Synthesize

**118.** 1, 2, 4, 6. Relaxation techniques and listening to calming music decrease anxiety and promote sleep. Seroquel is often effective in decreasing nightmare and flashbacks and has a beneficial side effect of drowsiness. Leaving her door slightly open will decrease the noise of making 15 minute checks at night. Staying in the dayroom in a recliner with all the noise and lights is not likely to help. Processing memories an hour or two before bedtime doesn’t allow enough time to calm down before sleep.


 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Psychosocial adaptation;  
CL: Analyze

**120.** 1. Combining a benzodiazepine with an antacid impairs the absorption rate of the benzodiazepine. Acetaminophen, vitamins, and aspirin are

safe to take with a benzodiazepine because no major drug interactions occur.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**121.** 2. Valium, like any benzodiazepine, cannot be stopped abruptly. The client must be slowly tapered off of the medication to decrease withdrawal symptoms, which would be similar to withdrawal from alcohol. Alcohol in combination with a benzodiazepine produces an increased central nervous system depressant effect and therefore should be avoided. Valium can cause drowsiness, and the client should be warned about driving until tolerance develops. Valium has muscle relaxant properties and will help tight, tense muscles feel better.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


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

 CN: Psychosocial adaptation; CL: Apply


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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize


**125. 2.** The effectiveness of St. John's Wort with depression is unconfirmed. The critical issue is that the combination of St. John's Wort and Zoloft (an SSRI antidepressant) can produce Serotonin Syndrome which can be fatal. The client should not take the St. John's Wort while taking Zoloft.

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Psychosocial adaptation; CL: Synthesize


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

 CN: Psychosocial adaptation; CL: Analyze

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Synthesize


**130. 1, 3, 4, 6.** Managing suicidal thought, urges to self-mutilate and the intense anger are critical safety issues. Then the focus can switch to communication methods for each alter and the integration issues. Process groups can be overwhelming when too much is revealed or when child alters are unable to understand the group content. There are no known medicines to stop the process of dissociating.

 CN: Psychosocial adaptation; CL: Create

**131. 1, 2, 3, 6.** A client experiencing a Dissociate Fugue needs to feel safe and supported as well as evaluated medically and neurologically. Then it is appropriate to discuss what she can remember about the trip to the bank and her feelings about all that has happened to her since then. It is not appropriate to seclude her from others or to apply pressure to get details about the crime at this time. The police and the bank will ask these questions during their investigations.


 CN: Psychosocial adaptation; CL: Create

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

 CN: Safety and infection control; CL: Synthesize


### The Client with a Somatoform Disorder

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

 CN: Psychosocial adaptation; CL: Synthesize

**134. 3.** The nurse instructs the nursing assistant to invite the client to lunch and accompany him to the dining room to decrease manipulation, secondary


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

 CN: Management of care; CL: Synthesize


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

 CN: Management of care; CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation; CL: Evaluate

## Managing Care Quality and Safety

### 139.


3. Page the ED physician and prepare to give diazepam (Valium) intravenously.

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

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

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

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

 CN: Safety and infection control;  
CL: Synthesize

### 140.

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

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

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


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

The safety of the client is the top priority. Then the nurse can ask the other clients to leave and meet with another nurse to discuss their feelings about

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

 CN: Safety and infection control;  
CL: Synthesize

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

 CN: (S); CL: Synthesize

**142.**

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

2. Implement constant observation.

4. Administer haloperidol (Haldol) and lorazepam (Ativan) I.M. as ordered.

3. Monitor vital signs every 15 minutes.

1. Obtain an order to place the client in restraints, if needed.

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

After orienting the client to time and place, the nurse should assure constant observation of the client to prevent the client from getting hurt. The administration of the Haldol and Ativan are needed to quickly decrease the symptoms of DTs (delirium tremens) and lower the vital signs. Monitoring vital signs assesses the client's stability and need for additional medications. The nurse can ask another

staff to contact the health care provider to request an order for restraints in case the client becomes violent toward self or others. After the DT symptoms subside the Haldol would be stopped due to the decrease in the seizure threshold. Other detoxification protocols would then begin. Last, chart the client's response.

 CN: Safety and infection control;  
CL: Synthesize

**143.** 2. The statement, "The client is a weak individual and could stop if he desires," is false and indicates a lack of understanding regarding alcohol dependency. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revised, criteria for substance dependency includes the inability to stop using even when wanting to do so. The client cannot stop or control the amount used when dependent on a substance. Alcohol dependency affects individuals from every culture and socioeconomic background and has nothing to do with being a "weak" individual. The devastating effects of alcohol dependency are felt by every member of the family and not just the individual with the alcohol problem. Family members need education about the physical, physiologic, and psychological effects of alcohol and referrals to self-help groups for support. They have felt and lived with the devastating effects of the disease. A simple and commonly held view of alcoholism is that alcohol is a problem when it interferes with life or disrupts family, work, or social relationships.

 CN: Management of care; CL: Evaluate

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

 CN: Management of care; CL: Apply

**TEST**  
**4**

# Stress, Crisis, Anger, and Violence

- The Client Managing Stress
- The Client Coping with a Physical Illness
- The Client in Crisis
- The Client with Problems Expressing Anger
- The Client with Interpersonal Violence
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client Managing Stress

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

- 1. "When I get my prosthesis, I want to learn to walk so I can participate in walk-a-thons."
- 2. "I hope to get skilled enough at using my prosthesis to help others like me adjust."
- 3. "Whenever I start to feel sorry for myself, I remember that my buddy died in that accident."
- 4. "I hope I can handle having a prosthesis, but I'm really wondering what my wife will think."

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

- 1. Assuring the client that pain is not associated with the procedure.
- 2. Providing a brief explanation and then doing the procedure quickly.
- 3. Giving a demonstration of what is to be done.
- 4. Indicating to the client that it is normal to feel anxious and fearful before such a procedure.

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

- 1. Moderate to severe anxiety.
- 2. Disinterest in the illness.
- 3. Early-onset dementia.
- 4. Normal reaction to learning a new skill.

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

- 1. Tell the client to distract himself with games and television.
- 2. Reassure the client that he will come through surgery without incident.
- 3. Explain the surgical procedure to the client and what happens before and after surgery.
- 4. Ask the surgeon to refer the client to a psychiatrist who can work with the client to diminish his anxiety.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1. "I can't think about the weekend right now. I've got to study for the exam."
- 2. "I know I'm not good in sports, but I feel good about my grades."
- 3. "Now when I'm mad at my wife, I talk to her instead of taking it out on the kids."
- 4. "For years I couldn't remember being molested; now I know I have to face it."

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

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

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

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

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

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

**19.** A client who has not left the bus station for 3 days is brought to the mental health facility by a police officer because she has been bothering other people. She denies this, holds tightly to her purse, and refuses to talk to anyone except to say, “You have no right to keep me here. I have money, and I can take care of myself.” The police officer thinks she needs psychiatric evaluation. Evaluation reveals that the client stopped taking her psychotropic medication, but she agrees to start taking her medication again. The charge nurse informs the other staff members that the physician is discharging the client because involuntary commitment is not indicated. An unlicensed personnel states, “How can her physician be so cruel? She should stay in the hospital instead of being discharged.” Which response is best for the nurse to make to the unlicensed personnel?

- 1. “I agree with you. She does have symptoms of mental illness.”
- 2. “Although she may have a mental illness, she is not gravely disabled or dangerous to herself or others now.”
- 3. “The client wants to leave, so the physician is not going to put her through the commitment process.”
- 4. “The client has a home to go to and family to support her. She doesn’t need to be here.”

**20.** Which of the following questions or statements should the nurse use to encourage client evaluation of his or her own behavior?

- 1. “I can hear that it’s still hard for you to talk about this.”
- 2. “So what does this all mean to you now?”
- 3. “What did you do differently with your coworker this time?”
- 4. “What will it take to carry out your new plans?”

**21.** With shorter lengths of stay becoming the norm, which statement is true of the stages of the nurse-client relationship?

- 1. Different phases of the relationship involve emphasizing different processes and goals related to client needs.
- 2. Building trust is the most that can be accomplished during the relationship.
- 3. What can be achieved during the relationship is problem identification and referrals.
- 4. Teaching new skills becomes the most important aspect of the relationship phases.

**22.** Even when the client understands problems and is motivated to change, the client may have fears about failing. Which of the following interventions is most likely to facilitate change?

- 1. Reality testing about the need for change.
- 2. Asking the client about fears that need to be overcome.
- 3. Teaching new communication skills.
- 4. Practicing new behaviors with the nurse.

## The Client Coping with Physical Illness

**23.** A 68-year-old client who has coped successfully with Type 2 diabetes for several years was diagnosed with breast cancer a week ago and the physician has recommended that she have a mastectomy. When approached about giving consent for the mastectomy, the client says “What is the use in trying to get rid of the cancer? It will just come back! I can’t handle another thing—having diabetes is enough. Besides, I’m getting old. It would be different if I were younger and had more energy.” What should the nurse do?

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

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

- 1. Accepting his death as imminent.
- 2. Expressing his angry feelings to the nurse.
- 3. Decreasing interaction with peers to conserve energy.
- 4. Gaining an intellectual understanding of the illness.

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

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

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

- 1. “I can tell you more about the surgery if you like.”
- 2. “What do you mean by that statement?”
- 3. “Aren’t you being a bit hard on him? He’s trying to help you.”
- 4. “Does that remark have something to do with the operation he wants you to have?”



**27.** A client becomes increasingly morose and irritable after being told that she has cancer. She is rude to visitors and pushes nurses away when they attempt to give her medications and treatments. Which of the following should the nurse do when the client has a hostile outburst?

- 1. Offer the client positive reinforcement each time she cooperates.
- 2. Encourage the client to discuss her immediate concerns and feelings.
- 3. Continue with the assigned tasks and duties as though nothing has happened.
- 4. Encourage the client to direct her anger at staff members instead of her visitors.

**28.** Arrangements are made for a member of the colostomy club to meet with a client before bowel surgery. Which of the following is accomplished by having a representative from the club visit the client preoperatively?

- 1. Letting the client know that he has resources in the community to help him.
- 2. Providing support for the physician's plan of therapy for the client.
- 3. Providing the client with support and realistic information on the colostomy.
- 4. Convincing the client that he will not be disfigured and can lead a full life.

**29.** A client who was transferred to the medical unit from intensive care after suffering a myocardial infarction 3 days ago states, "My secretary should be here by now. I don't have time to lie around here and do nothing. I've never had time to relax, and I don't plan on starting now." Based on this initial information, which of the following nursing diagnoses should the nurse judge to be of **least** importance?

- 1. *Ineffective coping* related to serious illness, as evidenced by the statement about lying around and doing nothing.
- 2. *Deficient knowledge* related to cardiac rehabilitation, as evidenced by the client's statement about not planning to relax at present.
- 3. *Hopelessness* related to serious illness, as evidenced by the client's turning over her work to her secretary.
- 4. *Anxiety* related to delayed arrival of the client's secretary, as evidenced by her statement of expecting that the secretary should already have arrived.

**30.** The client hospitalized for diagnosis and treatment of atrial fibrillation states to the nurse, "Please hand me the telephone. I need to check on my stocks and bonds." Which of the following responses by the nurse is **most** therapeutic?

- 1. "You will get more upset if you make that call."
- 2. "You have atrial fibrillations. Let's talk about what that means."
- 3. "You really don't care about the fact that you're sick, do you?"
- 4. "Do you realize you have a life-threatening condition?"

**31.** The nurse should determine that a client lacks understanding of her acute cardiac illness and the ability to make changes in her lifestyle by which of the following statements?

- 1. "I already have my airline ticket, so I won't miss my meeting tomorrow."
- 2. "These relaxation tapes sound okay; I'll see if they help me."
- 3. "No more working 10 hours a day for me unless it's an emergency."
- 4. "I talked with my husband yesterday about working on a new budget together."

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

- 1. "I will have a talk with your wife to see if she is suicidal."
- 2. "You need to be strong and optimistic when you are with her."
- 3. "I'm glad you shared this with me. I can imagine that this is scary for you."
- 4. "I'm sure she will feel differently when we get this episode under control."
- 5. "We can talk about what you can say to her that may help."

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

- 1. "I'll leave, but you need to eat."
- 2. "I'll get you something for your pain."
- 3. "Your anger doesn't bother me. I'll be back later."
- 4. "You sound angry. What is upsetting you?"

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

- 1. "Your ulcerative colitis has made you perfectionistic and it has caused your OCD."
- 2. "There is no relationship at all between your colitis and your OCD. They are separate disorders."
- 3. "The perfectionism and anxiety related to your obsessions and compulsions have led to your colitis."
- 4. "It is possible that your desire to have everything be perfect has caused stress that may have worsened your colitis, but there's no proof that either disorder caused the other."

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

- 1. Neologism.
- 2. Confabulation.
- 3. Flight of ideas.
- 4. Emotional lability.

### The Client in Crisis

**36.** A nurse in an Employee Assistance Program (EAP) is seeing a woman who wants to report her boss to the police for sexual harassment. She states he says that she will never get a promotion unless she “works and plays at his house on weekends.” After getting more details on the boss’ statements and behaviors, the nurse should do which of the following?

- 1. Encourage the client to file a police report as soon as possible.
- 2. Tell the client to return to EAP if she is denied a promotion.
- 3. Show the client the company’s Workplace Violence Policy and agree to help her follow the process.
- 4. Go with the client to confront her boss about his behaviors and possible consequences.

**37.** A woman is being seen in the rape crisis center a few days after being raped. She is reporting loss of appetite, anxiety, depression, and nightmares. The nurse is to make an assessment to determine if she should be admitted to the hospital. In which order of priority from first to last should the nurse assess the following?

1. The client’s reaction to the event, including any suicidal thoughts.

2. The client’s perceptions of her current skills for coping with the event.

3. The availability of the client’s personal support systems.

4. The effect of the event on other aspects of the client’s life.

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

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

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

- 1. “You mean you have had sexual intercourse?”
- 2. “Describe what you mean by hooking up.”
- 3. “I think we need to talk about what’s involved in sexual intercourse.”
- 4. “All you have been doing with your boyfriend is hooking up?”

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

- 1. “Try not to worry until after the pregnancy test.”
- 2. “You know, pregnancy is a normal event.”
- 3. “You’re only 40 years old and not too old to have a baby.”
- 4. “I see you’re upset. Take some deep breaths to relax a little.”

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

- 1. The boys probably fear punishment.
- 2. Sniffing glue is illegal.
- 3. The boys’ observations could be wrong.
- 4. Glue-sniffing is a minor form of substance abuse.

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

- 1. “Ask the caller to tell you why he or she is calling you today.”
- 2. “Tell the caller to make an appointment at the walk-in crisis clinic.”
- 3. “Instruct the caller to go to the nearest emergency room.”
- 4. “Tell the caller to let you speak to anyone else in the house.”

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

- 1. "Callers to a crisis line use this service when they're overwhelmed and exhausted."
- 2. "People use crisis hotlines when they're in the most pain and nothing is working for them."
- 3. "Most people in crisis will be calling the line once every day for at least a year."
- 4. "One benefit is that a person will know how to handle stressful situations better in the future."

**44.** Three months after the death of her husband in an automobile accident, a client is admitted to the hospital after attempting to overdose on her antidepressant. She states, "I can't live without him. It's no use. I just want to die." Which of the following nursing diagnoses is the priority in the client's plan of care?

- 1. *Complicated grieving* related to husband's death as evidenced by a suicide attempt.
- 2. *Powerlessness* related to husband's death as evidenced by statement of "It's no use."
- 3. *Hopelessness* related to husband's death as evidenced by the client's statement of inability to live without the husband.
- 4. *Risk for self-directed violence* related to husband's death as evidenced by the client's wish to die.

**45.** A family, including an 8-year-old boy and a 13-year-old girl, have been long-time members of a cult split off from a conservative religious group. The girl ran away from the group's compound to her aunt's house. The aunt brought the girl to the emergency department after finding multiple knife cuts in various stages of healing on the girl's body. She is admitted to the unit because of many trauma-related symptoms. The nurse should take which of the following actions? Select all that apply.

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

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

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

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

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

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

- 1. Relinquishment of dysfunctional coping.
- 2. Reestablishment of lost support systems.
- 3. Acquisition of new coping skills.
- 4. Gain of crisis prevention knowledge.

**49.** A client is being discharged after 3 days of hospitalization for a suicide attempt that followed the receipt of a divorce notice. Which of the following, if verbalized by the client, indicates to the nurse that the client is ready for discharge?

- 1. A readiness for discharge.
- 2. Names and phone numbers of two divorce lawyers.
- 3. A list of support persons and community resources.
- 4. Emotional stability.

**50.** A distraught father is waiting for his son to come out of surgery. He accidentally backed the car into his son, causing multiple fractures and a serious head injury. Which of the following statements by the father should alert the nurse to the need for a psychiatric consultation?

- 1. "My son will be fine, but I may be charged with reckless driving."
- 2. "His mother is going to kill me when she finds out about this."
- 3. "I just didn't see him run behind the car."
- 4. "If he dies, there will be nothing for me to do but join him."

**51.** A grandson who calls the crisis center expressing concern about his grandmother who lost her husband a month ago states, “She has been in bed for a week and is not eating or showering. She told me that she did not want to kill herself, but it’s not like her to do nothing for herself. She won’t even talk to me when I visit her.” The nurse encourages the grandson to bring his grandmother to the center for evaluation based on which of the following reasons?

- 1. The behaviors may reflect passive suicidal thoughts.
- 2. The behaviors reflect altered role performance.
- 3. Seeing the grandson and grandmother together will be helpful.
- 4. Refusing to talk to the grandson alone indicates a major problem.

**52.** A 16-year-old client who is being seen by the crisis nurse after making several superficial cuts on her wrist complains that all her friends are siding with her ex-boyfriend and won’t talk to her anymore. She says she knows that the relationship is over, but “If I can’t have him, no one else will.” Which of the following nursing diagnoses is **most** important?

- 1. *Situational low self-esteem* related to rejection by friends as evidenced by friends not talking to her.
- 2. *Risk for other-directed violence* related to break-up of the relationship as evidenced by the statement, “If I can’t have him, no one else will.”
- 3. *Risk for suicide* related to loss of the relationship as evidenced by client’s acting-out behaviors.
- 4. *Risk prone health behavior* related to rejection by the boyfriend as evidenced by self-mutilation.

**53.** A client who comes to the crisis center in a very distressed state tells the nurse, “I just can’t get over being fired last week. I’ve asked for help. I’ve talked to friends. I’ve tried everything to get through this, but nothing is working. Help me!” Which of the following should the nurse use as the initial crisis intervention strategy?

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

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

- 1. The name and phone number of the client’s physician.
- 2. Emergency resources and when to use them.
- 3. The coping strategies they are using.
- 4. Long-term solutions they plan to tell the client to use.

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

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

**56.** A nurse manager of the Crisis Access Center of a psychiatric facility in New York City notices a sudden increase in the number of incoming calls one afternoon. After quickly surveying the call sheets, the nurse finds that most callers are very anxious after Air Force One flew very low over the city so that pictures could be taken of the President’s plane near famous sites. Which of the following strategies would be **most** appropriate in this situation? Select all that apply.

- 1. Instruct the crisis workers to additionally screen callers about where they were on 9/11/01 and their memories of that event.
- 2. Give the crisis workers a list of symptoms of PTSD and techniques for dealing with these symptoms.
- 3. Ask for an emergency meeting with the managers of the inpatient and outpatient services to formulate a contingency plan for increased services if needed.
- 4. Ask the major media outlets in the city to make a scripted public service announcement about the possible recurrence of symptoms experienced after the events of 9/11/01.
- 5. Prepare for a scripted interview with the local media about PTSD symptoms and techniques for dealing with these symptoms.
- 6. Ask the Director of Psychiatric Services to call the U.S. Government to ask that the President issue an apology for the flyover by Air Force One.

## The Client with Problems Expressing Anger

**57.** A female client in an anger management group states, “My doctor tells me I need to get mad more often and not let people tell me what to do. Maybe she thinks I should be more aggressive.” What information should the nurse incorporate in the response to this client?

- 1. Denial of anger and lack of assertiveness can be as serious as aggressiveness.
- 2. Assertive behavior in women is not culturally acceptable.
- 3. The client has most likely misinterpreted what the physician said.
- 4. The client is trying to gain acceptance by the group.

**58.** The father of a U.S. Marine who was killed 2 days ago in Iraq is admitted after a serious suicide attempt. He is medically stable and has signed a no harm contract. During a talk with the nurse, he says, “Terrorism and war are holding me and the whole world hostage. It’s so unfair. I’d rather be dead than live alone in constant fear.” Which of the following nursing interventions are important in the next few days? Select all that apply.

- 1. Discussing effective ways to express justifiable anger.
- 2. Teaching stress management and relaxation techniques.
- 3. Identifying community groups for relatives of military personnel.
- 4. Recommending an antiwar advocacy group.
- 5. Strategizing about ways to increase a personal sense of security.

**59.** In developing a plan of care for a client who has had previous episodes of angry verbal outbursts the nurse plans to take an educational approach to the problem. Arrange the following steps the nurse should take from first to last.

1. Assisting the client to recognize the early cues that he is angry.

2. Helping the client identify triggers for his anger.

3. Practicing with the client appropriate ways to express his anger.

4. Identifying alternate ways to express his anger.





**60.** A client is admitted to the hospital because of threatening, aggressive behavior toward his family. In the first group meeting after the client is admitted, another client sits near the nurse and says loudly, “I’m sitting here because I’m afraid of Ted. He’s so big, and I heard him talk about hitting people.” The nurse should say to the client:

- 1. “Everyone is here for different problems. You know you don’t have to worry.”
- 2. “Ted is new to the group. Let’s go around and introduce ourselves to him.”
- 3. “You don’t know Ted yet. Once you get to know him, I’m sure you won’t be afraid.”
- 4. “It’s frightening to have new people on the unit. We’re here to talk about things like being afraid.”

**61.** The treatment team recommends that a client take an assertiveness training class offered in the hospital. Which of the following behaviors indicates that the client is becoming more assertive?

- 1. Begins to arrive late for unit activities. When asked why he’s late, he says, “Because I feel like it!”
- 2. Asks the nurse to call his employer about his insurance.
- 3. Asks his roommate to put away his dirty clothes after telling the roommate that this bothers him.
- 4. Follows the nurse’s advice of asking his doctor about being passive-aggressive.

**62.** Which of the following physiologic responses should the nurse expect as **unlikely** to occur when a client is angry?

- 1. Increased respiratory rate.
- 2. Decreased blood pressure.
- 3. Increased muscle tension.
- 4. Decreased peristalsis.

**63.** Which of the following responses to anger from others should the nurse expect as common in clients?

- 1. Increased self-esteem.
- 2. Feelings of invulnerability.
- 3. Fear of harm.
- 4. Powerlessness.

**64.** When planning the care of a client experiencing aggression, the nurse incorporates the principle of “least restrictive alternative,” meaning that less restrictive interventions must be tried before more restrictive measures are employed. Which of the following measures should the nurse consider to be the most restrictive?

- 1. Tension reduction strategies.
- 2. Haloperidol (Haldol) given orally.
- 3. Voluntary seclusion or time-out.
- 4. Haloperidol given intramuscularly.

**65.** As an angry client becomes more agitated while talking about his problems, the nurse decides to ask for staff assistance in taking control of the situation when the client demonstrates which of the following behaviors?

- 1. Swearing about his wife's behaviors when discussing marital problems.
- 2. Picking up a pool cue stick and telling the nurse to get out of his way.
- 3. Making a fist and pounding loudly on the table.
- 4. Coming out of his room instead of staying in time-out.

**66.** The nurse is advising a client with schizophrenia about what to do when she begins to get agitated. The client has been compliant with taking her medications and has worked with clinic staff on dealing with her illness and recognizing when she is becoming agitated. Indicate the order from first to last in which the nurse should suggest the following actions be taken.

1. "Take your oral lorazepam (Ativan)."

2. "Take your oral haloperidol (Halodol)."

3. "Remove yourself to a quiet environment."

4. "Tell trusted people that you are becoming upset."





**67.** When a client is about to lose control, the extra staff who come to help commonly stay at a distance from the client unless asked to move closer by the nurse who is talking to the client. Which of the following best explains the primary rationale for staying at a distance initially?

- 1. The client is more likely to act out if there is an audience, even additional staff.
- 2. The nurse talking to the client makes the decisions about other staff actions.
- 3. The client is likely to perceive others as being closer than they are and feel threatened.
- 4. When the extra staff is visible, the client is less likely to regain self-control.

**68.** When preparing to use seclusion as an alternative to restraint for a client who has not yet lost control, the nurse expects to use a room with limited furniture and no access to dangerous articles. What should the nurse also consider as critical for the safety of the client?

- 1. A security window in the door or a room camera.
- 2. Lights that can be dimmed from outside the room.
- 3. A staff member to stay in the room with the client.
- 4. A doctor's order for the seclusion before it is initiated.

**69.** The nurse is required initially to restrain all four of a client's extremities. For which of the following reasons should the nurse anticipate the need to add a full-length restraint blanket?

- 1. The client complains that restraints are tight and uncomfortable.
- 2. The staff want extra protection for themselves.
- 3. The client is at risk for injury from fighting the restraints.
- 4. Staff assessment reveals that the client will feel more secure under the blanket.

**70.** Which of the following is the top priority for the client who is placed in restraints?

- 1. Monitoring the client every 15 minutes.
- 2. Assisting with nutrition and elimination.
- 3. Performing range-of-motion exercise for each limb, one at a time.
- 4. Changing the client's position every 2 hours.

**71.** According to hospital protocol, after a client is restrained, the staff meet and discuss the restraint situation. In addition to sharing feelings and offering support, what should the nurse identify as the long-term goal?

- 1. Providing feedback to each other on how procedures were handled.
- 2. Comparing the perceptions of the various staff members.
- 3. Deciding when to release the client from restraints.
- 4. Improving the staff's use of restraint procedures.

## The Client with Interpersonal Violence

**72.** Based on a client's history of violence toward others and her inability to cope with anger, which of the following should the nurse use as the **most** important indicator of goal achievement before discharge?

- 1. Acknowledgment of her angry feelings.
- 2. Ability to describe situations that provoke angry feelings.
- 3. Development of a list of how she has handled her anger in the past.
- 4. Verbalization of her feelings in an appropriate manner.

**73.** A client is admitted to the psychiatric hospital for evaluation after numerous incidents of threatening others, angry outbursts, and two episodes of hitting a coworker at the grocery store where he works. The client is very anxious and tells the nurse who admits him, "I didn't mean to hit him. He made me so mad that I just couldn't help it. I hope I don't hit anyone here." To ensure a safe environment the nurse should **first**:

- 1. Letting other clients know that he has a history of hitting others so that they will not provoke him.
- 2. Putting him in a private room and limiting his time out of the room to when staff can be with him.
- 3. Telling him that hitting others is unacceptable behavior and asking him to tell a staff member when he begins feeling angry.
- 4. Obtaining an order for a medication to be administered to decrease his anxiety and threatening behavior.

**74.** A client loses control and throws two chairs toward another client. What should the nurse do next?

- 1. Ask the client to go to the quiet area and talk about the behavior.
- 2. Administer an oral tranquilizer and prepare for a show of determination.
- 3. Process the incident with the client and discuss alternative behaviors.
- 4. Use restraints and administer an intramuscular tranquilizer.

**75.** A client with a history of self-mutilation and substance abuse begins talking about memories of torture and ritual abuse that ended 15 years ago. She describes that her parents locked her in a closet whenever they were gone, starved and beat her, sexually abused her and mutilated her genitals, and gave her drugs to keep her sedated. To her knowledge, no others were or are being abused by the parents. To assist the client recover from such torture and abuse the nurse should? Select all that apply.

- 1. Dealing with ambivalent feelings toward her parents.
- 2. Planning a confrontation with her parents.
- 3. Determining alternatives to self-destructive behaviors.
- 4. Filing criminal charges against her parents.
- 5. Developing safe ways to deal with her rage and guilt.

**76.** A woman who was raped in her home was brought to the emergency department by her husband. After being interviewed by the police, the husband talks to the nurse. "I don't know why she didn't keep the doors locked like I told her. I can't believe she has had sex with another man now." The nurse should respond by saying:

- 1. "Let's talk about how you feel. Maybe it would help to talk to other men who have been through this."
- 2. "Maybe the doors were locked, but the man broke in anyway."
- 3. "Your wife needs your support right now, not your criticism."
- 4. "It was not consensual sex. Let's see if your wife was physically injured."

**77.** A young man makes an appointment to see the psychiatric nurse at the Employee Assistance Program of a large corporation. He complains that his female boss is making him very uncomfortable. He reports that she wants to date him, sends him provocative e-mails, and makes seductive remarks on his voice mail at home. The nurse informs him about Occupational Safety and Health Association services and Corporate Workplace Violence Guidelines. He agrees to work with Corporate Security on the issue. What should the nurse do next?

- 1. Refer the client to his boss's supervisor to file a report.
- 2. Suggest the client contact Human Resources to request a job transfer.
- 3. Ask the client about his reactions to this situation.
- 4. Report the incident to the client's coworkers who are at risk for similar harassment.

**78.** A 75-year-old woman was brought to the crisis center by her husband. The husband reports that his wife has been in shock and anxious since her purse was stolen outside of their home. The woman blames herself for being robbed, is worried about her stolen wallet and credit cards, and is afraid to go home. The nurse should do which of the following? Select all that apply.

- 1. Request an order for lorazepam (Ativan) to decrease her anxiety.
- 2. Encourage her to talk about the robbery and her feelings.
- 3. Discuss what changes at home would help her feel safe.
- 4. Investigate if she has physical injuries from the robbery.
- 5. Ask her what she thinks she could have done to prevent the robbery.

**79.** A 35-year-old has been killed as a result of a terrorist attack. What should the nurse advise the friends and relatives of the victim to do during the early stages of the recovery process? Select all that apply.

- 1. Keep in contact with other family and friends.
- 2. Attend memorial or religious services.
- 3. Use relaxation techniques and physical activities.
- 4. Speak out publicly about the impact of the loss.
- 5. Attend community meetings with others who have lost loved ones.

### Managing Care Quality and Safety

**80.** When the client is involuntarily committed to a hospital because he is assessed as being dangerous to himself or others, which of the following rights are lost?

- 1. The right to refuse medications and treatments.
- 2. The right to send and receive uncensored mail.
- 3. Freedom from seclusion and restraints.
- 4. The right to leave the hospital against medical advice.

**81.** The nurse manager on a psychiatric unit is reviewing the outcomes of staff participation in an aggression management program. Evaluation of such a program would be based primarily on which of the following indicators?

- 1. Fewer client injuries during restraint procedures.
- 2. A reduction of complaints by clients' relatives.
- 3. Fewer staff injuries during restraint procedures.
- 4. A reduction in the total number of restraint procedures.

**82.** A young woman has been stalked and then beaten by an ex-boyfriend. Treatment of her injuries is complete and she is ready for discharge. To ensure the woman's safety and security prior to discharge the nurse should? Select all that apply.

- 1. Determine the current location of the ex-boyfriend.
- 2. Ask if she plans to see the ex-boyfriend again.
- 3. **Provide** information on resources and a safety plan.
- 4. Ensure that she has a safe place to stay after discharge.
- 5. Obtain consent to send her emergency department records to her family physician.

**83.** A 21-year-old female was arrested on charges of solicitation. Jail staff asked for a mental health evaluation when the woman used a fork to stab herself. She also had an episode of rage after waking up from a nightmare and screamed repeatedly to let her out of "the locked room." After she was admitted to the psychiatric unit, she admitted to being kidnapped and held from ages 8 to 16 by a convicted child pornographer. She said she never contacted her family after her release from captivity. The nurse should do the following in what order of priority from first to last?

1. Initiate suicide precautions and a no harm contract.

2. Ask the client if she wishes to contact her family while hospitalized.

3. Offer empathy and support and be non-judgmental and honest with her.

4. Encourage safe verbalizations of her emotions, especially anger.



**84.** The nurse is planning care for a group of clients. Which client should the nurse identify as needing the **most** assistance in accepting being ill?

- 1. An 8-year-old boy who alternately cries for his mother and is angry with the nurse about being hospitalized after a bike accident.
- 2. A 32-year-old woman diagnosed with depression related to lupus erythematosus who discusses her medication's adverse effects with the nurse.
- 3. A 45-year-old man who just suffered a severe myocardial infarction and talks to the nurse about concerns regarding resuming sexual relations with his wife.
- 4. A 60-year-old woman diagnosed with chronic obstructive pulmonary disease who refuses to wear an oxygen mask even though poor oxygenation makes her confused.


**85.** The nurse judges that a client is ready to be released from seclusion and restraints when the client demonstrates which of the following behaviors?

- 1. Is adequately sedated.
- 2. Struggles less against the restraints.
- 3. Stops swearing and yelling.
- 4. Shows signs of self-control.

**86.** Despite education and role-play practice of restraint procedures, a staff member is injured when actually restraining a client. When helping the uninjured staff deal with the incident, the nurse should address which of the following about the injured member?


- 1. The emotional responses may be similar to those of other crime victims.
- 2. The member is likely to resign after experiencing such an injury.
- 3. Legal action against the client will take time and energy.
- 4. The member must debrief with the assaultive client before returning.

## Answers, Rationales, and Test Taking Strategies


The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client Managing Stress


**1. 4.** The client expressing doubts about his wife's response to his amputation as well as possible doubt on his part is still struggling with body image issues. Looking forward to participating in walk-a-thons and helping others indicate plans for the future that imply an acceptance of his amputee status. Remembering that his friend died in the accident that caused his amputation indicates that the client is aware that there was a worse end result to the accident than his amputation.

 CN: Psychosocial adaptation;  
CL: Evaluate

**2. 2.** A short explanation followed by quick completion of the procedure minimizes anxiety. The client may be fearful of pain, and assuring him that there will be no pain offers false reassurance. A demonstration may cause increased anxiety. Informing the client that his feelings are common normalizes anxiety and puts the client more at ease, but it is not the most reassuring approach.


 CN: Psychosocial adaptation;  
CL: Synthesize

**3. 1.** Anxiety, especially at higher levels, interferes with learning and memory retention. After the client's anxiety lessens, it will be easier for him to learn the steps of the blood glucose monitoring. Because the client's illness is a chronic, lifelong illness that severely changes his lifestyle, it is unlikely that he is uninterested in the illness or how to treat it. It is also unlikely that dementia would be the cause of the client's frustration and lack of memory. The client's response indicates anxiety. Client responses that would indicate lessening anxiety would be questions to the nurse or requests to repeat part of the instruction.


 CN: Psychosocial adaptation;  
CL: Analyze

**4. 3.** An explanation of what to expect decreases anxiety about upcoming events that could be seen as traumatic by the client. Distraction, such as


with games or television, only decreases anxiety temporarily and does not fulfill the client's need for information about the procedure. Reassurance about an uncomplicated outcome is not appropriate; the nurse cannot guarantee that the client will come through surgery without problems. Referring the client to a psychiatrist is not indicated for moderate, expected preoperative anxiety.

 CN: Physiological adaptation;  
CL: Synthesize

**5. 3.** With mild anxiety, perceptions are accurate. Slight muscle tension reflects a motor response. Occasional irritability is an emotional response. Loss of contact with reality is a cognitive characteristic of severe anxiety.

 CN: Physiological adaptation;  
CL: Analyze


**6. 1.** Suicide attempts and violence are psychomotor responses to a panic level of anxiety. Desperation and rage are emotional responses. Disorganized reasoning and loss of contact with reality are cognitive responses.

 CN: Physiological adaptation;  
CL: Analyze

**7. 2.** Mild anxiety motivates the client to focus on issues and resolve them. Therefore, learning and problem solving can occur at a mild level of anxiety. Taking control for the client is reserved for a near-panic level of anxiety. Severe anxiety interferes with reasoning and functioning. Therefore, reducing stimuli and pressure is crucial at a severe level. Tension reduction is appropriate at a moderate level to help the client think more clearly and engage in problem solving.


 CN: Physiological adaptation;  
CL: Analyze

**8. 4.** Minimal functioning, causing new problems to develop, is a reflection of dysfunctional coping. The ability to objectively and rationally problem solve demonstrates adaptive coping. Tension reduction activities demonstrate palliative coping. However, such activities alone do not solve problems; they must be followed by problem solving. Anger management alone may prevent new problems, such as violence toward oneself or others, but it does not solve problems directly. It is considered maladaptive coping.


 CN: Physiological adaptation;  
CL: Analyze

**9. 4.** Because relationships inherently lead to stress and anxiety, conflict resolution skills are essential for solving relationship problems. Dealing with anger is more effective than suppressing


it. Suppression is a mechanism that avoids the issue rather than solving it. Balancing a checkbook involves calculations, not coping skills. Following directions is a passive activity that reflects a lack of problem solving by the client.

 CN: Psychosocial adaptation;  
CL: Analyze


**10. 4.** The client's statement that he and his wife listen to each other reflects improved efforts at communicating about issues. The other statements provide some insight into the need for better communication. However, they are but steps along the way to coping effectively with the problem.

 CN: Psychosocial adaptation;  
CL: Evaluate

**11. 1.** Assessment examines the client's thoughts, feelings, and behaviors within a context. Whether the client's behavior is appropriate for the situation is important assessment data. Setting priorities is part of making nursing diagnoses and planning; motivation to change and identifying the need for a no harm contract are part of the planning stage.

 CN: Psychosocial adaptation;  
CL: Analyze

**12. 3.** Writing a list of strengths and needs is short-term, achievable, and measurable. Achieving positive self-esteem would occur over the long-term. Going to school involves complex future steps to a long-term goal. Using skills is likely to be stressful and is best attempted after the client has done a self-assessment.

 CN: Psychosocial adaptation;  
CL: Synthesize


**13. 4.** The ultimate outcome is to have the client solve problems by himself, collaborating in his own care. Client follow-up with the psychiatrist, while desirable, does not ensure that the client will fully comply with treatment or medication. Knowledge of the medication's effects and adverse effects and compliance can help the client but alone will not ensure success unless the client knows how to address and solve problems without help from others.

 CN: Health promotion and maintenance;  
CL: Synthesize


**14. 1.** Substituting rational beliefs is a major goal when using cognitive-behavioral models, which focus more on thinking and behaviors than feelings. Unconscious processes are the focus of psychoanalytic models. Analysis of fears and barriers to growth are the focus of developmental models. Tension and stress are targets of the stress models.

 CN: Psychosocial adaptation; CL: Apply

**15. 3.** Displacement refers to a defense mechanism that involves taking feelings out on a less-threatening object or person instead of tackling the issue or problem directly. Talking to his wife directly reflects insight into the client's use of the defense mechanism and his ability to overcome it. Not thinking about the weekend is suppression. Here the client is focusing on the issue with the highest priority. Focusing on academic rather than athletic achievement is compensation, highlighting one's strengths instead of weaknesses. Not remembering the molestation is repression.

 CN: Psychosocial adaptation;  
CL: Evaluate


**16. 3.** Legally there is a duty to warn a potential victim of a client's intent to harm. Staff can be held accountable if the client injures the ex-partner and the staff failed to warn that person. The client's permission is needed to share information with a spouse. Only client initials are used in student papers. Release of information is made directly to the client's insurance company, not to the employer.

 CN: Safety and infection control;  
CL: Apply

**17. 2, 5.** The client is showing increased anxiety and anger as well as refusing to stay in the hospital, which are immediate and crucial concerns at admission. The client is not likely to give permission to talk to his wife and boss at this point. Housing issues and divorce counseling may be relevant before discharge, but not initially. Suspiciousness and grandiosity may be relevant after the client's anxiety and anger are under control.


 CN: Psychosocial adaptation; CL: Create

**18. 2.** The nurse is required to set limits on inappropriate behavior while conveying respect and acceptance of that person. Doing so conveys to the client that he is worthy without posing any harm or embarrassment to the client. Touch is a complex issue that must be used cautiously. Touch may be misinterpreted or misperceived by a client who has been abused or who has perceptual or thought disturbances. Mutual sharing reflects a social friendship, not a therapeutic one. Total confidentiality is not desirable. For example, treatment team members and insurance companies need selected information to ensure quality services.

 CN: Psychosocial adaptation;  
CL: Apply

**19. 2.** To be committed involuntarily, a client must not only be suffering from a mental illness but must be gravely disabled (unable to care for self or likely to come to harm if discharged) or dangerous to

self or others. Having a mental illness alone is not grounds for commitment. Wanting to leave the hospital is not sufficient cause for discharge if the client is dangerous to self or others or is gravely disabled. The physician would not avoid committing a client who meets the criteria to be committed. Having a supportive family or home but not wanting treatment may still result in involuntary commitment if indicated or necessary to ensure the well-being of the client or another person.

 CN: Psychosocial adaptation;  
CL: Synthesize


**20. 3.** Asking for descriptions of changes in behavior (what the client did differently) encourages evaluation. Conveying empathy, such as stating that it is still hard for the client to talk about it, encourages data collection. Asking for meaning helps with the nursing diagnosis. Asking the client about what her husband said the previous night is part of evaluation.

 CN: Psychosocial adaptation; CL: Apply

**21. 1.** With the shorter lengths of stay, the processes and goals of a particular stage are chosen according to the client's current needs and abilities. Building trust (orientation stage) is a priority with psychotic and suspicious clients. It is less crucial for the client ready to work on issues. Making referrals (termination stage) is appropriate for all clients regardless of their needs. The other needs will be addressed in counseling after discharge. Teaching skills (working stage) is appropriate for clients with insight and readiness for change. They may not be appropriate for clients with severe psychosis or suspiciousness, especially if denial is present.

 CN: Management of care; CL: Apply


**22. 4.** Practicing new behaviors builds confidence and reinforces appropriate behaviors. Reality testing, asking about fears, and teaching new communication skills are some of the many steps when trying out new behaviors.

 CN: Psychosocial adaptation;  
CL: Apply

### The Client Coping with Physical Illness

**23. 4.** While the client does have a right to accept or reject treatment, she has not explored her feelings, her possible mastectomy, or the future. The nurse should assist the client in exploring her feelings and moving toward a fuller understanding of her options. Giving the client survival rates indicates that the nurse feels she

should have the surgery and negates her fears and concerns. While the chaplain might be helpful, this step should be done after the client has explored her feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**24. 2.** Diagnosis of a serious illness would be a shock to anyone, but particularly a young person. Feelings of anger are normal and should be expressed. Gaining an intellectual understanding of his illness would also be necessary, but such learning will not take place if the client's feelings have not been addressed. There is no indication that the client needs to conserve energy because of his condition, nor is it clear that death is imminent. Neither situation is likely at the point of first diagnosis unless the disease is well advanced, which is not indicated here.

 CN: Psychosocial adaptation; CL: Apply

**25. 2.** The psychotropic drugs used to treat chronic mental illnesses have side effects that can lead to noncompliance. Therefore, teaching the clients measures to deal with the common side effects would be most important. Teaching should be focused on the need for compliance and the specific interests of the target audience. Teaching should concentrate on the medications commonly used to treat chronic mental illness, not on many psychotropic drugs or those used in acute illness. Such topics as the role of medication in the treatment of chronic mental illness and the effects of using common street drugs with psychotropic medication should be discussed after the issue of compliance is addressed.


 CN: Psychosocial adaptation; CL: Create

**26. 2.** When the client seems to be questioning the physician's goals, it is best for the nurse to present an open statement and ask the client what he means. This technique helps the client express his feelings. Telling the client about the surgery is less therapeutic when he is upset. Chastising the client and defending the physician is likely to inhibit communication about the client's needs and feelings. Making assumptions can also interfere with communication, especially if the assumption is incorrect.


 CN: Psychosocial adaptation;  
CL: Synthesize

**27. 2.** When the client has hostile outbursts, it is best for the nurse to help her express her feelings. This serves as a release valve for the client. Offering positive reinforcement for cooperation does not help the client express herself appropriately. Continuing with assigned tasks ignores the client's feelings and may lead to further escalation. Encouraging the client to direct anger to the staff


is inappropriate. The client needs to express her feelings appropriately.

 CN: Psychosocial adaptation;  
CL: Synthesize


**28. 3.** Preoperative visits and talks with others who have made successful adjustments to colostomies are helpful and tend to make the client less fearful of the operation and its consequences. Knowing about resources in the community will be helpful as the client approaches discharge. Supporting the physician is less important than supporting the client and giving him information. The client will have a change in body image, with disfigurement due to the creation of a colostomy. However, the client should be able to lead a full life.

 CN: Psychosocial adaptation; CL: Apply


**29. 3.** *Hopelessness* is the least appropriate nursing diagnosis because the client projects an image of a person who is planning for the future and is usually in charge and productive. *Ineffective coping* is an appropriate diagnosis because the client is rushing to resume her normal activities. *Deficient knowledge* is an appropriate diagnosis because the client indicates a lack of awareness about the need for relaxation. *Anxiety* is an appropriate diagnosis because the client is demonstrating impatience and an inability to relax.

 CN: Psychosocial adaptation;  
CL: Analyze

**30. 2.** The nurse must present reality to the client about his condition to help decrease his denial about his physical status. By stating the name of the condition and talking about what it means, the nurse provides the client with information and conveys concerns about him and a willingness to help him understand his illness. It may not be true that the client would be made more upset by the call; the news might be good. However, this statement does not provide the client with the reality of his condition. Telling the client that he really doesn't care or asking the client if he realizes that he has a life-threatening condition is belittling and may make the client defensive.

 CN: Psychosocial adaptation;  
CL: Synthesize


**31. 1.** Leaving the hospital and immediately flying to a meeting indicates poor judgment by the client and little understanding of what she needs to change regarding her lifestyle. The other statements show that the client understands some of the changes she needs to make to decrease her stress and lead a more healthy lifestyle.

 CN: Psychosocial adaptation;  
CL: Evaluate


**32. 1, 3, 5.** Suicide is a risk with chronic illnesses. The husband needs validation of his feelings and support as well as suggestions for helping his wife with her concerns. Telling him to be strong and optimistic ignores the client's needs. It is false to assume that the client will no longer be suicidal when the lupus is under control.

 CN: Psychosocial adaptation;  
CL: Synthesize

**33. 4.** The nurse's best response is one that directly expresses the nurse's observations to the client and offers the client the opportunity to talk about his feelings or concerns to decrease somatization (the need to express feelings through physical symptoms). Leaving, offering to provide pain medication, and stating that anger does not bother the nurse ignore the client's needs.

 CN: Psychosocial adaptation;  
CL: Synthesize

**34. 4.** Though ulcerative colitis and OCD have some features in common, and stress can make both illnesses worse, there is no definitive cause-effect relationship between ulcerative colitis and OCD. Therefore, the only appropriate nursing response would be to acknowledge the effect of stress on both illnesses and indicate there is no proof that either illness causes the other.


 CN: Physiological adaptation;  
CL: Synthesize

**35. 4.** This type of behavior illustrates *emotional lability*, which is a readily changeable or unstable emotional affect. *Neologism* is using a word when it can have two or more meanings, or a play on words. *Confabulation* involves replacing memory loss by fantasy to hide confusion; it is unconscious behavior. *Flight of ideas* refers to a rapid succession of verbal expressions that jump from one topic to another and are only superficially related.

 CN: Psychosocial adaptation; CL: Analyze

### The Client in Crisis

**36. 3.** Employers are required to have a Workplace Violence Policy that outlines procedures related to this issue. Filing a police report may or may not be appropriate after the procedures of the policy are completed. Having the client only come back to EAP if a promotion is denied is an inappropriate suggestion. Confronting the boss with the client is only needed if other steps of the procedure are not effective.

 CN: Psychosocial adaptation;  
CL: Synthesize

**37.**


1. The client's reaction to the event, including any suicidal thoughts.

4. The effect of the event on other aspects of the client's life.


2. The client's perceptions of her current skills for coping with the event.

3. The availability of the client's personal support systems.


The nurse should first determine the client's reactions to the rape, especially if she has been suicidal, and then the nurse can assess the full effect of the rape on the client's functioning and life; these are crucial in determining the need for hospitalization for safety and security. Assessing the client's view of the effectiveness of her coping skills and then the availability of her support systems will assist in planning referrals for counseling and other services.

 CN: Psychosocial adaptation;  
CL: Synthesize

**38. 3.** Before any interventions can occur, knowing whether the client is pregnant is crucial in formulating a plan of care. Asking the client about what things she had thought about doing, giving the client some ideas about what to expect next, and questioning the client about her feelings and possible parental reactions would be appropriate after it is determined that the client is pregnant.


 CN: Psychosocial adaptation;  
CL: Synthesize

**39. 2.** Because of the client's potential pregnancy, the nurse needs to determine exactly what the client means by the term "hooking up" by asking the client to describe what she has been doing in sexual encounters with her boyfriend. Asking the client if she means sexual intercourse or telling the client that they need to talk about sexual intercourse makes an assumption that may or may not be appropriate. The nurse needs to determine exactly what the client means by the terms used. Repeating the client's statement does not elicit the necessary information to interpret the client's statement. Additionally, this type of response assumes an understanding of what the client has said.


 CN: Psychosocial adaptation;  
CL: Synthesize

**40. 4.** Because people in an emotional crisis find it difficult to focus their thinking, the goal is to return the client to noncrisis functioning. Pointing


out and decreasing the client's level of anxiety is the first step in attaining this goal. Telling an obviously distressed person not to worry is ineffective because it ignores the client's distress and concerns. Although pregnancy is a normal event, and 40 years of age may not be too old for a pregnancy, these responses also ignore the client's distress and feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**41. 1.** Telephoning the crisis shelter indicates that the boys are alarmed but are reluctant to talk with their parents. The boys may fear that their parents will assume that they have been sniffing glue and punish them. The nurse should focus on helping the boys talk with their parents. Although sniffing glue is dangerous and potentially lethal, it is not illegal. To prove that the observations are incorrect requires an intervention beginning with the boys' parents. Sniffing glue is included in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revised, as inhalant abuse. It is not a minor form of substance abuse.

 CN: Psychosocial adaptation;  
CL: Synthesize


**42 1.** The crisis worker needs to use active focusing techniques to determine the crisis-precipitating event or the immediate problem. Asking the caller, "Why are you calling today?" or "What is the immediate problem?" will assist the caller to focus on the specific need or event. Telling the client to make an appointment is inappropriate because the problem might be life-threatening. Telling the caller to go to the nearest emergency room is precipitous and may be unnecessary. Asking to speak to someone else in the home may be futile because the caller might be alone. This action also ignores the caller and his or her feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**43. 3.** The concern that someone may call the crisis hotline every day for a year indicates that further understanding about crisis and crisis intervention is needed. A crisis situation is time-limited, typically resolving in 4 to 6 weeks if handled effectively. If a person calls the line daily for a year, that person has not been properly dealt with or is probably in a highly disorganized state requiring an alternative intervention. The nurse needs to further review and clarify the material presented. Callers are typically in pain, overwhelmed, and exhausted when they call. A crisis can help an individual cope better in the future if he learns to handle the situation.

 CN: Psychosocial adaptation;  
CL: Evaluate

**44. 4.** *Risk for self-directed violence* is the priority nursing diagnosis for a client who has attempted or verbalizes the intent to harm herself. Although the client is depressed, feeling hopeless and powerless, and is grieving, these are not the priority concern at this time.

 CN: Psychosocial adaptation;  
CL: Analyze


**45. 2, 3, 4, 5, 6.** Controlling self-destructive behaviors is a priority, but developing emotion management skills and processing emotions and memories are also important. Assessing for injuries, pregnancy, STD's and drugs in her system is important due to the fact that most cults foster sex and pregnancy in young teens and often use drugs to achieve compliance from the girls. It is not appropriate to ask the client to share her experiences in a group of teens. It could be more damaging to the client unless the other teens are also trauma/torture survivors.

 CN: Psychosocial adaptation;  
CL: Synthesize


**46. 2.** Generally, 4 to 6 weeks is viewed as the length of time a client can tolerate the severe level of disturbance of a true crisis. In the first week or two, the client usually is still trying to use normal coping skills and support systems. After 6 weeks of continuous crisis, a client is probably becoming so physically and emotionally drained that he has sought or has been brought by others for medical or psychiatric care.

 CN: Psychosocial adaptation; CL: Apply

**47. 1.** The initial goal in crisis intervention is helping the client regain emotional security and equilibrium. Resolution of the underlying emotional problems, development of insight and personal growth, and formulation of more effective support systems are goals to address as the crisis subsides.


 CN: Psychosocial adaptation;  
CL: Apply

**48. 3.** Learning new coping skills is the major factor necessary for higher functioning. Better coping is likely to lead to regaining support systems, giving up dysfunctional coping, and awareness of how to prevent future crises.


 CN: Psychosocial adaptation;  
CL: Apply

**49. 3.** The risk of suicide can persist for 2 to 3 months even after a crisis has abated. Therefore, it is important for the client to be able to verbalize information about appropriate support persons and community resources and to have this information


readily available. Although the client may state that she is ready to be discharged, this is not the most reliable indicator. A divorce lawyer may not be appropriate at this point. At 3 days after a suicide attempt, emotional stability is not likely.

 CN: Psychosocial adaptation;  
CL: Evaluate


**50. 4.** The statement about joining the son if he dies indicates potential for self-harm and subsequent suicide, always a risk during crisis. Although the father may be charged with reckless driving, this is not an indication for a psychiatric consultation. Although the son's mother may be extremely upset and angry about the event, this statement is more likely an overstatement, not a real risk. The statement about not seeing the son run behind the car illustrates the father's attempts at trying to process the situation.

 CN: Psychosocial adaptation;  
CL: Evaluate

**51. 1.** Passive suicidal thoughts, such as a wish to die or giving up on self-care, can be as much of a risk as active suicidal ideation (the idea of killing one's self directly), especially for older clients because they commonly lack the means, energy, and motivation for an active suicide attempt. Seeing the grandson and grandmother together may help later. Not talking to the grandson and experiencing altered role performance may be real issues, but these are not as critical as the risk of indirect (passive) suicide.

 CN: Psychosocial adaptation;  
CL: Analyze

**52. 2.** The threat toward the ex-boyfriend is the most immediate concern now, as the client turns her anger toward him instead of herself. Although *Situational low self-esteem*, *Risk for suicide*, and *Risk prone health behavior* are accurate, these nursing diagnoses are less of a concern at this time.


 CN: Psychosocial adaptation;  
CL: Analyze

**53. 3.** Letting the client express his feelings (emotion management) is essential before trying to problem solve about the situation or deciding what kind of referral is appropriate. A referral for counseling, assessment of the client's support system, and unemployment assistance may be appropriate after the client's anxiety is reduced.


 CN: Psychosocial adaptation; CL: Apply

**54. 2.** During a crisis, support persons demonstrate preparedness to help the client by verbalizing the emergency resources available and knowing when to use them. Follow-up medical care may be


helpful as the crisis subsides. The coping strategies used by the support persons may or may not be relevant to the client's needs and situation. Long-term solutions and advice may or may not be appropriate. The focus needs to be on the client's immediate needs and situation.

 CN: Psychosocial adaptation;  
CL: Analyze

**55. 1.** The nurse needs to focus on the client and address her feelings. Talking about her feelings helps to decrease the risk of self-harm. Doing so takes precedence over questions about the husband's estate, the cause of death, and her children's support.

 CN: Psychosocial adaptation;  
CL: Synthesize

**56. 1, 2, 3, 4, 5.** All of the options are correct and in an appropriate sequence of actions except for Option 6. The flyover of Air Force One over New York City is likely to trigger vivid memories and emotions in those living near the city related to the tragedy of the Twin Towers on 9/11/01. The severity of the flashbacks will vary in degree, just as they did after the original event. It is not appropriate to call the government to ask for an apology.

 CN: Psychosocial adaptation;  
CL: Synthesize

### The Client with Problems Expressing Anger

**57. 3.** It is unlikely that the physician would imply that the client should be more aggressive. Denial of anger with passive, unassertive behavior and the aggressive expression of anger are dysfunctional behavior patterns. Gender-based stereotypes are not conducive to mental health, and deeming assertive behavior in women as culturally unacceptable interferes with the goal of developing assertiveness skills. Group acceptance should not be based on whether a client is demonstrating assertive or aggressive behavior.

 CN: Psychosocial adaptation; CL: Apply

**58. 1, 2, 3, 5.** Dealing with anger, stress, and anxiety, identifying resources and support groups, and increasing a sense of safety and security are appropriate interventions at this time. However, recommending an antiwar advocacy group may or may not be appropriate, even much later in the client's recovery.

 CN: Psychosocial adaptation;  
CL: Synthesize

**59.**


2. Helping the client identify triggers for his anger.

1. Assisting the client to recognize the early cues that he is angry.


4. Identifying alternate ways to express his anger.

3. Practicing with the client appropriate ways to express his anger.


Angry clients may not realize what makes them angry and the cues that their behavior is becoming out of control. The nurse should first help the client identify what triggered the anger. Once the cause of the anger and cues to the loss of control are discovered, the nurse should assist the client in identifying safe and appropriate alternative expressions of anger and then practice those techniques prior to facing a real anger-producing situation.

 CN: Psychosocial adaptation;  
CL: Synthesize


**60. 4.** The nurse needs to acknowledge the client's feelings. In doing so, the nurse helps the group accept a new member. Focusing on "everyone" and telling the client not to worry ignores the client's fears. Having the other group members introduce themselves places the focus on the other clients in the group and does not address the client's fears. Implying that getting to know someone will reduce the fear is false reassurance.

 CN: Psychosocial adaptation;  
CL: Synthesize

**61. 3.** By requesting that the roommate respect his rights (asking the roommate to put the dirty clothes on the floor away after telling him that this bothers him), the client is asserting himself. Arriving late is commonly passive resistance and thus not an indicator that the client is becoming assertive. Asking the nurse to call is dependent behavior. Although asking the doctor is more assertive, the client is relying on the nurse's direction to do so.

 CN: Psychosocial adaptation;  
CL: Analyze

**62. 2.** Blood pressure, as well as respiratory rate and muscle tension, increase during anger because of the autonomic nervous system response to epinephrine secretion. Peristalsis also decreases.

 CN: Physiological adaptation;  
CL: Apply


**63. 3.** Fear of harm is a common response to anger in clients who lack coping skills and assertiveness. Decreased self-esteem is common because most clients are aware that they have difficulty in responding to anger effectively. Although anger may provide an initial feeling of strength and invulnerability, this is rarely a sustained response. Powerlessness more commonly leads to anger, rather than resulting from it.

 CN: Psychosocial adaptation; CL: Apply

**64. 4.** When given intramuscularly, haloperidol is considered most restrictive because it is intrusive and a client usually does not receive the drug voluntarily. Oral haloperidol is considered less restrictive because the client usually accepts the pill voluntarily. Tension reduction strategies and voluntary seclusion are considered less restrictive because they are not intrusive and the client usually consents to their use.

 CN: Psychosocial adaptation; CL: Apply

**65. 2.** Asking the staff for assistance is appropriate when the client demonstrates behaviors that involve the direct threat of violence. Holding a stick and telling the nurse to move is the most direct threat of violence. Swearing and pounding on a table may be disturbing, but these actions are less of a threat. Coming out of his room may indicate noncompliance with directions. However, further assessment is needed to determine whether this behavior was a direct threat of violence.

 CN: Psychosocial adaptation;  
CL: Analyze

**66.**

3. "Remove yourself to a quiet environment."

4. "Tell trusted people that you are becoming upset."

1. "Take your oral lorazepam (Ativan)."

2. "Take your oral haloperidol (Halodol)."

Since external stimuli can greatly contribute to agitation, the nurse should teach the client that the first step is to go to a quiet area, then enlist the help of others, and finally take medication. Taking the lorazepam first of the two medications would help decrease anxiety quickly, thus diminishing agitation. If the lorazepam is not successful, the client could take the oral haloperidol to help clear the client's thoughts and decrease agitation.


 CN: Health promotion and maintenance;  
CL: Synthesize



**67. 3.** The client who is about to lose control is experiencing a high degree of anxiety or agitation, which alters the client's ability to perceive reality. Initially, the client may feel threatened by the presence of others. A client who is out of control is not thinking about having an audience. Although the nurse with the client who is about to lose control is generally the one giving directions, this is not a rationale for staying at a distance. When seeing extra staff, the client may or may not be able to gain self-control.

 CN: Psychosocial adaptation; CL: Apply


**68. 1.** When using seclusion, the safety of the client is paramount. Therefore, staff must be able to see the client in seclusion at all times, such as through a security window in the door or with a room camera. Although outside access for dimming the lights to decrease stimuli may be appropriate, it is not critical for the client's safety. Having one staff member stay in a room alone with a potentially violent client is unsafe. A doctor's order for seclusion can be obtained before or after it is initiated.

 CN: Psychosocial adaptation;  
CL: Synthesize

**69. 3.** A full-length restraint blanket is added when the client is at risk for injury from fighting the restraints. The increased degree of restriction is justified only when the risk of client injury increases. Feeling more secure is not a sufficient cause for using a more restrictive measure. Client complaints that restraints are tight and uncomfortable require the nurse to assess the situation and adjust the restraints if necessary to ensure adequate circulation. Four-way restraints already provide adequate protection for the staff.


 CN: Psychosocial adaptation; CL: Apply

**70. 1.** Safety of the client and staff is the utmost priority. Therefore, the client must be monitored closely and frequently, such as every 15 minutes, to ensure that the client is safe and free from injury. Assisting with nutrition and elimination, performing range-of-motion exercises on each limb, and changing the client's position every 2 hours are important after the safety of the client and staff is ensured by close, frequent monitoring.

 CN: Psychosocial adaptation;  
CL: Synthesize


**71. 4.** The long-term goal of the debriefing after restraining a client is to improve aggression management procedures so that prevention of aggression improves and the frequency of restraint use decreases. Providing feedback and comparing perceptions are single aspects that would eventually lead to the ultimate goal of improving

aggression management procedures. When a client can be released from restraints is not immediately predictable.


 CN: Psychosocial adaptation;  
CL: Synthesize

## The Client with Interpersonal Violence


**72. 4.** Verbalizing feelings, especially feelings of anger, in an appropriate manner is an adaptive method of coping that reduces the chance that the client will act out these feelings toward others. The client's ability to verbalize her feelings indicates a change in behavior, a crucial indicator of goal achievement. Although acknowledging feelings of anger and describing situations that precipitate angry feelings are important in helping the client reach her goal, they are not appropriate indicators that she has changed her behavior. Asking the client to list how she has handled anger in the past is helpful if the nurse discusses coping methods with the client. However, based on this client's history, this would not be helpful because the nurse and client are already aware of the client's aggression toward others.

 CN: Psychosocial adaptation;  
CL: Evaluate

**73. 3.** The nurse must clearly address behavioral expectations, such as telling the client that hitting is unacceptable and also provide alternatives for the client, such as letting staff members know when he begins to feel angry. Making others responsible for the client's behavior or isolating the client in his room is inappropriate because it does not include the client in managing his behavior. Although medication may be helpful, this action does not give the client responsibility for his behavior and is not warranted at this time.

 CN: Psychosocial adaptation;  
CL: Synthesize


**74. 4.** The client is in the crisis phase of the assault cycle. Therefore, the nurse must act immediately, using restraints and an intramuscular tranquilizer to prevent injury to others or further property damage. It is too late to ask the client to go to a quiet area to talk because the client's behavior is past the triggering phase. Giving the client an oral tranquilizer and preparing for a show of determination are nursing interventions used in the escalation phase. Processing the incident with the client and discussing alternative behaviors are interventions used in the post-crisis phase.

 CN: Psychosocial adaptation;  
CL: Synthesize


**75. 1, 3, 5.** Survivors of torture and ritual abuse typically have intense feelings, including mixed emotions about the abusers, anger, rage, and guilt. With self-destructive behavior, they need ways to handle these urges, such as dealing with ambivalent feelings, determining alternatives to self-destructive behaviors, and developing safe ways to deal with rage and guilt. Confrontation with the abusers is not necessarily appropriate. Filing criminal charges is not likely due to the statute of limitations.

 CN: Psychosocial adaptation;  
CL: Synthesize

**76. 1.** The nurse should respond to the husband's needs and concerns and should offer support. Protecting or defending the wife against his criticism ignores the husband's needs.

 CN: Psychosocial adaptation;  
CL: Synthesize


**77. 3.** It is important to know the client's reactions in order to plan appropriate interventions. Until the client's reactions are known, it is premature to suggest a job transfer, file a report to his boss' supervisor, or alert his coworkers.

 CN: Psychosocial adaptation;  
CL: Synthesize

**78. 2, 3, 4.** After the impact of a crime, the client's most important needs are for physical safety and emotional security. There is no indication that the client has a severe level of anxiety; therefore, lorazepam is not indicated. Asking her how she could have prevented the robbery implies that she could be at fault.


 CN: Psychosocial adaptation;  
CL: Synthesize

**79. 1, 2, 3, 5.** Receiving support from family, friends, other survivors, and community services is generally helpful after such events. Relaxation and participation in activities help manage stress reactions. Speaking out publicly may or may not be helpful later in the recovery process, but may actually hinder recovery in the early stages.


 CN: Psychosocial adaptation;  
CL: Synthesize

### Managing Care Quality and Safety

**80. 4.** When a client is committed involuntarily, the right to leave against medical advice is forfeited. All the other rights are preserved unless there is further court action or a case of imminent danger to self or others (hitting staff, cutting self).

 CN: Safety and infection control;  
CL: Apply

**81. 4.** The primary goal of an aggression management program is to prevent violence. This goal is evidenced by a reduction in the total number of restraint procedures used or needed. Although fewer client and staff injuries are important, these goals are secondary to prevention. Reduction in the number of complaints by clients' relatives is affected by more variables than just restraint procedures.

 CN: Psychosocial adaptation;  
CL: Evaluate

**82. 1, 2, 3, 4.** The crucial interventions involve safety and support. Asking for consent is a Health Information Portability and Accountability Act issue, not a safety issue, and is not essential to the discharge process.

 CN: Safety and infection control;  
CL: Synthesize

**83.**

1. Initiate suicide precautions and a no harm contract.

3. Offer empathy and support and be non-judgmental and honest with her.

4. Encourage safe verbalizations of her emotions, especially anger.

2. Ask the client if she wishes to contact her family while hospitalized.


Safety is a priority after the client stabbed herself. A survivor of trauma/torture needs empathy, support, honesty, and a nonjudgmental stance from the nurse. Then the client is more willing to learn safe ways to express feeling, especially anger. It will be the client's decision if she wants to contact her family and, if so, under what conditions. She would need extensive preparation before any contact with her family.

 CN: Safety and infection control;  
CL: Synthesize


**84. 4.** The 60-year-old woman is acting in a way that worsens her physical and mental condition because she does not want to be sick. The 8-year-old child is acting normally for someone his age who is unexpectedly hospitalized. The cooperation demonstrated by the client with lupus and the client who had a myocardial infarction indicates a level of acceptance of their illnesses and of their role as being ill.

 CN: Management of care; CL: Analyze

**85. 4.** The client is ready to be released from restraints when he shows signs of self-control, decreased anxiety and agitation, reality orientation, mood stabilization, increased attention span, and judgment. Adequate sedation, struggling less against restraints, and not swearing and yelling are not adequate signs of being calm and in control.

 CN: Psychosocial adaptation;  
CL: Evaluate

**86. 1.** Being injured by a client can result in emotional responses similar to those of other crime victims. A resignation after being injured is relatively rare. Legal action against the client is sometimes discussed but rarely initiated. Debriefing with the client may be inappropriate or unnecessary to resolve the situation.

 CN: Psychosocial adaptation;  
CL: Synthesize

TEST  
5

# Mental Health Problems of Children, Adolescents, and Families

- The Client Experiencing Abuse
- The Adolescent with an Eating Disorder
- Child and Adolescent Behavior Problems
- Managing Care Quality and Safety
- Answers, Rationales, and Test Taking Strategies

## The Client Experiencing Abuse

1. A married female client has been referred to the mental health center because she is depressed. The nurse notices bruises on her upper arms and asks about them. After denying any problems, the client starts to cry and says, “He didn’t really mean to hurt me, but I hate for the kids to see this. I’m so worried about them.” Which of the following is the most crucial information for the nurse to determine?

- 1. The type and extent of abuse occurring in the family.
- 2. The potential of immediate danger to the client and her children.
- 3. The resources available to the client.
- 4. Whether the client wants to be separated from her husband.

2. A client with suspected abuse describes her husband as a good man who works hard and provides well for his family. She does not work outside the home and states that she is proud to be a wife and mother just like her own mother. The nurse interprets the family pattern described by the client as best illustrating which of the following as characteristic of abusive families?

- 1. Tight, impermeable boundaries.
- 2. Unbalanced power ratio.
- 3. Role stereotyping.
- 4. Dysfunctional feeling tone.

3. When planning the care for a client who is being abused, which of the following measures is **most** important to include?

- 1. Being compassionate and empathetic.
- 2. Teaching the client about abuse and the cycle of violence.
- 3. Explaining to the client her personal and legal rights.
- 4. Helping the client develop a safety plan.

4. A nurse is assessing a client who is being abused. The nurse should assess the client for which characteristic? Select all that apply.

- 1. Assertiveness.
- 2. Self-blame.
- 3. Alcohol abuse.
- 4. Suicidal thoughts.
- 5. Guilt.

5. During the third session with the nurse, a client who is being abused states, “I don’t know what to do anymore. He doesn’t want me to go anywhere while he’s at work, not even to visit my friends.” Which nursing diagnosis should the nurse formulate regarding this information?

- 1. *Risk for other-directed violence* related to an abusive husband, as evidenced by the victim’s statement of being battered.
- 2. *Situational low self-esteem* related to victimization, as evidenced by not being able to leave the house.
- 3. *Powerlessness* related to control by husband, as evidenced by the inability to make decisions.
- 4. *Ineffective coping* related to victimization, as evidenced by crying.

6. After months of counseling, a client abused by her husband tells the nurse that she has decided to stop treatment. There has been no abuse during this time, and she feels better able to cope with the needs of her husband and children. In discussing this decision with the client, the nurse should:

- 1. Tell the client that this is a bad decision that she will regret in the future.
- 2. Find out more about the client’s rationale for her decision to stop treatment.
- 3. Warn the client that abuse commonly stops when one partner is in treatment, only to begin again later.
- 4. Remind the client of her duty to protect her children by continuing treatment.

**7.** A third-grade child is referred to the mental health clinic by the school nurse because he is fearful, anxious, and socially isolated. After meeting with the client, the nurse talks with his mother, who says, "It's that school nurse again. She's done nothing but try to make trouble for our family since my son started school. And now you're in on it." The nurse should respond by saying:

- 1. "The school nurse is concerned about your son and is only doing her job."
- 2. "We see a number of children who go to your son's school. He isn't the only one."
- 3. "You sound pretty angry with the school nurse. Tell me what has happened."
- 4. "Let me tell you why your son was referred, and then you can tell me about your concerns."

**8.** The mother of a school-aged child tells the nurse that, "For most of the past year my husband was unemployed and I worked a second job. Twice during the year I spanked my son repeatedly when he refused to obey. It has not happened again. Our family is back to normal." After assessing the family, the nurse decides that the child is still at risk for abuse. Which of the following observations best supports this conclusion?

- 1. The parents say they are taking away privileges when their son refuses to obey.
- 2. The child has talked about family activities with the nurse.
- 3. The parent's are less negative toward the nurse.
- 4. The child wears long sleeve shirts and long pants, even in warm weather.

**9.** When caring for a client who was a victim of a crime, the nurse is aware that recovery from any crime can be a long and difficult process depending on the meaning it has for the client. Which of the following should the nurse establish as a victim's ultimate goal in reconstructing his or her life?

- 1. Getting through the shock and confusion.
- 2. Carrying out home and work routines.
- 3. Resolving grief over any losses.
- 4. Regaining a sense of security and safety.

**10.** A client tells the nurse that she has been raped but has not reported it to the police. After determining whether the client was injured, whether it is still possible to collect evidence, and whether to file a report, the nurse's next priority is to offer which of the following to the client?

- 1. Legal assistance.
- 2. Crisis intervention.
- 3. A rape support group.
- 4. Medication for disturbed sleep.

**11.** In working with a rape victim, which of the following is **most** important?

- 1. Continuing to encourage the client to report the rape to the legal authorities.
- 2. Recommending that the client resume sexual relations with her partner as soon as possible.
- 3. Periodically reminding the client that she did not deserve and did not cause the rape.
- 4. Telling the client that the rapist will eventually be caught, put on trial, and jailed.

**12.** In the process of dealing with the intense feelings about being raped, victims commonly verbalize that they were afraid they would be killed during the rape and wish that they had been. The nurse should decide that further counseling is needed if the client voices which of the following?

- 1. "I didn't fight him, but I guess I did the right thing because I'm alive."
- 2. "Suicide would be an easy escape from all this pain, but I couldn't do it to myself."
- 3. "I wish they gave the death penalty to all rapists and other sexual predators."
- 4. "I get so angry at times that I have to have a couple of drinks before I sleep."

**13.** One of the myths about sexual abuse of young children is that it usually involves physically violent acts. Which of the following behaviors is more likely to be used by the abusers?

- 1. Tying the child down.
- 2. Bribery with money.
- 3. Coercion as a result of the trusting relationship.
- 4. Asking for the child's consent for sex.

**14.** A preadolescent child is suspected of being sexually abused because he demonstrates the self-destructive behaviors of self-mutilation and attempted suicide. Which common behavior should the nurse also expect to assess?

- 1. Inability to play.
- 2. Truancy and running away.
- 3. Head banging.
- 4. Over-control of anger.

**15.** Adolescents and adults who were sexually abused as children commonly mutilate themselves. The nurse interprets this behavior as:

- 1. The need to make themselves less sexually attractive.
- 2. An alternative to bingeing and purging.
- 3. Use of physical pain to avoid dealing with emotional pain.
- 4. An alternative to getting high on drugs.

**16.** A young child who has been sexually abused has difficulty putting feelings into words. Which of the following should the nurse employ with the child?

- 1. Engaging in play therapy.
- 2. Role-playing.
- 3. Giving the child's drawings to the abuser.
- 4. Reporting the abuse to a prosecutor.

**17.** When working with a group of adult survivors of childhood sexual abuse, dealing with anger and rage is a major focus. Which strategy should the nurse expect to be successful? Select all that apply.

- 1. Directly confronting the abuser.
- 2. Using a foam bat while symbolically confronting the abuser.
- 3. Keeping a journal of memories and feelings.
- 4. Writing letters to the abusers that are not sent.
- 5. Writing letters to the adults who did not protect them that are not sent.

**18.** After a client reveals a history of childhood sexual abuse, the nurse should ask which of the following questions **first**?

- 1. "What other forms of abuse did you experience?"
- 2. "How long did the abuse go on?"
- 3. "Was there a time when you did not remember the abuse?"
- 4. "Does your abuser still have contact with young children?"

**19.** Which parental characteristic is **least** likely to be a risk factor for child abuse?

- 1. Low self-esteem.
- 2. History of substance abuse.
- 3. Inadequate knowledge of normal growth and development patterns.
- 4. Being a member of a large family.

**20.** When obtaining a nursing history from parents who are suspected of abusing their child, which of the following characteristics about the parents should the nurse particularly assess?

- 1. Attentiveness to the child's needs.
- 2. Self-blame for the injury to the child.
- 3. Ability to relate the child's developmental achievements.
- 4. Difficulty with controlling aggression.

**21.** A 3-year-old child with a history of being abused has blood drawn. The child lies very still and makes no sound during the procedure. Which of the following comments by the nurse would be **most** appropriate?

- 1. "It's okay to cry when something hurts."
- 2. "That really didn't hurt, did it?"
- 3. "We're mean to hurt you that way, aren't we?"
- 4. "You were very good not to cry with the needle."

**22.** While interviewing a 3-year-old girl who has been sexually abused about the event, which approach would be **most** effective?

- 1. Describe what happened during the abusive act.
- 2. Draw a picture and explain what it means.
- 3. "Play out" the event using anatomically correct dolls.
- 4. Name the perpetrator.

**23.** Which of the following observations by the nurse should suggest that a 15-month-old toddler has been abused?

- 1. The child appears happy when personnel work with him.
- 2. The child plays alongside others contentedly.
- 3. The child is underdeveloped for his age.
- 4. The child sucks his thumb.

**24.** When planning interventions for parents who are abusive, the nurse should incorporate knowledge of which factor as a common parental indicator?

- 1. Lower socioeconomic group.
- 2. Unemployment.
- 3. Low self-esteem.
- 4. Loss of emotional family attachments.

### The Adolescent Client with Eating Disorders

**25.** The nurse is planning an eating disorder protocol for hospitalized clients experiencing bulimia and anorexia. Which elements should be included in the protocol? Select all that apply.

- 1. Clients must eat within view of a staff member.
- 2. Clients are not told their weight and cannot see their weight while being weighed.
- 3. Clients are not allowed to discuss food or eating in groups or informal conversation with peers.
- 4. Clients must rest within view of a staff member and not go to the bathroom for one half hour to an hour after eating.
- 5. Clients cannot participate in any groups after admission until they gain 1 lb.

**26.** A hospitalized adolescent diagnosed with anorexia nervosa refuses to comply with her daily before-breakfast weigh-in. She states that she just drank a glass of water, which she feels will unfairly increase her weight. What is the nurse's **best** response to the client?

- 1. "You are here to gain weight so that will work in your favor."
- 2. "Don't drink or eat for 2 hours and then I'll weigh you."
- 3. "You must weigh in every day at this time. Please step on the scale."
- 4. "If you don't get on the scale, I will be forced to call your doctor."

**27.** The nurse discovers that an adolescent client with anorexia nervosa is taking diet pills rather than complying with the diet. What should the nurse do **first**?

- 1. Explain to the client how diet pills can jeopardize health.
- 2. Listen to the client about fears of losing control of eating while being treated.
- 3. Talk with the client about how weight loss and emaciation worry the health care providers.
- 4. Inquire about the client's family's worries concerning the client's physical and emotional health.

**28.** When teaching a group of adolescents about anorexia nervosa, the nurse should describe this disorder as being characterized by which of the following?

- 1. Excessive fear of becoming obese, near-normal weight, and a self-critical body image.
- 2. Obsession with the weight of others, chronic dieting, and an altered body image.
- 3. Extreme concern about dieting, calorie-counting, and an unrealistic body image.
- 4. Intense fear of becoming obese, emaciation, and a disturbed body image.

**29.** When developing a teaching plan for a high school health class about anorexia nervosa, which of the following should the nurse include as the primary group affected by this disease?

- 1. Women, age at onset between 12 and 20 years.
- 2. Men, onset during the college years.
- 3. Women, onset typically after 30 years.
- 4. Men, onset after 20 years.

**30.** The parents of a newly diagnosed 15-year-old with anorexia nervosa are meeting with the nurse during the admission process. Which of the following remarks by the parents should the nurse interpret as typical for a client with anorexia nervosa?

- 1. "We've given her everything and look how she repays us!"
- 2. "She's had behavior problems for the past year both at home and at school."
- 3. "She's been a model child. We've never had any problems with her."
- 4. "We have five children, all normal kids with some problems at times."

**31.** Which of the following nursing diagnoses should the nurse formulate as the priority for a client who is admitted to the mental health unit with a diagnosis of anorexia nervosa and who is 5 feet 4 inches tall and weighs only 82 lb?

- 1. *Situational low self-esteem* related to feelings of inadequacy and loss of control.
- 2. *Disturbed body image* related to self-view of being overweight.
- 3. *Interrupted family processes* related to over-protectiveness and avoidance of conflict.
- 4. *Imbalanced nutrition: Less than body requirements* related to severe restriction of intake.

**32.** A young adult female client and her roommate go the emergency department due to gastrointestinal problems. The client reveals that she attends college and works at a coffee shop each evening. A diet history indicates that the client has unhealthy eating habits, commonly eating large amounts of carbohydrates and junk food with few fruits and vegetables. "Her stomach is upset a lot," the roommate says. She further reports that the client is "in the bathroom all the time." The nurse should refer the client to:

- 1. A mental health clinic and physician.
- 2. A weight loss program.
- 3. An overeating support group.
- 4. The client's family physician.

**33.** A nurse is working with a client with bulimia. Which of the following goals should be included in the care plan? Select all that apply.

- 1. The client will maintain normal weight.
- 2. The client will comply with medication therapy.
- 3. The client will achieve a positive self-concept.
- 4. The client will acknowledge the disorder.
- 5. The client will never have the desire to purge again.

**34.** A nurse works with a client diagnosed with bulimia. What is an appropriate long-term client goal for this client?

- 1. Eating meals at home without bingeing or purging.
- 2. Being able to eat out without bingeing or purging.
- 3. Managing stresses in life without bingeing or purging.
- 4. Being able to attend college in another state without bingeing or purging.

**35.** While coaching a youth soccer team, the nurse has observed one of the teammates bingeing and purging on multiple occasions. The nurse asks the girl's mother to stay after practice and talk privately. Which of the following ways is best for the nurse to begin the conversation?

- 1. "Thank you for letting your daughter play on the team. She's a very good player and is also pleasant and easy to coach."
- 2. "I have some very bad news for you. Your daughter has a serious problem that is diagnosed as an eating disorder."
- 3. "I am a nurse. I have seen your daughter doing things that are considered to be part of an eating disorder."
- 4. "Let me get right to the point. Your daughter is very sick and needs to see a mental health therapist right away."

**36.** A client newly diagnosed with bulimia is attending the nurse-led group at the mental health center. She tells the group that she came only because her husband said he would divorce her if she didn't get help. Which of the following responses by the nurse is appropriate?

- 1. "You sound angry with your husband. Is that correct?"
- 2. "You will find that you like coming to group. These people are a lot of fun."
- 3. "Tell me more about why you are here and how you feel about that."
- 4. "Tell me something about what has caused you to be bulimic."

**37.** A client diagnosed with bulimia tells the nurse she only eats excessively when upset with her best friend, and then she vomits to avoid gaining a lot of weight. The nurse should next:

- 1. Schedule daily family therapy sessions.
- 2. Enroll client in a coping skills group.
- 3. Work with the client to limit her purging.
- 4. Have client take lorazepam (Ativan) 1 mg as needed whenever she feels the urge to binge.

**38.** During the initial interview, a client with a compulsive eating disorder remarks, "I can't stand myself and the way I look." Which of the following statements by the nurse is **most** therapeutic?

- 1. "Everyone who has the same problem feels like you do."
- 2. "I don't think you look bad at all."
- 3. "Don't worry, you'll soon be back in shape."
- 4. "Tell me more about your feelings."

**39.** A community health nurse working with a group of 5<sup>th</sup> grade girls is planning a primary prevention to help the girls avoid developing eating disorders during their teen years. The nurse should focus on which of the following?

- 1. Working with the school nurse to closely monitor the girls' weight during middle school.
- 2. Limiting the girls access to media images of very thin models and celebrities.
- 3. Telling the girls' parents to monitor their daughter's weight and media access.
- 4. Helping the girls accept and appreciate their bodies and feel good about themselves.

## Children and Adolescents with Behavior Problems

**40.** A 17-year-old client who has been taking an antidepressant for 6 weeks has returned to the clinic for a medication check. When the nurse talks with the client and her mother, the mother reports that she has to remind the client to take her antidepressant every day. The client says, "Yeah, I'm pretty bad about remembering to take my meds, but I never miss a dose because Mom always bugs me about taking it." Which of the following responses would be effective for the nurse to make to the client?

- 1. "It's a good thing your mom takes care of you by reminding you to take your meds."
- 2. "It seems there are some difficulties with being responsible for your medications that we need to address."
- 3. "You'll never be able to handle your medication administration at college next year if you're so dependent on her."
- 4. "I'm surprised your mother allows you to be so irresponsible."

**41.** The school nurse assesses a 10-year-old girl who excessively cleans and categorizes. Her parents report that she has always been orderly, but since her brother died of cancer 6 months ago, her cleaning and categorizing have escalated. In school, she reads instead of playing with other children. These behaviors are now interfering with homework and leisure activities. To bolster her self-esteem, the nurse should encourage the child to:

- 1. Be a library helper.
- 2. Organize a party for the class.
- 3. Be in charge of a group project with four peers.
- 4. Be captain of the kickball team.

**42.** A 13-year-old junior high school student has come to the school nurse, stating that her father has physically abused her for 3 years. Initially, the client accepted the abuse, thinking it was because her father had been laid off, but the abuse continued after he got a job 4 months ago. She fears that her mother will not believe her and her father will reject her if they discover she has revealed the abuse. The nurse should **first**:

- 1. Inform the mother in a face-to-face meeting without the girl present.
- 2. Call the father, confront him, and then call the police to have him arrested.
- 3. Meet with both parents together. Include the daughter in the meeting so she can speak for herself.
- 4. Report the alleged abuse to Child Protective Services that day, and then provide for the child's safety.



**43.** A 15-year-old is a heavy user of marijuana and alcohol. When the nurse confronts the client about his drug and alcohol use, he admits previous heavy use in order to feel more comfortable around peers and achieve social acceptance. He says he has been trying to stay clean since his parents found out and had him seek treatment. When the nurse develops a plan of care with the client, what should be the highest priority to help him maintain sobriety?

- 1. Peer recognition that does not involve substance use.
- 2. Support and guidance from his parents.
- 3. A strict no-drug policy at his high school.
- 4. The threat of legal charges if caught drinking or smoking marijuana.

**44.** A 17-year-old is admitted to a psychiatric day treatment program due to severe lower back pain since her mother's death 3 years ago. Medical examinations have not discovered a physical cause for her pain. She cares for her four younger siblings after school and on weekends because of her father's long work hours. Which pre-discharge statement indicates that treatment for her condition has been successful?

- 1. "I understand now why my father spends so much time away from home."
- 2. "My back pain is worse on weekends with more chores and homework."
- 3. "I don't want to talk about my family. It's my back that is hurting."
- 4. "I just need more rest and relaxation and then my back will feel fine."

**45.** When collaborating with the health care provider to develop a the plan of care for a child diagnosed with attention deficit hyperactivity disorder (ADHD), the treatment plan will likely include which of the following?

- 1. Antianxiety medications, such as buspirone (BuSpar), and home schooling.
- 2. Antidepressant medications, such as imipramine (Tofranil), and family therapy.
- 3. Anticonvulsant medications, such as carbamazepine (Tegretol), and monthly blood levels.
- 4. Psychostimulant medications, such as methylphenidate (Ritalin), and behavior modification.

**46.** The nurse meets with the mother of a child diagnosed with attention deficit hyperactivity disorder. The mother states, "I feel so guilty that he has this disease, like I did something wrong. I feel like I need to be with him constantly in order for him to get better. But still sometimes I feel like I'm going to lose control and hurt him." The nurse should suggest which of the following to the mother?

- 1. Arranging for respite care to watch her child and give herself a regular break.
- 2. Taking a job to allow herself to feel some success because her child won't ever improve.
- 3. Arranging to have coffee with friends daily as a way to begin a support group.
- 4. Considering foster care if she feels that she can't handle her child's problems.

**47.** The nurse is with the parents of a 16-year-old boy who recently attempted suicide. The nurse cautions the parents to be especially alert for which of the following in their son?

- 1. Expression of a desire to date.
- 2. Decision to try out for an extracurricular activity.
- 3. Giving away valued personal items.
- 4. Desire to spend more time with friends.

**48.** The nurse is assessing a 7-year-old boy with Tourette syndrome. Which of the following is a priority for the nurse to assess?

- 1. Multiple motor and verbal tics.
- 2. Primarily motor tics.
- 3. Isolated verbal tics.
- 4. Alternating simple and complex motor tics.

**49.** When comparing the signs and symptoms of depression found in children with those found in adults, which of the following should the nurse expect?

- 1. Adults commonly display sad behaviors, while children have more somatic complaints and possible acting-out behaviors.
- 2. Adults have more problems performing in the work setting than children have in performing in the school setting.
- 3. Adults typically will not be able to function at work and at home but children continue to succeed in school activities while depressed.
- 4. Adults usually have few major problems functioning with depression, while children usually cannot function at school or with tasks at home.

**50.** Assessment of suicidal risk in children and adolescents requires the nurse to know which of the following?

- 1. Children rarely commit suicide unless one of their parents has already committed suicide, especially in the past year.
- 2. The risk of suicide increases during adolescence, with those who have recently suffered a loss, abuse, or family discord being most at risk.
- 3. Children do have a suicidal risk that coincides with some significant event such as a recent gun purchase in the family.
- 4. Adolescents typically don't choose suicide unless they live in certain geographical regions of the United States, including the western states.

**51.** When counseling a 5-year-old girl who recently suffered the loss of her mother, which of the following statements reflects the typical understanding about death at this age?

- 1. "My mommy died last week, but I'm going to see her again."
- 2. "My daddy said mommy went to heaven and I'm glad Jesus took her there."
- 3. "My dog died and now we got another one."
- 4. "I think Mommy went to heaven and I'll get to see her someday when I die."

**52.** A child with Asperger's disorder is being referred to the mental health clinic along with his parents. To provide the best care for this family, the nurse makes a care plan based on the fact that this disorder differs from autism in which of the following areas?

- 1. Asperger's disorder, commonly diagnosed earlier than autism, is associated with fewer major problems in interpersonal interactions.
- 2. In Asperger's disorder, behavior commonly is similar to that of other children with autism but without the problems with school.
- 3. Asperger's disorder is recognized later than autism, and interpersonal interaction problems typically become more apparent when the child begins school.
- 4. There are significant problems with language development, as with autism, but there are no delays or difficulties with motor development.

**53.** The mother of a 14-year-old girl who is diagnosed with oppositional defiant disorder tells the nurse that she has read extensively on this disorder and does not believe the diagnosis is correct for her daughter. Which of the following responses by the nurse is appropriate?

- 1. "It sounds like you are very interested in your daughter. Let's focus on what is best for her."
- 2. "Tell me what you have found in your reading that is leading you to that conclusion."
- 3. "Your doctor has had many years of education and experience so you can believe he's right."
- 4. "That doesn't matter now because we just need to help her get better."

**54.** A 12-year-old girl has been diagnosed with oppositional defiant disorder. She is observed by the nurse on the unit kissing two of the male clients. Given the client's developmental level and diagnosis, the nurse decides to intervene with the client in which of the following ways? Select all that apply.

- 1. Discussing with the client when and where it is acceptable to kiss boys.
- 2. Reinforcing that kissing and touching other clients is not allowed.
- 3. Telling the client that her behavior will be reported to her psychiatrist.
- 4. Restricting the client to her room to work on an assignment about anger.
- 5. Showing the client a video about human reproduction.

**55.** At the admission interview, the father of a 4-year-old boy with attention deficit hyperactivity disorder (ADHD) says to the nurse, "I know that my wife or I must have caused this disease." Which of the following is the nurse's best response?

- 1. "ADHD is more common within families, but there is no evidence that problems with parenting cause this disorder."
- 2. "What do you think you might have done that could have led to causing this disorder to develop in your son?"
- 3. "Many parents feel this way, but I doubt there is anything that you did that caused ADHD to develop in your child."
- 4. "Let's not focus on the cause but rather on what needs to be done to help your son get better. I know that you and your wife are very interested in helping him to improve his behavior."

**56.** A member of a nurse-led group for depressed adolescents tells the group that she is not coming back because she is taking medication and no longer needs to talk about her problems. Which of the following responses by the nurse is **most** appropriate?

- 1. "I'm glad that you are taking your medication, but how can we know that you will continue to take it? After all, you haven't been on it for very long and you might decide to stop taking it."
- 2. "I think that it is important to let everyone respond to what you said, so let's go around the group and let everyone give their thoughts about what you have decided."
- 3. "The purpose of the group is to provide each of you with a place to discuss the problems of being a teenager with depression with others who also are experiencing a similar situation."
- 4. "You don't have to stay in the group if you don't want to, but if you choose to leave, then you won't be able to change your mind later and return to the group."

**57.** When assessing a 17-year-old male client with depression for suicide risk, which of the following questions is best?

- 1. "What movies about death have you watched lately?"
- 2. "Can you tell me what you think about suicide?"
- 3. "Has anyone in your family ever committed suicide?"
- 4. "Are you thinking about killing yourself?"

**58.** A teacher is talking to the school nurse about a child in her classroom who has a tic disorder. The teacher mentions that the boy frequently trips other children although no one has ever been hurt. The teacher then further states that she ignores him when that happens because it is part of his disorder. The nurse should tell the teacher?

- 1. "Tripping other children is not a tic, so you can respond to that as you would in any other child."
- 2. "I can't believe that you actually allow him to get away with that!"
- 3. "I think that is the best choice unless some parents of the other children start to complain about it."
- 4. "If no one else is getting hurt then it seems harmless and might prevent the development of a worse behavior."

**59.** A 15-year-old boy being successfully treated for Tourette's syndrome tells the nurse, "I'm not going to take this medication anymore. Anyone who is really my friend will accept me as I am tics and all!" The nurse should tell the client?

- 1. "You and your family came to the clinic for treatment, so you can terminate it whenever you wish."
- 2. "Won't your lack of medication cause more tics and make you be less attractive to girls?"
- 3. "Let's talk about what brought you into treatment and why you now want to stop taking medication."
- 4. "I think that is a very unwise decision, but you're entitled to do whatever you wish."

**60.** The nurse leading a group session for parents of children diagnosed with oppositional defiant disorder. The nurse should give which of the following recommendations for discipline?

- 1. Avoid limiting the child's use of the television and computer for punishment.
- 2. Be consistent with discipline while assisting with ways for the child to more positively express anger and frustration.
- 3. Use primarily positive reinforcement for good behavior while ignoring any demonstrated bad behavior.
- 4. Use time-out as the primary means of punishment for the child regardless of what the child has done.

**61.** A 15-year-old girl is sent to the school nurse with complaints of dizziness and nausea. While assessing the girl, who denies any health problems, the nurse smells alcohol on her breath. Which of the following responses by the nurse is **most** appropriate?

- 1. "Don't tell me that you have been drinking alcohol before you came to school this morning!"
- 2. "Why don't you tell me the real reason that you are feeling sick this morning?"
- 3. "Tell me everything that you have had to eat and drink yesterday and today."
- 4. "I know that high school is stressful, but drinking alcohol is not the best way to handle it."

**62.** Parents of a 7-year-old child newly diagnosed with attention deficit hyperactivity disorder (ADHD) ask the nurse whether their son will always have to take medication for this condition. The nurse should tell the parents:

- 1. "Yes, almost everyone with this disorder has to continue taking medication forever."
- 2. "Between one third and one half of children experiencing ADHD and taking medication will need to continue to take medication as adults."
- 3. "Most children with this disorder do not need to continue taking medications as adults."
- 4. "There is just a small percentage of adults with ADHD who can manage without medications."

**63.** A 9-year-old client with attention deficit hyperactivity disorder tells the nurse, “No one in my class likes me because they think I’m stupid. They’re right, I am stupid!” The nurse identifies which of the following nursing diagnoses as relevant for this client?

- 1. *Situational low self-esteem* related to client’s perception of how other’s view him.
- 2. *Ineffective coping* related to an inability to be objective about peers.
- 3. *Interrupted family processes (disabling)* related to the family’s difficulty in coping with the child.
- 4. *Anxiety* related to dislike of the client by his peers.

**64.** Which of the following should the nurse include in the teaching plan for the parents of a child who is receiving methylphenidate (Ritalin)?

- 1. Giving the medication at the same time every evening.
- 2. Having the child take two doses at the same time if the last dose was missed.
- 3. Giving the single-dose form of the medication early in the day.
- 4. Allowing concurrent use of any over-the-counter medications with this drug.

**65.** A 6-year-old female is brought to the school nurse for refusal to sit in class. She denies feeling sick but insists that her mother be called so she can go home. She is pacing and chewing on a fingernail. This has occurred daily since school began 4 weeks ago. She tells the nurse that she is afraid something bad is going to happen to her mother. The nurse should continue to gather data that indicates which of the following?

- 1. Obsessive-compulsive disorder.
- 2. Major depression.
- 3. Attention deficit hyperactivity disorder.
- 4. Separation anxiety disorder.

**66.** A 7-year-old client is diagnosed with conduct disorder. After admission, the nurse identifies his problematic behaviors as cruelty to animals, stealing, truancy, aggression with peers, lying, and explosive angry outbursts resulting in destruction of property. The nurse is now talking with the client about his behavioral contract, which should include which crucial components? Select all that apply.

- 1. Taking prescribed medications.
- 2. Acceptable methods for expressing anger.
- 3. Consequences for unacceptable behaviors.
- 4. Rules for interacting with staff and other clients.
- 5. Personal possessions allowed on the unit.

**67.** The nurse is meeting weekly with an adolescent recently diagnosed with depression to monitor progress with therapy and antidepressant medication. The nurse should be **most** concerned when the client reports which of the following?

- 1. An acquaintance hung herself 2 days ago.
- 2. She is experiencing intermittent headaches as a side-effect of taking the antidepressant.
- 3. She received a low score on her last history test.
- 4. Her younger brother has been starting fights with her for the last week.

### Managing Care Quality and Safety

**68.** Which of the following children should the nurse identify as being more at risk for an episode of major depression?

- 1. Michael, a 16-year-old, who has been struggling in school, making only Cs and Ds.
- 2. Lauren, a 13-year-old, who was upset over not being chosen as a cheerleader.
- 3. Cody, a 10-year-old, who has never liked school and basically has few friends.
- 4. Gretchen, a 14-year-old, who recently moved to a new school after her parents’ divorce.

**69.** A staff nurse on the mental health unit tells the nurse manager that kids with conduct disorders might as well be jailed because they all end up as adults with antisocial personality disorder anyway. What is the best reply by the nurse manager?

- 1. “You really sound burned out. Do you have a vacation coming up soon?”
- 2. “These children are more likely to have problems with depression and anxiety disorder as adults.”
- 3. “You sound really frustrated. Let’s talk about the meaning of their behavior.”
- 4. “My experience hasn’t been that negative. Let’s see what the other staff members think; maybe I’m wrong.”

**70.** Which of the following children should the nurse assess as demonstrating behaviors that need further evaluation?

- 1. Joey, age 2, who refuses to be toilet-trained and talks to himself.
- 2. Adrienne, age 6, who sucks her thumb when tired and has never spent the night with a friend.
- 3. Curt, age 10, who frequently tells his mother that he is going to run away whenever they argue.
- 4. Stephen, age 2, who is indifferent to other children and adults and is mute.

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

### The Client Experiencing Abuse

**1. 2.** The safety of the client and her children is the most immediate concern. If there is immediate danger, action must be taken to protect them. The other options can be discussed after the client's safety is assured.

🔑 CN: Psychosocial adaptation;  
CL: Analyze

**2. 3.** The traditional and rigid gender roles described by the client are examples of role stereotyping. Impermeable boundaries, unbalanced power ratio, and dysfunctional feeling tone are also common in abusive families.

🔑 CN: Psychosocial adaptation;  
CL: Analyze

**3. 4.** The client's safety, including the need to stay alive, is crucial. Therefore, helping the client develop a safety plan is most important to include in the plan of care to ensure the client's safety. Being empathetic, teaching about abuse, and explaining the person's rights are also important after safety is ensured.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**4. 2, 3, 4, 5.** The victim of abuse is usually compliant with the spouse and feels guilt, shame, and some responsibility for the battering. Self-blame, substance abuse, and suicidal thoughts and attempts are possible dysfunctional coping methods used by abuse victims. The victim of abuse is not likely to demonstrate assertiveness.

🔑 CN: Psychosocial adaptation;  
CL: Analyze

**5. 3.** Based on the client's statements, such as "I don't know what to do anymore," the data here best support the nursing diagnosis of *Powerlessness* related to control by husband, as evidenced by inability to make decisions. A nursing diagnosis of *Risk for other-directed violence* would be appropriate if the client had talked about being beaten up the previous

night. A nursing diagnosis of *Situational low self-esteem* would be appropriate if the client verbalized feelings of embarrassment in leaving the house and worthlessness. A nursing diagnosis of *Ineffective coping* would be appropriate if the client was crying or talked about crying herself to sleep at night.

🔑 CN: Psychosocial adaptation;  
CL: Analyze

**6. 2.** The nurse needs more information about the client's decision before deciding what intervention is most appropriate. Judgmental responses could make it difficult for the client to return for treatment should she want to do so. Telling the client that this is a bad decision that she will regret is inappropriate because the nurse is making an assumption. Warning the client that abuse commonly stops when one partner is involved in treatment may be true for some clients. However, until the nurse determines the basis for the client's decision, this type of response is an assumption and therefore inappropriate. Reminding the client about her duty to protect the children would be appropriate if the client had talked about episodes of current abuse by her partner and the fear that her children might be hurt by him.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**7. 3.** The mother's feelings are the priority here. Addressing the mother's feelings and asking for her view of the situation is most important in building a relationship with the family. Ignoring the mother's feelings will hinder the relationship. Defending the school nurse and the school puts the client's mother on the defensive and stifles communication.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**8. 4.** Parental use of nonviolent discipline, the child's talk about what the family is doing and the easing of the parent's negativity toward the school nurse are all signs of progress. Avoidance and wearing clothes inappropriate for the weather implies that the child has something to hide, likely signs of physical abuse.

🔑 CN: Psychosocial adaptation;  
CL: Analyze

**9. 4.** Ultimately, a victim of a crime needs to move from being a victim to being a survivor. A reasonable sense of safety and security is key to this transition. Getting through the shock and confusion, carrying out home and work routines, and resolving grief over any losses represent steps along the way to becoming a survivor.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize


**10. 2.** The experience of rape is a crisis. Crisis intervention services, especially with a rape crisis nurse, are essential to help the client begin dealing with the aftermath of a rape. Legal assistance may be recommended if the client decides to report the rape and only after crisis intervention services have been provided. A rape support group can be helpful later in the recovery process. Medications for sleep disturbance, especially benzodiazepines, should be avoided if possible. Benzodiazepines are potentially addictive and can be used in suicide attempts, especially when consumed with alcohol.

 CN: Psychosocial adaptation;  
CL: Synthesize

**11. 3.** Guilt and self-blame are common feelings that need to be addressed directly and frequently. The client needs to be reminded periodically that she did not deserve and did not cause the rape. Continually encouraging the client to report the rape pressures the client and is not helpful. In most cases, resuming sexual relations is a difficult process that is not likely to occur quickly. It is not necessarily true that the rapist will be caught, tried, and jailed. Most rapists are not caught or convicted.

 CN: Psychosocial adaptation; CL: Apply

**12. 4.** Use of alcohol reflects unhealthy coping mechanisms. A client's report of needing alcohol to calm down needs to be addressed. Survival is the most important goal during a rape. The client's acknowledging this indicates that she is aware that she made the right choice. Although suicidal thoughts are common, the statement that suicide is an easy escape but the client would be unable to do it indicates low risk. Fantasies of revenge, such as giving the death penalty to all rapists, are natural reactions and are a problem only if the client intends to carry them out directly.


 CN: Psychosocial adaptation;  
CL: Evaluate

**13. 3.** Coercion is the most common strategy used because the child commonly trusts the abuser. Tying the child down usually is not necessary. Typically the abusive person can control the child by his or her size and weight alone. Bribery usually is not necessary because the child wants love and affection from the abusive person, not money. Young children are not capable of giving consent for sex before they develop an adult concept of what sex is.


 CN: Psychosocial adaptation; CL: Apply

**14. 2.** Truancy and running away are common symptoms for young children and adolescents. The stress of the abuse interferes with school success, leading to the avoidance of school. Running away is an effort to escape the abuse and/or lack of support


at home. Rather than an inability to play or a lack of play, play is likely to be aggressive with sexual overtones. Children tend to act out anger rather than control it. Head banging is a behavior typically seen with very young children who are abused.

 CN: Psychosocial adaptation;  
CL: Analyze


**15. 3.** Dealing with the physical pain associated with mutilation is viewed as easier than dealing with the intense anger and emotional pain. The client fears an aggressive outburst when anger and emotional pain increase. Self-mutilation seems easier and safer. Additionally, self-mutilation may occur if the client feels unreal or numb or is dissociating. Here, the mutilation proves to the client that he or she is alive and capable of feeling. The client may want to be less sexually attractive, but this aspect usually is not related to self-mutilation. Bingeing and purging is commonly done in addition to, not instead of, self-mutilation. Although a few clients report an occasional high with self-mutilation, usually the experience is just relief from anger and rage.

 CN: Psychosocial adaptation;  
CL: Analyze


**16. 1.** The dolls and toys in a play therapy room are useful props to help the child remember situations and reexperience the feelings, acting out the experience with the toys rather than putting the feelings into words. Role-playing without props commonly is more difficult for a child. Although drawing itself can be therapeutic, having the abuser see the pictures is usually threatening for the child. Reporting abuse to authorities is mandatory, but doesn't help the child express feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**17. 2, 3, 4, 5.** Using a foam bat while symbolically confronting the abuser, keeping a journal of memories and feelings, and writing letters about the abuse but not sending them are appropriate strategies because they allow anger to be expressed safely. Directly confronting the abuser is likely to result in further harm because the abusers commonly deny the abuse, rationalize about it, or blame the victim.

 CN: Psychosocial adaptation;  
CL: Synthesize


**18. 4.** The safety of other children is a primary concern. It is critical to know whether other children are at risk for being sexually abused by the same perpetrator. Asking about other forms of abuse, how long the abuse went on, and if the victim did not remember the abuse are important questions after the safety of other children is determined.

 CN: Psychosocial adaptation;  
CL: Synthesize


**19. 4.** From documented cases of child abuse, a profile has emerged of a high-risk parent as a person who is isolated, impulsive, impatient, and single with low self-esteem, a history of substance abuse, a lack of knowledge about a child's normal growth and development, and multiple life stressors. Just because a parent comes from a large family, there is no increase in the incidence of the parent abusing their own children unless they possess the other risk factors.

 CN: Psychosocial adaptation; CL: Apply


**20. 4.** Parents of an abused child have difficulty controlling their aggressive behaviors. They may blame the child or others for the injury, may not ask questions about treatment, and may not know developmental information.

 CN: Psychosocial adaptation;  
CL: Analyze


**21. 1.** It is not normal for a preschooler to be totally passive during a painful procedure. Typically a preschooler reacts to a painful procedure by crying or pulling away because of the fear of pain. However, an abused child may become "immune" to pain and may find that crying can bring on more pain. The child needs to learn that appropriate emotional expression is acceptable. Telling the child that it really didn't hurt is inappropriate because it is untrue. Telling the child that nurses are mean does not build a trusting relationship. Praising the child will reinforce the child's response not to cry, even though it is acceptable to do so.

 CN: Psychosocial adaptation;  
CL: Synthesize


**22. 3.** A 3-year-old child has limited verbal skills and should not be asked to describe an event, explain a picture, or respond verbally or nonverbally to questions. More appropriately, the child can act out an event using dolls. The child is likely to be too fearful to name the perpetrator or will not be able to do so.

 CN: Psychosocial adaptation;  
CL: Synthesize

**23. 3.** An almost universal finding in descriptions of abused children is underdevelopment for age. This may be reflected in small physical size or in poor psychosocial development. The child should be evaluated further until a plausible diagnosis can be established. A child who appears happy when personnel work with him is exhibiting normal behavior. Children who are abused often are suspicious of others, especially adults. A child who plays alongside others is exhibiting normal behavior, that of parallel play. A child who sucks his thumb contentedly is also exhibiting normal behavior.

 CN: Psychosocial adaptation;  
CL: Analyze

**24. 3.** Parents who are abusive often suffer from low self-esteem, commonly because of the way they were parented, including not being able to develop trust in caretakers and not being encouraged or offered emotional support by parents. Therefore, the nurse works to bolster the parents' self-esteem. This can be achieved by praising the parents for appropriate parenting. Employment and socioeconomic status are not indicators of abusive parents. Abusive parents usually are attached to their children and do not want to give them up to foster care. Parents who are abusive love their children and feel close to them emotionally.


 CN: Psychosocial adaptation;  
CL: Analyze

### Adolescents with Eating Disorders


**25. 1, 2, 4.** In hospital settings, clients are not allowed to know their weight at the time they are being weighed to decrease obsessing about weight gain. They must also eat and rest in staff view and cannot use the bathroom for a period to prevent discarding food or vomiting ingested food (purging). The rest prevents the client from exercising off the calories they just consumed. Barring clients from ever talking about food or attending groups until they have gained weight diminishes the therapeutic value of the inpatient hospital stay.

 CN: Psychosocial adaptation; CL: Create

**26. 3.** In responding to the client, the nurse must be nonjudgmental and matter of fact. Telling her that weight gain is in her favor ignores the client's extreme fear of gaining weight. Putting off the weigh-in for 2 hours allows the client to manipulate the nurse and interferes with the need to weigh the client at the same time each day. Threatening to call the doctor is not likely to build rapport or a working relationship with the client.

 CN: Psychosocial adaptation;  
CL: Synthesize

**27. 2.** A client with anorexia nervosa commonly has an extreme fear of not being able to control weight. The nurse should address this fear. Explaining the dangers of diet pills or discussing health care provider or family concerns focuses on the effect of the client's weight loss on other people rather than the client. Unless the client is motivated to stop, the client will likely not be successful.

 CN: Psychosocial adaptation;  
CL: Synthesize

**28. 4.** An intense fear of becoming obese, emaciation, and a disturbed body image all are considered to be characteristic of anorexia nervosa. Near-normal


weight is not associated with anorexia. The weight of others is not a primary factor. Concern about dieting is not strong enough language to describe the control of food intake in the individual with anorexia nervosa.

 CN: Psychosocial adaptation; CL: Apply


**29. 1.** Anorexia nervosa occurs most commonly in girls and women, with the age at onset between 12 and 20 years. It begins less commonly after 30 years. Although anorexia occurs in men, the prevalence rate is less than 5% to 10% of all cases of anorexia.

 CN: Psychosocial adaptation; CL: Apply

**30. 3.** Parents commonly describe their child as a model child who is a high achiever and compliant. These adolescents are typically well liked by teachers and peers. It is not typical for behavior problems to be reported. The description about having given the child everything and being repaid is more likely to describe an adolescent who is exhibiting behavior problems.

 CN: Psychosocial adaptation;  
CL: Analyze

**31. 4.** The client is in a state of starvation as evidenced by her body weight compared with height. The priority nursing diagnosis is *Imbalanced nutrition: Less than body requirements* because the client is in danger of dying or suffering damage to her body as a result of starvation. *Situational low self-esteem*, *Disturbed body image*, and *Interrupted family processes* are important and relevant, but the priority is the client's state of starvation and need for refeeding.

 CN: Psychosocial adaptation;  
CL: Analyze

**32. 1.** The large carbohydrate intake and significant time in the bathroom are characteristics of bulimia. To address the problem, the client must obtain an evaluation of her physical and psychological status. Suggesting going to a weight loss program or overeating support group frames the problem as strictly a weight issue and ignores the psychological etiology of the problem. Seeing the family physician does not address the psychological aspect of the client's illness, and the client must make the appointment herself.

 CN: Psychosocial adaptation; CL: Apply

**33. 1, 2, 3, 4.** Because of the large number of calories ingested in a binge and the fact that a purge does not eliminate all calories consumed, the client with bulimia is of more normal weight, but still must have a goal of maintaining that weight. Research has shown that selective serotonin reuptake inhibitors are effective in treating bulimia, and the client


is usually amenable to taking the medication. The client with an eating disorder (bulimia and anorexia) has negative self-concepts that fuel her disordered eating, and attaining a positive self-concept is an appropriate goal. The nurse should work with the client with bulimia to help her recognize her eating as disordered. That recognition can make the client more amenable to treatment. It is not realistic to establish a goal that the client with bulimia will never have the desire to purge again.

 CN: Psychosocial adaptation; CL: Create


**34. 3.** A successful outcome for a bulimic client is to avoid using the eating disorder as a coping measure when dealing with stress. Being able to attend college in another state, eat at home, and eat out without bingeing and purging are important goals, but do not address the primary problem of stress management and its connection to eating.

 CN: Psychosocial adaptation; CL: Create

**35. 3.** By telling the mother that the coach is a nurse and relaying the behaviors observed, the nurse gives the mother a chance to recognize the expertise of the coach and introduces the possibility of an eating disorder. Thanking the mother and complimenting the player does not begin to approach the topic. Telling the mother that the nurse has some very bad news is negative and dramatic. Additionally, although the observed behaviors suggest an eating disorder, it would be inappropriate for the nurse to medically diagnose the daughter. Although the daughter may indeed be very sick and need to see a therapist, the nurse should relate the information in a matter-of-fact, unemotional way.


 CN: Psychosocial adaptation;  
CL: Synthesize

**36. 3.** Encouraging the client to talk about why she is here and her feelings may reveal more information about what led her to come to the group and what led to her diagnosis. It also provides the nurse with valuable information needed to develop an appropriate plan of care. The comment that the client sounds angry presumes what the client is feeling and focuses the talk on her husband. The focus should be on the client, not the husband. Telling the client that she will like coming to group imposes the nurse's view onto the client. The statement also focuses on having fun in the group instead of stressing the therapeutic value. Having the client tell the nurse something about the cause of her bulimia ignores the client's original statement. In addition, it requires the client to have insight into the cause of her disease, which may not be possible at this point. Also, it may be too early in the relationship to discuss this disorder.

 CN: Psychosocial adaptation;  
CL: Synthesize




**37. 2.** Because the client eats excessively when upset, the best treatment would be a group to help her learn alternative coping skills. Trying to limit purging without controlling bingeing would result in weight gain and likely increase the client's purging. Daily family therapy sessions are not realistic. Taking lorazepam whenever she feels she needs to binge may temporarily calm the client, but does not address the cause of the bingeing and purging and further, will lead to drug dependence with long-term use.

 CN: Psychosocial adaptation;  
CL: Synthesize

**38. 4.** The nurse needs to explore more about the client's feelings to assess what underlies the eating disorder. The nurse also needs to evaluate the client's suicide risk. The other statements are not therapeutic because they minimize the client's feelings.


 CN: Psychosocial adaptation;  
CL: Synthesize

**39. 4.** The goal of a primary prevention program for eating disorders is for the girls to have positive feelings about themselves and their bodies. Monitoring of weight by parents and/or school nurses might note eating disorders early, particularly anorexia, but will not address the cause of the disorder. Limiting the girls' access to media would be impossible and does not prevent distress with one's body image.

 CN: Psychosocial adaptation;  
CL: Synthesize


### Children and Adolescents with Behavior Problems

**40. 2.** The client and mother need to address the issue of responsibility for medication administration and only Option 2 opens that subject to discussion. Option 1 reinforces the mother's over-involvement in medication taking. Options 3 and 4 make negative comments about the client and mother that are unlikely to engage them in problem-solving about the matter.


 CN: Psychosocial adaptation;  
CL: Synthesize

**41. 1.** This child is demonstrating signs of anxiety and withdrawal. Being a library helper enables the client to use an interest (reading) when interacting with others and gaining pride in helping others. Most interaction will be one-to-one and with adults, which is likely to be more comfortable for her in her state of anxiety. Organizing a class party, a group

project with her peers, and a kickball team involve multiple peer interactions, which are likely to be difficult for her at this time. Also, there is no mention of the child liking sports, so kickball would not be an appropriate activity.

 CN: Psychosocial adaptation;  
CL: Synthesize


**42. 4.** All suspected child abuse must be reported, but this child's age and ability to describe the abuse make this allegation particularly strong. Because parental reaction to her allegation is not predictable, the nurse must ensure the child's safety. The nurse should not discuss the situation with the client or the parents. The nurse must refer this case to Child Protective Services.

 CN: Psychosocial adaptation;  
CL: Synthesize

**43. 1.** Peer acceptance and recognition is a very powerful force in the lives of adolescents, leading to positive or negative behavior depending on the child's peers. While the influence of parents remains strong, peer acceptance combined with the adolescent's desire for independence can lead to disobeying the parents. The sanctions provided at school and in the community by law enforcement will support those teens that have other support in their lives, but are generally not sufficient to prevent substance use in adolescents lacking support at home and with peers.

 CN: Psychosocial adaptation; CL: Create

**44. 2.** This statement indicates insight into possible emotional causes for her pain. After insight is achieved, the client can make behavior changes to effectively cope with her anxiety-related disorder. Saying that she understands why her father is away so often demonstrates insight into her father's actions rather than her own. Wanting to discuss her pain and not her family indicates denial of any connection between her pain and her stress, which perpetuates her current situation. While rest may help her back, the client's statement does not address psychological issues related to the back pain.


 CN: Psychosocial adaptation;  
CL: Evaluate

**45. 4.** ADHD is typically managed by psychostimulant medications, such as methylphenidate and pemoline (Cylert), along with behavior modification. Antianxiety medications, such as buspirone, are not appropriate for treating ADHD. Home schooling commonly is not a possibility because both parents work outside the home. Antidepressants, such as imipramine, are not recommended for use in children. Family therapy may be a part of the treatment. Anticonvulsant medications, such as carbamazepine, are not appropriate for ADHD.


Also, carbamazepine levels are obtained weekly early during therapy to avoid toxicity and ascertain therapeutic levels.

 CN: Psychosocial adaptation; CL: Apply

**46. 1.** Suggesting that the mother arrange for respite care so that she can have a regular break would help to alleviate some of the stress that she feels when she is with her child constantly. The mother also could use family and friends to provide some care, thereby helping with giving her a break. The child may improve, so suggesting that the mother take a job to provide a feeling of success would be inappropriate. Having coffee daily with friends may provide some opportunities for socialization. However, friends may not be able to provide the verbal support that the mother needs. Rather, attending a support group of other parents with children with attention deficit hyperactivity disorder might be helpful. Placing the child in foster care is an extreme measure that may damage the therapeutic relationship with the nurse and dramatically and negatively affect the relationship between the mother and child.

 CN: Psychosocial adaptation;  
CL: Synthesize

**47. 3.** Giving away personal items has consistently been shown to be an indicator of suicide plans in a depressed and suicidal individual. Expression of a desire to date, trying out for an extracurricular activity, or the desire to spend more time with friends indicates a return of interest in normal adolescent activities.

 CN: Psychosocial adaptation;  
CL: Analyze

**48. 1.** Tourette syndrome is characterized by motor and verbal tics. The disorder begins with simple tics, such as finger twitching, and may progress to a complex tic involving movement of the entire arm. There also may be difficulties with obsessions and compulsions.

 CN: Psychosocial adaptation;  
CL: Analyze

**49. 1.** Children are not as likely as adults to display sad behaviors but instead frequently have somatic complaints and acting-out behaviors. Both adults and children can have problems with performance.

 CN: Psychosocial adaptation;  
CL: Analyze

**50. 2.** Adolescents are more likely than children to attempt or commit suicide. Loss, abuse, and family discord remain significant risk factors. There is no evidence to support that children rarely commit suicide. Additionally, evidence fails to support the

belief that children who have lost a parent to suicide will attempt it themselves. Significant events, such as a recent firearm purchase, have not been linked to suicide attempts in children. No geographical region in the United States is free from adolescent suicide.

 CN: Psychosocial adaptation; CL: Apply


**51. 1.** Five-year-old children view death as reversible, so talking about seeing her mother again is a normal statement for a child of this age. A child this age would not usually state that she was glad Jesus took her mom but instead might be afraid that Jesus would also take her or her dad. The idea of replacing her mother with a new one, as hinted in the statement that they got another dog after the dog died, has not been supported by studies of grieving children. Stating that mommy went to heaven and that the child will see her someday when the child dies is reflective of more advanced abstract thinking than a 5-year-old would demonstrate.

 CN: Health promotion and maintenance;  
CL: Analyze


**52. 3.** Asperger's disorder is recognized later than autism, and the interpersonal problems worsen with school attendance. These children usually have restricted and repetitive patterns of behavior. School problems exist as a result of the interaction difficulties and behavior differences. Motor development may be delayed, but language commonly progresses normally.

 CN: Psychosocial adaptation; CL: Apply

**53. 2.** The nurse needs to find out what exactly the mother knows and has read. Reviewing what the mother has found in her reading that is leading her to doubt the diagnosis will help direct the nurse's teaching and clarify any misperceptions or misinformation that the mother may have. The physician may indeed have many years of education and experience, and the focus should be on the daughter, but the nurse needs to address the mother's concerns at this time.

 CN: Psychosocial adaptation;  
CL: Synthesize


**54. 1, 2.** Discussing relationship issues related to the opposite sex with an early adolescent beginning at or near pubescence is appropriate. Kissing and touching other clients is discouraged and this needs reinforcement because she is likely to defy rules. Staying in her room with an assignment and seeing a video on reproduction may be appropriate approaches later on, but do not help the client learn appropriate sexual and social behaviors outside of the hospital. Calling her psychiatrist is not necessary because it is not an emergency.

 CN: Psychosocial adaptation;  
CL: Synthesize


**55. 1.** Stating that attention deficit hyperactivity disorder occurs more commonly in families takes the opportunity for teaching while also helping the father realize that he and his wife are not to blame. Parents who are commonly blamed by society for their child's behavior need help with education. Questioning the father on what he thinks he may have done implies that the parents played some role in this disorder, possibly contributing to the father's guilt. Telling the father that many parents feel this way and that the nurse does not think the parents are at fault is premature at this point. Telling the father that he should focus on what needs to be done, rather than what caused the disorder, minimizes the father's concerns and feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**56. 3.** Focusing on the purpose of the group is the best response. Adolescents are greatly influenced by their peers. Medication alone is not typically the most successful treatment strategy. Questioning whether the client will continue the medication is negative and is not the reason for her to stay in the group. Asking the rest of the group to respond may or may not give the nurse support for the teenager remaining in the group. Groups commonly have rules regarding movement of members in and out of the group, but this does not address the reasons for the client to remain in the group.

 CN: Psychosocial adaptation;  
CL: Synthesize

**57. 4.** Asking whether the client is thinking about killing himself is the most direct and therefore the best way to assess suicidal risk. Knowing whether the client has watched movies on suicide and death, what the client thinks about suicide, and whether other family members have committed suicide will not tell the nurse whether the client is thinking about committing suicide right now.


 CN: Psychosocial adaptation; CL: Analyze

**58. 1.** The teacher needs to be informed that this behavior is inappropriate. Therefore, educating the teacher and encouraging her to respond to misbehavior consistently is correct. Telling the teacher that the nurse can't believe the teacher lets the child get away with the behavior is demeaning and condescending. Allowing the child to continue the misbehavior is counterproductive to discipline and could create other problems.


 CN: Psychosocial adaptation;  
CL: Synthesize

**59. 3.** When an adolescent wants to stop treatment with medication it represents a desire for more control over his/her life as well as a wish to


be free of the disorder with which they have been diagnosed. If the caregiver merely acknowledges the client's right to stop treatment or warns of consequences if the client stops medication, he or she abdicates the adult role of healthcare advisor. Before any action is taken, the nurse should explore the client's reasoning to see if anything in the medication regimen could be changed to make it more palatable for the client. The client also needs to know if his current objections cannot be overcome, he can return later to restart his medication.

 CN: Psychosocial adaptation;  
CL: Synthesize


**60. 2.** Consistent discipline and alternative methods of anger management are two important tools for parents who have a child with oppositional defiant disorder. Consistent discipline sets limits for the child. Helping the child learn more appropriate ways to manage anger assists the child in living within societal expectations. Avoiding restriction of television and computer time for punishment or using time-out as the primary means of punishment has not been suggested as an appropriate management method. Typically, using many strategies is more effective. Ignoring bad behavior could be dangerous and does not reinforce to the child that limits on behavior exist in society.

 CN: Psychosocial adaptation;  
CL: Synthesize

**61. 3.** Asking the client to report everything that she has had to eat and drink yesterday and today is the least judgmental approach and also provides helpful information. Confronting the client about drinking alcohol or asking the client to admit the real reason for feeling sick can put the girl on the defensive and block further communication. The nurse should avoid putting the client on the defensive to facilitate communication that may eventually enable the nurse to get the truth and identify interventions.

 CN: Psychosocial adaptation;  
CL: Synthesize

**62. 2.** Studies show that usually one-third to one-half of people diagnosed with ADHD do not need medication as adults.


 CN: Psychosocial adaptation;  
CL: Synthesize

**63. 1.** The client is stating that he is stupid like his classmates believe. Attention deficit hyperactivity disorder commonly causes problems in school, which can lead to problems with self-esteem. *Ineffective coping* would be manifested by the client's hitting a peer who laughs at him. *Interrupted family processes* would be evidenced by the parents' not being able to help their son cope or by their own inability to cope with their son and


his disorder. *Anxiety* would be associated with the client's reporting tense or nervous feelings.

 CN: Psychosocial adaptation;  
CL: Analyze

**64. 3.** The single-dose form of methylphenidate should be taken 10 to 14 hours before bedtime to prevent problems with insomnia, which can occur when the daily or last dose of the medication is taken within 6 hours (for multiple dosing) or 10 to 14 hours (for single dosing) before bedtime. It is recommended that a missed dose be taken as soon as possible; the dose is skipped if it is not remembered until the next dose is due. Any other medication, including over-the-counter medications, should be discussed with the health care provider before use to eliminate the risk of a possible drug interaction.

 CN: Pharmacological and parenteral therapies; CL: Create

**65. 4.** The child's refusal to sit in class, insistence on calling her mother when she isn't ill, fear that something bad is going to happen to her mother, and physical appearance of anxiety best fit separation anxiety disorder. Children with separation anxiety disorder display these types of behaviors for a month or longer. Obsessive-compulsive disorder would be manifested by ritualistic, repetitive behaviors that are excessive and interfere with normal activities. Major depression in children is evidenced by sadness or acting-out behaviors. Attention deficit hyperactivity disorder is manifested by failure to complete tasks, an inability to pay attention during class, and easy distractibility.


 CN: Psychosocial adaptation;  
CL: Analyze

**66. 1, 2, 3, 4.** The crucial elements of a behavioral contract include compliance with the medication regimen if medication is prescribed, appropriate anger management, consequences for unacceptable behaviors, and rules for interactions with others. Personal possessions may be limited by unit rules, but are not part of an individualized behavioral contract.

 CN: Psychosocial adaptation; CL: Create


**67. 1.** While all the occurrences could upset the client in the early stage of treatment, the one involving the most risk to safety is the suicide completion

of a peer. Adolescents are susceptible to "copycat" suicides. The fact that she knows the method of suicide of the acquaintance and is at a critical period in treatment, when her antidepressant may have given her increased energy while still experiencing low self-esteem, can put her at significant risk for suicide.

 CN: Safety and infection control;  
CL: Analyze

## Managing Care Quality and Safety

**68. 4.** Children who experience serious losses, especially multiple losses, such as old friends or a parent, are more at risk for depression. Girls also are at greater risk than boys during the adolescent years.

 CN: Health promotion and maintenance;  
CL: Analyze

**69. 3.** The nurse manager needs to focus on the frustration that the nurse is expressing. Additionally, the nurse manager needs to correct any misinformation or misinterpretation that the staff nurse has. Saying that the nurse sounds burned out and asking about a vacation does not focus on the nurse's frustration or address the inaccuracy of the nurse's statement. There is no evidence to suggest that children with conduct disorder have more than the average adult's risk of depression or anxiety. Therefore, this response is inaccurate and inappropriate. Anecdotal information from personal experience does not supply the nurse with accurate, reliable information.

 CN: Management of care; CL: Synthesize

**70. 4.** Indifference to other people and mutism may be indicators of autism and would require further investigation. A 2-year-old who talks to himself and refuses to cooperate with toilet training is displaying behaviors typical for this age. Occasional thumb sucking and not having spent the night with a friend would be normal at age 6. Threats to run away when angry is considered within the range of normal behaviors for a 10-year-old child.

 CN: Health promotion and maintenance;  
CL: Analyze

PART

3

# Postreview Tests

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## COMPREHENSIVE

### TEST

# 1

**1.** A client with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome confides that he is homosexual and his employer does not know his HIV status. Which response by the nurse is **best**?

- 1. "Would you like me to help you tell them?"
- 2. "The information you confide in me is confidential."
- 3. "I must share this information with your family."
- 4. "I must share this information with your employer."

**2.** The mother of a child with bronchial asthma tells the nurse that the child wants a pet. Which of the following pets is **most** appropriate?

- 1. Cat.
- 2. Fish.
- 3. Gerbil.
- 4. Canary.

**3.** An elderly client is being admitted to same-day surgery for cataract extraction. The client has several diamond rings. The nurse should explain to the client that:

- 1. Her rings will be taped before the surgery.
- 2. She will sign a valuables envelope that will be placed in a safe.
- 3. The rings will be locked in the narcotics box.
- 4. The nursing supervisor will hold onto the rings during the surgery.

**4.** When an infant resumes taking oral feedings after surgery to correct intussusception, the parents comment that the child seems to suck on the pacifier more since the surgery. The nurse explains that sucking on a pacifier:

- 1. Provides an outlet for emotional tension.
- 2. Indicates readiness to take solid foods.
- 3. Indicates intestinal motility.
- 4. Is an attempt to get attention from the parents.

**5.** Under which circumstance may a nurse communicate medical information without the client's consent?

- 1. When certifying the client's absence from work.
- 2. When requested by the client's family.
- 3. When treating the client with a sexually transmitted disease.
- 4. When ordered by another physician.

**6.** A 22-year-old client is brought to the emergency department with his fiancée after being involved in a serious motor vehicle accident. His Glasgow Coma Scale score is 7 and he demonstrates evidence of decorticate posturing. Which of the following is appropriate for obtaining permission to place a catheter for intracranial pressure (ICP) monitoring?

- 1. The nurse will obtain a signed consent from the client's fiancée because he is of legal age and they are engaged to be married.
- 2. The physician will get a consultation from another physician and proceed with placement of the ICP catheter until the family arrives to sign the consent.
- 3. Two nurses will receive a verbal consent by telephone from the client's next of kin before inserting the catheter.
- 4. The physician will document the emergency nature of the client's condition and that an ICP catheter for monitoring was placed without a consent.

**7.** A 68-year-old client's daughter is asking about the follow-up evaluation for her father after his pneumonectomy for primary lung cancer. The nurse's **best** response is which of the following?

- 1. "The usual follow-up is chest X-ray and liver function tests every 3 months."
- 2. "The follow-up for your father will be a chest X-ray and a computed tomography scan of the abdomen every year."
- 3. "No follow-up is needed at this time."
- 4. "The follow-up for your father will be a chest X-ray every 6 months."

**8.** The nurse is preparing to administer blood to a client who requires postoperative blood replacement. The nurse should use a blood administration set that has a:

- 1. Micron mesh filter.
- 2. Nonfiltered blood administration set.
- 3. Special leukocyte-poor filter.
- 4. Microdrip administration set.

**9.** During the health history interview, which of the following strategies is the **most** effective for the nurse to use to help clients feel that they have an active role in their health care?

- 1. Ask clients to complete a questionnaire.
- 2. Provide clients with written instructions.
- 3. Ask clients for their description of events and for their views concerning past medical care.
- 4. Ask clients if they have any questions.

**10.** The nurse is planning care for a client who chews the fingers constantly. Before applying mitten restraints, the nurse could try which of the following interventions? Select all that apply.

- 1. Ask the client to rub lotion over the hands every day after bathing.
- 2. Encourage physical activity, such as ambulation.
- 3. Provide frequent contacts for communication and socialization.
- 4. Provide family education.
- 5. Encourage involvement of family and friends.

**11.** A client with severe major depression states, "My heart has stopped and my blood is black ash." The nurse interprets this statement to be evidence of which of the following?

- 1. Hallucination.
- 2. Illusion.
- 3. Delusion.
- 4. Paranoia.

**12.** When a client wants to read his chart, the nurse should:

- 1. Call the doctor to obtain permission.
- 2. Give the client the chart and answer questions for him.
- 3. Tell the client that he can read the chart when the doctor makes rounds.
- 4. Ask the client what he wants to know and answer those questions without giving him the chart.

**13.** A client with a fractured leg has been instructed to ambulate without weight bearing on the affected leg. The nurse evaluates that the client is ambulating correctly if she uses which of the following crutch-walking gaits?

- 1. Two-point gait.
- 2. Four-point gait.
- 3. Three-point gait.
- 4. Swing-to gait.

**14.** A client with major depression states, "Life isn't worth living anymore. Nothing matters." Which of the following responses by the nurse is **best**?

- 1. "Are you thinking about killing yourself?"
- 2. "Things will get better, you know."
- 3. "Why do you think that way?"
- 4. "You shouldn't feel that way."

**15.** A client with bipolar 1 disorder has been prescribed olanzapine (Zyprexa) 5 mg two times a day and lamotrigine (Lamictal) 25 mg two times a day. Which of the following adverse effects should the nurse report to the physician immediately? Select all that apply.

- 1. Rash.
- 2. Nausea.
- 3. Sedation.
- 4. Hyperthermia.
- 5. Muscle rigidity.

**16.** A client is prescribed atropine 0.4 mg intramuscularly. The atropine vial is labeled 0.5 mg/mL. How many milliliters should the nurse plan to administer? \_\_\_\_\_ mL.

**17.** A multiparous client tells the nurse that she is using medroxyprogesterone (Depo-Provera) for contraception. The nurse should instruct the client to increase her intake of which of the following?

- 1. Folic acid.
- 2. Vitamin C.
- 3. Magnesium.
- 4. Calcium.

**18.** Which of the following statements made by a pregnant woman in the first trimester are consistent with this stage of pregnancy? Select all that apply.

- 1. "My husband told his friends we will have to give up the Mustang for a minivan."
- 2. "Oh my, how did this happen? I don't need this now."
- 3. "I can't wait to see my baby. Do you think it will have my blond hair and blue eyes?"
- 4. "I used a Disney theme for decorating the room."
- 5. "I wonder how it will feel to buy maternity clothes and be fat."
- 6. "We went to the mall yesterday to buy a crib and dressing table."

**19.** The nurse is teaching a client about using topical gentamicin sulfate (Garamycin). Which of the following comments by the client indicates the need for additional teaching?

- 1. "I will avoid being out in the sun for long periods."
- 2. "I should stop applying it once the infected area heals."
- 3. "I'll call the physician if the condition worsens."
- 4. "I should apply it to large open areas."

**20.** A client takes hydrochlorothiazide (HCTZ) for treatment of essential hypertension. The nurse should instruct the client to report which of the following? Select all that apply.

- 1. Muscle twitching.
- 2. Abdominal cramping.
- 3. Diarrhea.
- 4. Confusion.
- 5. Lethargy.
- 6. Muscle weakness.

**21.** A client has been taking imipramine (Tofranil) for his depression for 2 days. His sister asks the nurse, "Why is he still so depressed?" Which of the following responses by the nurse is **most** appropriate?

- 1. "Your brother is experiencing a very serious depression."
- 2. "I'll be sure to convey your concern to his physician."
- 3. "It takes 2 to 4 weeks for the drug to reach its full effect."
- 4. "Perhaps we need to change his medication."

**22.** Which interventions should the nurse use to assist the client with grandiose delusions? Select all that apply.

- 1. Accepting the client while not arguing with the delusion.
- 2. Focusing on the feelings or meaning of the delusion.
- 3. Focusing on events and topics based in reality.
- 4. Confronting the client's beliefs.
- 5. Interacting with the client only when he is based in reality.

**23.** Which of the following responses is **most** helpful for a client who is euphoric, intrusive, and interrupts other clients engaged in conversations to the point where they get up and leave or walk away?

- 1. "When you interrupt others, they leave the area."
- 2. "You are being rude and uncaring."
- 3. "You should remember to use your manners."
- 4. "You know better than to interrupt someone."

**24.** The nurse coordinates with the laboratory staff to have the gentamicin trough serum level drawn. At what time should the blood be drawn in relation to the administration of the I.V. dose of gentamicin sulfate (Garamycin)?

- 1. 2 hours before the administration of the next I.V. dose.
- 2. 3 hours before the administration of the next I.V. dose.
- 3. 4 hours before the administration of the next I.V. dose.
- 4. Just before the administration of the next I.V. dose.

**25.** Older adults with known cardiovascular disease must balance which of the following measures for optimum health?

- 1. Diet, exercise, and medication.
- 2. Stress, hypertension, and pain.
- 3. Mental health, diet, and stress.
- 4. Social events, diet, and smoking.

**26.** A 4-year-old is brought to the emergency department with sudden onset of a temperature of 103° F (39.5° C), sore throat, and refusal to drink. The child will not lie down and prefers to lean forward while sitting up. Which of the following should the nurse do **next**?

- 1. Give 600 mg of acetaminophen (Tylenol) rectally, as ordered.
- 2. Inspect the child's throat for redness and swelling.
- 3. Have an appropriate-sized tracheostomy tube readily available.
- 4. Obtain a specimen for a throat culture.

**27.** Assessment of a client taking lithium reveals dry mouth, nausea, thirst, and mild hand tremor. Based on an analysis of these findings, which of the following should the nurse do **next**?

- 1. Hold the lithium and obtain a stat lithium level to determine therapeutic effectiveness.
- 2. Continue the lithium and immediately notify the physician about the assessment findings.
- 3. Continue the lithium and reassure the client that these temporary side effects will subside.
- 4. Hold the lithium and monitor the client for signs and symptoms of increasing toxicity.

**28.** A client asks the nurse how long she has to take her medicine for hypothyroidism. The nurse's response is based on the knowledge that:

- 1. Lifelong daily medicine is necessary.
- 2. The medication is expensive, and the dose can be reduced in a few months.
- 3. The medication can be gradually withdrawn in 1 to 2 years.
- 4. The medication can be discontinued after the client's thyroid-stimulating hormone level is normal.

**29.** The nurse should advise which of the following clients who is taking lithium to consult with the physician regarding a potential adjustment in lithium dosage?

- 1. A client who continues work as a computer programmer.
- 2. A client who attends college classes.
- 3. A client who can now care for her children.
- 4. A client who is beginning training for a tennis team.

**30.** The nurse is discharging a client who has been hospitalized for preterm labor. The client needs further instruction when she says:

- 1. "If I think I have a bladder infection, I need to see my obstetrician."
- 2. "If I have contractions, I should contact my health care provider."
- 3. "Drinking water may help prevent early labor for me."
- 4. "If I travel on long trips, I need to get out of the car every 4 hours."



**31.** A client admitted with a gastric ulcer has been vomiting bright red blood. His hemoglobin level is 5.11 g/dL, and his blood pressure is 100/50 mm Hg. The client and his family state that their religious beliefs do not support the use of blood products and refuse blood transfusions as a treatment for the bleeding. The nurse should collaborate with the physician and family to **next**:

- 1. Discontinue all measures.
- 2. Notify the hospital attorney.
- 3. Attempt to stabilize the client through the use of fluid replacement.
- 4. Give enough blood to keep the client from dying.

**32.** The parents of a child with cystic fibrosis express concern about how the disease was transmitted to their child. The nurse should explain that:

- 1. A disease carrier also has the disease.
- 2. Two parents who are carriers may produce a child who has the disease.
- 3. A disease carrier and an affected person will never have children with the disease.
- 4. A disease carrier and an affected person will have a child with the disease.

**33.** A client with angina shows the nurse her nitroglycerin (Nitrostat) that she carries in a plastic bag in her pocket. The nurse instructs the client that nitroglycerin should be kept in:

- 1. The refrigerator.
- 2. A cool, moist place.
- 3. A dark container to shield from light.
- 4. A plastic bag where it is readily available.

**34.** When teaching a client with bipolar disorder, mania, who has started to take valproic acid (Depakene) about possible side effects of this medication, the nurse should include which of the following in the teaching plan?

- 1. Increased urination.
- 2. Slowed thinking.
- 3. Sedation.
- 4. Weight loss.

**35.** An infant is born with facial abnormalities, growth retardation, mental retardation, and vision abnormalities. These abnormalities are probably caused by maternal:

- 1. Alcohol consumption.
- 2. Vitamin B6 deficiency.
- 3. Vitamin A deficiency.
- 4. Folic acid deficiency.

**36.** Nonsteroidal anti-inflammatory drugs (NSAIDs) are commonly used in the treatment of musculoskeletal conditions. It is important for the nurse to remind the client to:

- 1. Take NSAIDs at least three times per day.
- 2. Exercise the joints at least 1 hour after taking the medication.
- 3. Take antacids 1 hour after taking NSAIDs.
- 4. Take NSAIDs with food.

**37.** The nurse should suspect that the client taking disulfiram (Antabuse) has ingested alcohol when the client exhibits which of the following symptoms?

- 1. Sore throat and muscle aches.
- 2. Nausea and flushing of the face and neck.
- 3. Fever and muscle soreness.
- 4. Bradycardia and vertigo.

**38.** The nurse holds the gauze pledget against an I.M. injection site while removing the needle from the muscle. This technique helps to:

- 1. Seal off the track left by the needle in the tissue.
- 2. Speed the spread of the medication in the tissue.
- 3. Avoid the discomfort of the needle pulling on the skin.
- 4. Prevent organisms from entering the body through the skin puncture.

**39.** A client whose condition remains stable after a myocardial infarction gradually increases his activity. Which the following conditions should the nurse assess to determine whether the activity is appropriate for the client?

- 1. Edema.
- 2. Cyanosis.
- 3. Dyspnea.
- 4. Weight loss.

**40.** The nurse is conducting a counseling session with a client experiencing post traumatic stress disorder (PTSD) using a 2-way video telehealth system from the hospital to the client's home, which is 2 hours away from the nearest mental health facility. Which of the following are expected outcomes of using telehealth as a venue to provide health care to this client? Select all that apply. The client will:

- 1. Save travel time from the house to the health care facility.
- 2. Avoid reliving a traumatic event which might be precipitated by visiting a health care facility.
- 3. Experience a shorter recovery time than being treated by being on-site at a health care facility.
- 4. Receive health care for this mental health problem.
- 5. Obtain group support from others with a similar health problem.

**41.** When a client with alcohol dependency begins to talk about not having a problem with alcohol, the nurse should use which of the following approaches?

- 1. Questioning the client about how much alcohol she drinks.
- 2. Confronting the client with the fact that she was intoxicated 2 days ago.
- 3. Pointing out how alcohol has gotten her into trouble.
- 4. Listening to what the client states and then asking her how she plans to stay sober.

**42.** Which of the following correctly describes Medicaid?

- 1. A program designed to assist ill, low-income older adults.
- 2. A federal insurance program for pregnant women.
- 3. A joint federal-state program for low-income persons.
- 4. A program administered by health maintenance organizations.

**43.** The nurse is preparing a teaching plan for a 45-year-old client recently diagnosed with type 2 diabetes mellitus. What is the **first** step in this process?

- 1. Establish goals.
- 2. Choose video materials and brochures.
- 3. Assess the client's learning needs.
- 4. Set priorities of learning needs.

**44.** A loading dose of digoxin (Lanoxin) is given to a client newly diagnosed with atrial fibrillation. The nurse begins instructing the client about the medication and the importance of monitoring his heart rate. An expected outcome of the education program will be:

- 1. A return demonstration of palpating the radial pulse.
- 2. A return demonstration of how to take the medication.
- 3. Verbalization of why the client has atrial fibrillation.
- 4. Verbalization of the need for the medication.

**45.** A multigravid client is scheduled for a percutaneous umbilical blood sampling procedure. The nurse instructs the client that this procedure is useful for diagnosing which of the following?

- 1. Twin pregnancies.
- 2. Fetal lung maturation.
- 3. Rh disease.
- 4. Alpha fetoprotein level.

**46.** Which of the following is an adverse effect of vancomycin (Vancocin) and needs to be reported promptly?

- 1. Vertigo.
- 2. Tinnitus.
- 3. Muscle stiffness.
- 4. Ataxia.

**47.** Which of the following statements indicates that the client with a peptic ulcer understands the dietary modifications he needs to follow at home?

- 1. "I should eat a bland, soft diet."
- 2. "It is important to eat six small meals a day."
- 3. "I should drink several glasses of milk a day."
- 4. "I should avoid alcohol and caffeine."

**48.** The client with a nasogastric (NG) tube begins to complain of abdominal distention. Which of the following measures should the nurse implement **first**?

- 1. Call the physician.
- 2. Irrigate the NG tube.
- 3. Check the function of the suction equipment.
- 4. Reposition the NG tube.

**49.** A male client has been diagnosed as having a low sperm count during infertility studies. After instructions by the nurse about some causes of low sperm counts, the nurse determines that the client needs further instructions when he says low sperm counts may be caused by which of the following?

- 1. Varicocele.
- 2. Frequent use of saunas.
- 3. Endocrine imbalances.
- 4. Decreased body temperature.

**50.** A nurse is relieving the triage nurse in the labor and delivery unit who is going to lunch. The report indicates that there are three clients having their vital signs assessed and a fourth client is on her way to the unit from the emergency department. In which order of priority should the nurse manage these clients?

1. The client with clear vesicles and brown vaginal discharge at 16 weeks' gestation.

2. The client with right lower quadrant pain at 10 weeks' gestation.

3. The client who is at term and has had no fetal movement for 2 days.

4. The client from the emergency department at term and screaming loudly because of labor contractions.

**51.** The nurse assesses a client and notes puffy eyelids, swollen ankles, and crackles at both lung bases. The nurse understands that these clinical findings are **most** specifically associated with fluid excess in which of the following compartments?

- 1. Interstitial compartment.
- 2. Intravascular compartment.
- 3. Extracellular compartment.
- 4. Intracellular compartment.

**52.** An expected physiologic response to a low potassium level is:

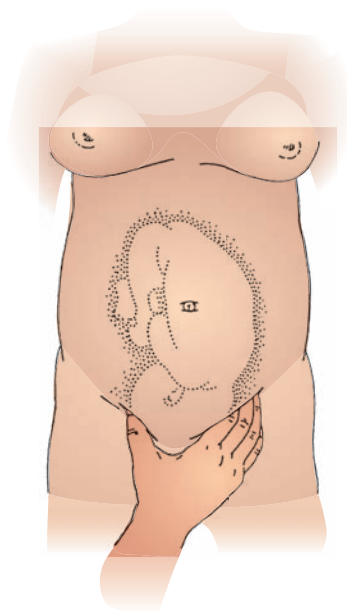
- 1. Cardiac dysrhythmias.
- 2. Hyperglycemia.
- 3. Hypertension.
- 4. Increased energy.

**53.** When teaching unlicensed assistive personnel (UAP) about the importance of hand washing in preventing disease, the nurse should instruct the UAP that?

- 1. "It is not necessary to wash your hands as long as you use gloves."
- 2. "Handwashing is the best method for preventing cross-contamination."
- 3. "Waterless commercial products are not effective for killing organisms."
- 4. "The hands do not serve as a source of infection."

**54.** The nurse is performing Leopold's maneuvers on a woman who is in her eighth month of pregnancy. The nurse is palpating the uterus as shown below. Which of the following maneuvers is the nurse performing?

- 1. First maneuver.
- 2. Second maneuver.
- 3. Third maneuver.
- 4. Fourth maneuver.



**55.** A client in a cardiac rehabilitation program states that he would like to make sure he is eating the right foods to ensure adequate endurance on the treadmill. Which of the following nutrients is **most** helpful for promoting endurance during sustained activity?

- 1. Protein.
- 2. Carbohydrate.
- 3. Fat.
- 4. Water.

**56.** A client's chest tube is connected to a drainage system with a water seal. The nurse notes that the fluid in the water-seal column is fluctuating with each breath that the client takes. The fluctuation means that:

- 1. There is an obstruction in the chest tube.
- 2. The client is developing subcutaneous emphysema.
- 3. The chest tube system is functioning properly.
- 4. There is a leak in the chest tube system.

**57.** A client with diabetes is explaining to the nurse how she will care for her feet at home. Which statement indicates that the client understands proper foot care?

- 1. "When I injure my toe, I will plan to put iodine on it."
- 2. "I should inspect my feet at least once a week."
- 3. "It is okay to go barefoot in the house."
- 4. "It is important to dry my feet carefully after my bath."

**58.** The nurse assesses a client with diverticulitis and suspects peritonitis when which of the following symptoms is noted?

- 1. Hyperactive bowel sounds.
- 2. Rigid abdominal wall.
- 3. Explosive diarrhea.
- 4. Excessive flatulence.

**59.** A nurse is assessing a client who has a potential diagnosis of pancreatitis. Which risk factors predispose the client to pancreatitis? Select all that apply.

- 1. Excessive alcohol use.
- 2. Gallstones.
- 3. Abdominal trauma.
- 4. Hypertension.
- 5. Hyperlipidemia with excessive triglycerides.
- 6. Hypothyroidism.

**60.** The nurse is beginning the shift and is now responsible for the following clients on the postpartum unit and has not yet made rounds on the clients. Additionally, the nurse is responsible for three other clients who are currently listed as stable. The nurse will also be getting a new admission in 15 minutes. For the best utilization of time and client safety, the nurse should make rounds on which of the following clients **first**?

- 1. The three clients who are reported to be stable.
- 2. The mother with a 4-hour-old infant with initial blood glucose of 33 mg/dL and now at 45 mg/dL breast-feeding her infant.
- 3. A mother who had a spontaneous vaginal delivery (SVD) client and received methylergonovine maleate (Methergine) 1 hour ago for increased bleeding.
- 4. A mother with a 3-day-old who had a bilirubin level of 13 mg/dL 30 minutes ago, and is now in a “bili blanket” at the mother’s bedside.

**61.** When performing chest percussion on a child, which of the following techniques should the nurse use?

- 1. Firmly but gently striking the chest wall to make a popping sound.
- 2. Gently striking the chest wall to make a slapping sound.
- 3. Percussing over an area from the umbilicus to the clavicle.
- 4. Placing a blanket between the nurse’s hand and the child’s chest.

**62.** The nurse walks into the room of a client who has a “do not resuscitate” order and finds the client without a pulse, respirations, or blood pressure. What is the **most** appropriate action?

- 1. Stay in the room and notify the nursing team for assistance.
- 2. Push the emergency alarm to call a code.
- 3. Dial the hospital phone number for a code.
- 4. Pull the curtain and leave the room.

**63.** A client is trying to lose weight at a moderate pace. If the client eliminates 1,000 calories per day from his normal intake, how many pounds would he lose in 1 week?

\_\_\_\_\_ lb.

**64.** A nulligravid client calls the clinic and tells the nurse that she forgot to take her oral contraceptive this morning. Which of the following should the nurse instruct the client to do?

- 1. Take the medication immediately.
- 2. Restart the medication in the morning.
- 3. Use another form of contraception for 2 weeks.
- 4. Take two pills tonight before bedtime.

**65.** The nurse recognizes that a client with pain disorder is improving when the client says which of the following?

- 1. “I need to have a good cry about all the pain I’ve been in and then not dwell on it.”
- 2. “I need to find another physician who can accurately diagnose my condition.”
- 3. “The pain medicine that you gave me helps me to relax.”
- 4. “I’m angry with all of the doctors I’ve seen who don’t know what they’re doing.”

**66.** A client admitted in an acute psychotic state says that she hears terrible voices in the head and thinks her neighbor is out to get her. Which of the following is the nurse’s **best** response?

- 1. “What has your neighbor been doing that bothers you?”
- 2. “How long have you been hearing these terrible voices?”
- 3. “We won’t let your neighbor visit, so you’ll be safe.”
- 4. “What exactly are these terrible voices saying to you?”

**67.** The nurse should assess the client with severe diarrhea for which acid-base imbalance?

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

**68.** A nurse is planning care for a client who has heart failure. Which goal is appropriate for a client with excess fluid volume?

- 1. A weight reduction of 10% will occur.
- 2. Pain will be controlled effectively.
- 3. Arterial blood gas values will be within normal limits.
- 4. Serum osmolality will be within normal limits.

**69.** A 7-year-old child is admitted to the hospital with the medical diagnosis of acute rheumatic fever. Which of the following laboratory blood findings confirms that the child has had a streptococcal infection?

- 1. High leukocyte count.
- 2. Low hemoglobin count.
- 3. Elevated antibody concentration.
- 4. Low erythrocyte sedimentation rate.

**70.** The nurse on the postpartum unit is caring for four couplets. There will be a new admission in 30 minutes. The new client is a G4 P4, Spanish-speaking only client with an infant who is in the special care nursery (SCN) for fetal distress. The nurse should place the new client in a room with which of the following clients?

- 1. A G4 P4 who is 2 days postpartum with infant, Spanish speaking only.
- 2. A G1 P1 who is 1 day postpartum with an infant in the SCN.
- 3. A G6 P6 who delivered 4 hours ago by C/S for fetal distress, infant at bedside.
- 4. A G1 P1 who is a non-English speaking client with infant in SCN for fetal distress.

**71.** A client is scheduled for hip replacement surgery and is interviewed by the nurse in the preadmission testing unit. The client states that he wishes to receive his own blood for the upcoming surgery. The nurse should:

- 1. Document the client's request on the chart.
- 2. Notify the hematology laboratory.
- 3. Notify the surgeon's office.
- 4. Call the blood bank.

**72.** A client needs surgery to relieve an intestinal obstruction. The nurse receives the following set of orders for the client. Which of the following orders should the nurse question before performing?

- 1. Tap water enemas until clear.
- 2. Out of bed as tolerated.
- 3. Neomycin sulfate 1 g P.O. every 4 hours.
- 4. Betadine scrub to abdomen.

**73.** After teaching a client about collecting a stool sample for occult testing, which client statement indicates effective teaching? Select all that apply.

- 1. "I will avoid eating meat for 1 to 3 days before getting a stool sample."
- 2. "I need to eat foods low in fiber a few days before collecting the sample."
- 3. "I'll take the sample from different areas of the stool that I have passed."
- 4. "I need to send the stool sample to the lab in a covered container right away."
- 5. "I can continue to take all of my regular medications at home."

**74.** A client who is on nothing-by-mouth status is constantly asking for a drink. Which of the following is the **most** appropriate nursing intervention?

- 1. Reexplain to the client why she cannot drink.
- 2. Offer ice chips every hour to decrease thirst.
- 3. Offer the client frequent oral hygiene care.
- 4. Divert the client's attention by turning on the television.

**75.** A female client is admitted with fatigue, cold intolerance, weight gain, and muscle weakness. The initial nursing assessment reveals brittle nails, dry hair, constipation, and possible goiter. The client is **most** likely experiencing signs and symptoms of:

- 1. Cushing's disease.
- 2. Hypothyroidism.
- 3. Hyperthyroidism.
- 4. A pituitary tumor.

**76.** A mother visiting the clinic for a routine visit with her 10-year-old daughter reports that her daughter has an increase in hair growth and breast enlargement. The nurse explains to the mother and daughter that after the symptoms of puberty are noticed, menstruation typically occurs within which of the following time frames?

- 1. 6 months.
- 2. 12 months.
- 3. 30 months.
- 4. 36 months.

**77.** While a mother is feeding her full-term neonate 1 hour after birth, she asks the nurse, "What are these white dots in my baby's mouth? I tried to wash them out, but they're still there." After assessing the neonate's mouth, the nurse explains that these spots are which of the following?

- 1. Koplik's spots.
- 2. Epstein's pearls.
- 3. Precocious teeth.
- 4. Thrush curds.

**78.** The nurse should assess a newborn with esophageal atresia and tracheoesophageal fistula (TEF) for which of the following? Select all that apply.

- 1. Copious frothy mucus.
- 2. Episodes of cyanosis.
- 3. Several loose stools.
- 4. Initial weight loss.
- 5. Poor gag reflex.

**79.** Which of the following factors is **most** important for healing an infected decubitus ulcer?

- 1. Adequate circulatory status.
- 2. Scheduled periods of rest.
- 3. Balanced nutritional diet.
- 4. Fluid intake of 1,500 mL/day.

**80.** A client is receiving digoxin (Lanoxin). His pulse range is normally 70 to 76 bpm. After assessing the apical pulse for 1 minute and finding it to be 60 bpm, the nurse should **first**:

- 1. Call the physician for orders.
- 2. Withhold the digoxin.
- 3. Administer the digoxin.
- 4. Notify the charge nurse.

**81.** While shopping at a local mall, the nurse hears a pregnant client yell, “Oh my! The baby’s coming!” After placing the client in a supine position and trying to maintain some privacy, the nurse sees that the neonate’s head is delivering. Which of the following should the nurse do **first**?

- 1. Suction the mouth with two fingertips.
- 2. Check for presence of a cord around the neck.
- 3. Tell the client to bear down with force.
- 4. Advise the mother that help is on the way.

**82.** The nurse is preparing a discharge plan for a 16-year-old who has fractured her femur and ulna. The client asks the nurse how quickly her fractures will heal so she can return to her normal activities. Which of the following responses is **most** appropriate for the nurse to make?

- 1. “The healing of your leg will be delayed because you have had skeletal traction.”
- 2. “It will take your arm about 12 weeks to heal completely, but it will take your leg about 24 weeks.”
- 3. “Because you are young and healthy, your bones should heal in less than 12 weeks.”
- 4. “You will require long-term rehabilitation and should expect it to take at least 8 months for your bones to heal.”

**83.** A client with delirium becomes very anxious and says, “I can’t stop what is happening to me. Make it stop, please!” Which of the following is the nurse’s **most** appropriate response?

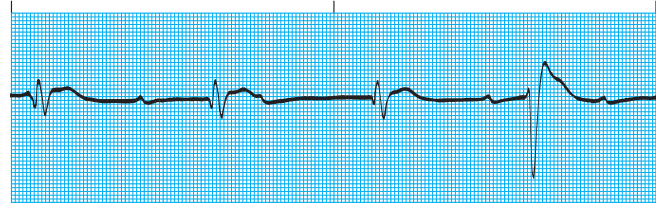
- 1. “I’ll get you some medicine to help you relax. The more you worry, the worse it will get.”
- 2. “As soon as we know what’s causing this, we can try to stop it. I’ll get you some medicine to help you relax.”
- 3. “I wish I could do something to make it stop, but unfortunately I can’t.”
- 4. “I’ll sit with you until you calm down a little.”

**84.** After teaching a primigravid client at 10 weeks’ gestation about the recommendations for exercise during pregnancy, which of the following client statements indicates successful teaching?

- 1. “While pregnant, I should avoid contact sports.”
- 2. “Even though I’m pregnant, I can learn to ski next month.”
- 3. “While we are on vacation next month, I can continue to scuba dive.”
- 4. “Sitting in a hot tub after exercise will help me to relax.”

**85.** The nurse is assessing a client who has had a myocardial infarction. The nurse notes the cardiac rhythm shown below. The nurse identifies that this rhythm is:

- 1. Atrial fibrillation.
- 2. Ventricular tachycardia.
- 3. Premature ventricular contractions.
- 4. Third-degree heart block.



**86.** The physician has ordered a chemotherapy drug to be administered to a client every day for the next week. The client is on an adult medical-surgical floor but the nurse assigned to the client has not been trained to handle chemotherapy agents. What is the nurse’s **most** appropriate response?

- 1. Send the client to the oncology floor for administration of the medication.
- 2. Ask a nurse from the oncology floor to come to the client and administer the medication.
- 3. Ask another nurse to help mix the chemotherapy agent.
- 4. Ask the pharmacy to mix the chemotherapy agent and administer it.

**87.** Which of the following nursing diagnoses should the nurse identify as a priority after surgical repair of a cleft lip?

- 1. *Acute pain.*
- 2. *Risk for infection.*
- 3. *Impaired physical mobility.*
- 4. *Impaired parenting.*

**88.** Which of the following is an appropriate outcome for a client with rheumatoid arthritis?

- 1. The client will manage joint pain and fatigue to perform activities of daily living.
- 2. The client will maintain full range of motion in joints.
- 3. The client will prevent the development of further pain and joint deformity.
- 4. The client will take anti-inflammatory medications as indicated by the presence of disease symptoms.

**89.** A client's burn wounds are being cleaned twice a day in a hydrotherapy tub. Which of the following interventions should be included in the plan of care before a hydrotherapy treatment is initiated?

- 1. Limit food and fluids 45 minutes before therapy to prevent nausea and vomiting.
- 2. Increase the I.V. flow rate to offset fluids lost through the therapy.
- 3. Apply a topical antibiotic cream to burns to prevent infection.
- 4. Administer pain medication 30 minutes before therapy to help manage pain.

**90.** A health care provider has been exposed to hepatitis B through a needlestick. Which of the following drugs should the nurse anticipate administering as postexposure prophylaxis?

- 1. Hepatitis B immune globulin.
- 2. Interferon.
- 3. Hepatitis B surface antigen.
- 4. Amphotericin B.

**91.** When performing an otoscopic examination of the tympanic membrane of a 2-year-old child, the nurse should pull the pinna in which of the following directions?

- 1. Down and back.
- 2. Down and slightly forward.
- 3. Up and back.
- 4. Up and forward.

**92.** Which of the following findings should the nurse note in the client who is in the compensatory stage of shock?

- 1. Decreased urinary output.
- 2. Significant hypotension.
- 3. Tachycardia.
- 4. Mental confusion.

**93.** A client has been prescribed hydrochlorothiazide (HydroDIURIL) to treat heart failure. For which of the following symptoms should the nurse monitor the client?

- 1. Urinary retention.
- 2. Muscle weakness.
- 3. Confusion.
- 4. Diaphoresis.

**94.** The son of a client with Alzheimer's disease excitedly tells the nurse, "Mom was singing one of her favorite old songs. I think she's getting her memory back!" Which of the following responses by the nurse is **most** appropriate?

- 1. "She still has long-term memory, but her short-term memory will not return."
- 2. "I'm so happy to hear that. Maybe she is getting better."
- 3. "Don't get your hopes up. This is only a temporary improvement."
- 4. "I'm glad she can sing even if she can't talk to you."

**95.** The nurse collects a urine specimen from a client for a culture and sensitivity analysis. Which of the following is the correct care of the specimen?

- 1. Promptly send the specimen to the laboratory.
- 2. Send the specimen with the next pickup.
- 3. Send the specimen the next time a nursing assistant is available.
- 4. Store the specimen in the refrigerator until it can be sent to the laboratory.

**96.** A 16-year-old client is in the emergency department for treatment of minor injuries from a car accident. A crisis nurse is with her because she became hysterical and was saying, "It's my fault. My Mom is going to kill me. I don't even have a way home." Which of the following should be the nurse's **initial** intervention?

- 1. Hold her hands and say, "Slow down. Take a deep breath."
- 2. Say, "Calm down. The police can take you home."
- 3. Put a hand on her shoulder and say, "It wasn't your fault."
- 4. Say, "Your mother is not going to kill you. Stop worrying."

**97.** The nurse is developing a community health education program about sexually transmitted diseases. Which information about women who acquire gonorrhea should be included?

- 1. Women are more reluctant than men to seek medical treatment.
- 2. Gonorrhea is not easily transmitted to women who are menopausal.
- 3. Women with gonorrhea are usually asymptomatic.
- 4. Gonorrhea is usually a mild disease for women.

**98.** A client has his leg immobilized in a long leg cast. Which of the following assessments indicates the early beginning of circulatory impairment?

- 1. Inability to move toes.
- 2. Cyanosis of toes.
- 3. Complaints of cast tightness.
- 4. Tingling of toes.

**99.** A client tells the nurse that she has had sexual contact with someone whom she suspects has genital herpes. Which of the following instructions should the nurse give the client in response to this information?

- 1. Anticipate lesions within 25 to 30 days.
- 2. Continue sexual activity unless lesions are present.
- 3. Report any difficulty urinating.
- 4. Drink extra fluids to prevent lesions from forming.

**100.** A multigravid client at 34 weeks' gestation who is leaking amniotic fluid has just been hospitalized with a diagnosis of preterm premature rupture of membranes and preterm labor. The client's contractions are 20 minutes apart, lasting 20 to 30 seconds. Her cervix is dilated to 2 cm. The nurse reviews the physician orders (see chart). Which of the following orders should the nurse initiate **first**?

- 1. Initiate fetal and contraction monitoring
- 2. Start the intravenous infusion
- 3. Obtain the urine specimen
- 4. Administer betamethasone

#### Physician Order

Continuous external fetal and contraction monitoring.  
 .IV of D5LR @ 125 mL hour.  
 I & O catheterization for Urinalysis and Culture and Sensitivity.  
 Betamethasone 12 mg I.M. daily × 2 days.

**101.** The nurse is assessing a client with irreversible shock. The nurse should document which of the following?

- 1. Increased alertness.
- 2. Circulatory collapse.
- 3. Hypertension.
- 4. Diuresis.

**102.** The nurse is caring for a client who has been diagnosed with deep vein thrombosis. When assessing the client's vital signs, the nurse notes an apical pulse of 150 bpm, a respiratory rate of 46 breaths/minute, and blood pressure of 100/60 mm Hg. The client appears anxious and restless. What should be the nurse's **first** course of action?

- 1. Notify the physician.
- 2. Administer a sedative.
- 3. Try to elicit a positive Homan's sign.
- 4. Increase the flow rate of intravenous fluids.

**103.** A client who has Ménière's disease is trying to cope with the chronic tinnitus that she is experiencing. Which of the following interventions is **most** appropriate for the nurse to suggest for coping with the tinnitus?

- 1. Maintain a quiet environment.
- 2. Play background music.
- 3. Avoid caffeine and nicotine.
- 4. Take a mild sedative.

**104.** A 4-year-old child who has been ill for 4 hours is admitted to the hospital with difficulty swallowing, a sore throat, and severe substernal retractions. The child's temperature is 104° F (40° C), and the apical pulse is 140 bpm. The white blood cell count is 16,000/mm<sup>3</sup>. Which of the following should the nurse identify as the immediate priority nursing diagnosis? analyze

- 1. *Anxiety* related to need for immediate and unplanned hospitalization.
- 2. *Risk for injury* (airway obstruction) related to epiglottal edema.
- 3. *Impaired gas exchange* related to excessive respiratory effort.
- 4. *Ineffective airway clearance* related to aspiration.

**105.** The nurse is conducting walking rounds and observes the client (see figure). The nurse should do which of the following?

- 1. Loosen the bed restraints so the client can sit up.
- 2. Raise the side rails to full upright position.
- 3. Assess the client to determine why she wants to sit up.
- 4. Elevate the head of the bed.



**106.** The nurse caring for a client with diabetes realizes that the client has a higher risk of developing cataracts and:

- 1. Background retinopathy.
- 2. Proliferative retinopathy.
- 3. Neuropathy.
- 4. Diabetic retinopathy.



**107.** The nurse assesses the assigned clients for the shift. Of the following assigned clients, which client is at **greatest** risk for falling?

- 1. A 22-year-old man with three fractured ribs and a fractured left arm.
- 2. A 70-year-old woman with episodes of syncope.
- 3. A 50-year-old man with angina.
- 4. A 30-year-old woman with a fractured ankle.

**108.** Which of the following baseline laboratory data should be established before a client is started on tissue plasminogen activator or alteplase recombinant (Activase)?

- 1. Potassium level.
- 2. Lee-White clotting time.
- 3. Hemoglobin level, hematocrit, and platelet count.
- 4. Blood glucose level.

**109.** The nurse is developing an education plan for clients with hypertension. Which of the following long-term goals is **most** appropriate for the nurse to emphasize?

- 1. Develop a plan to limit stress.
- 2. Participate in a weight reduction program.
- 3. Commit to lifelong therapy.
- 4. Monitor blood pressure regularly.

**110.** The nurse should consider which of the following principles when developing a plan of care to manage a client's pain from cancer?

- 1. Individualize the pain medication regimen for the client.
- 2. Select medications that are least likely to lead to addiction.
- 3. Administer pain medication as soon as the client requests it.
- 4. Change pain medications periodically to avoid drug tolerance.

**111.** After explaining to a multigravid client at 36 weeks' gestation who is diagnosed with severe hydramnios about the possible complications of this condition, which of the following statements indicates that the client needs further instruction?

- 1. "Because I have hydramnios, I may gain weight."
- 2. "Hydramnios has been associated with gastrointestinal disorders in the fetus."
- 3. "I should continue to eat high-fiber foods and avoid constipation."
- 4. "I can continue to work at my job at the automobile factory until labor starts."

**112.** An obese diabetic client complains of bilateral leg aching. His physician has referred him to cardiac rehabilitation to start an exercise program. Which of the following activities is **most** helpful for the client?

- 1. Interval training on the stationary bicycle.
- 2. Interval training on the treadmill.
- 3. Interval training on a commercial ski machine.
- 4. Interval training on the stair climber.

**113.** The nurse is assigned to a client with jaundice and collects the following data: poor appetite, nausea, and two episodes of emesis in the past 2 hours. The nurse should make which of the following nursing diagnoses?

- 1. *Imbalanced nutrition: Less than body requirements.*
- 2. *Acute pain* related to abdominal muscle spasms.
- 3. *Adult failure to thrive.*
- 4. *Ineffective health maintenance.*

**114.** Which of the following interventions is recommended protocol for all clients who are at risk for pressure sore development?

- 1. Identify at-risk clients on admission to the health care facility.
- 2. Place at-risk clients on an every-2-hour turning schedule.
- 3. Automatically place clients in specialty beds.
- 4. Provide at-risk clients with a high-protein, high-carbohydrate diet.

**115.** A client has been prescribed digoxin (Lanoxin). Which of the following symptoms should the nurse tell the client to report as a potential indication of digoxin toxicity?

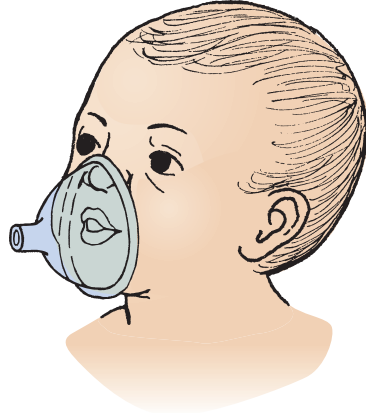
- 1. Urticaria.
- 2. Shortness of breath.
- 3. Visual disturbances.
- 4. Hypertension.

**116.** The nurse is instructing a client on how to care for skin that has become dry after radiation therapy. Which of the following statements by the client indicates that the client understands the teaching?

- 1. "I should take antihistamines to decrease the itching I am experiencing."
- 2. "It is safe to apply a nonperfumed lotion to my skin."
- 3. "A heating pad, set on the lowest setting, will help decrease my discomfort."
- 4. "I can apply an over-the-counter cortisone ointment to relieve the dryness."

**117.** A neonate is experiencing respiratory distress and is using a neonatal oxygen mask. An unlicensed assistive personnel has positioned the oxygen mask as shown below. The nurse is assessing the neonate and determines that the mask:

- 1. Is appropriate for the neonate.
- 2. Is too large because it covers the neonate's eyes.
- 3. Is too small because it is obstructing the nose.
- 4. Should be covered with a soft cloth before being placed against the skin.



**118.** The nurse is preparing a client for a thoracentesis. How should the nurse position the client for the procedure?

- 1. Supine with the arms over the head.
- 2. Sims' position.
- 3. Prone position without a pillow.
- 4. Sitting forward with the arms supported on the bedside table.

**119.** The antidote for heparin is:

- 1. Vitamin K.
- 2. Warfarin (Coumadin).
- 3. Thrombin.
- 4. Protamine sulfate.

**120.** Which of the following actions is **most** appropriate when dealing with a client who is expressing anger verbally, is pacing, and is irritable?

- 1. Conveying empathy and encouraging ventilation.
- 2. Using calm, firm directions to get the client to a quiet room.
- 3. Putting the client in restraints.
- 4. Discussing alternative strategies for when the client is angry in the future.

**121.** Which of the following measures should be implemented promptly after a client's nasogastric (NG) tube has been removed?

- 1. Provide the client with oral hygiene.
- 2. Offer the client liquids to drink.
- 3. Encourage the client to cough and deep breathe.
- 4. Auscultate the client's bowel sounds.

**122.** The nurse applies warm compresses to apply to a client's leg. To determine effectiveness of the compresses, the nurse should determine if there is:

- 1. Less scaling on the skin.
- 2. Decreased bruising.
- 3. Improved circulation to the area.
- 4. Decreased swelling in the area.

**123.** While assisting the physician with an amniocentesis on a multigravid client at 38 weeks' gestation, the nurse observes that the fluid is very cloudy and thick. The nurse interprets this finding as indicating which of the following?

- 1. Intrauterine infection.
- 2. Fetal meconium staining.
- 3. Erythroblastosis fetalis.
- 4. Normal amniotic fluid.

**124.** The nurse instructs the unlicensed assistive personnel on how to collect a 24-hour urine specimen. Which of the following instructions is correct for a collection that is scheduled to start at 7 a.m. Monday and end at 7 a.m. Tuesday?

- 1. Collect and save the urine voided at 7 a.m. on Monday.
- 2. Send the first voided urine specimen on Monday to the laboratory for culture.
- 3. Collect and save the urine voided at 7 a.m. on Tuesday.
- 4. Keep each day's urine collection in separate containers.

**125.** Which of the following abnormal serum chemistry values is present in a client with cirrhosis who has developed ascites?

- 1. Decreased aspartate aminotransferase.
- 2. Hypoalbuminemia.
- 3. Hyperkalemia.
- 4. Decreased alanine aminotransferase.

**126.** An infant is brought to the clinic for a regular checkup and the diphtheria, tetanus, and acellular pertussis (DTaP) and inactivated polio vaccine (IPV) immunizations. The child is recovering from a cold and is afebrile. The child's sibling has cancer and is receiving chemotherapy. Which of the following actions is **most** appropriate?

- 1. Giving the DTaP and withholding the IPV.
- 2. Administering the DTaP and IPV immunizations.
- 3. Postponing both immunizations until the sibling is in remission.
- 4. Withholding both immunizations until the infant is well.

**127.** When creating a program to decrease the primary cause of disability and death in children, which of the following is **most** effective for the community health nurse to do?

- 1. Encourage state legislators to draft legislation to promote prenatal care.
- 2. Recommend that the health department make immunizations available at no cost to all children.
- 3. Teach health and safety practices to children and their parents.
- 4. Have a nurse practitioner hired for each of the schools in the community.

**128.** A client has had an incisional cholecystectomy. Which of the following nursing interventions has the **highest** priority in postoperative care for this client?

- 1. Using incentive spirometry every 2 hours while awake.
- 2. Performing leg exercises every shift.
- 3. Maintaining a weight-reduction diet.
- 4. Promoting incisional healing.

**129.** During a home visit, the nurse is evaluating an infant for auditory ability. Which of the following is the expected response in an infant with normal hearing?

- 1. Stoppage of body movements when sound is introduced.
- 2. Evidence of shy and withdrawn behaviors.
- 3. Saying “da-da” by age 5 months.
- 4. Absence of squealing by age 4 months.

**130.** A client who had a transurethral resection of the prostate (TURP) 1 day earlier has a three-way Foley catheter inserted for continuous bladder irrigation. Which of the following statements **best** explains why continuous irrigation is used after TURP?

- 1. To control bleeding in the bladder.
- 2. To instill antibiotics into the bladder.
- 3. To keep the catheter free from clot obstruction.
- 4. To prevent bladder distention.

**131.** Which of the following sounds should the nurse expect to hear when percussing a distended bladder?

- 1. Hyperresonance.
- 2. Tympany.
- 3. Dullness.
- 4. Flatness.

**132.** A tour bus has overturned on an exit ramp. Many passengers are injured, but there are no fatalities. While the emergency department nurse prepares for treating the injured, the nurse also calls the crisis nurse based on the understanding about which of the following?

- 1. The accident victims will be experiencing grief and mourning.
- 2. Many of the passengers may be experiencing feelings of victimization.
- 3. There is a need for someone to coordinate calls from relatives about the passengers.
- 4. Some of the passengers will need psychiatric hospitalization.

**133.** A postoperative nursing goal for the infant who has had surgery to correct imperforate anus is to prevent tension on the perineum. To achieve this goal, the nurse should **not** place the neonate on the:

- 1. Abdomen, with legs pulled up under the body.
- 2. Back, with legs suspended at a 90-degree angle.
- 3. Left side, with hips elevated.
- 4. Right side, with hips elevated.

**134.** A child with meningococcal meningitis is being admitted to the pediatric unit. In preparation for the child’s arrival, the nurse should **first**:

- 1. Institute droplet precautions.
- 2. Obtain the child’s vital signs.
- 3. Ask the parent about medication allergies.
- 4. Inquire about the health of siblings at home.

**135.** When developing the plan of care for a 14-year-old boy with a nursing diagnosis of *Deficient diversional activity* related to immobility, which of the following activities is **most** appropriate?

- 1. Playing a card game with a boy the same age.
- 2. Putting together a puzzle with his mother.
- 3. Playing video games with a 9-year-old.
- 4. Watching a movie with his younger brother.

**136.** An adolescent is being prepared for an emergency appendectomy. The nurse should tell the client? Select all that apply.

- 1. Friends can visit whenever they want.
- 2. The scar will be small.
- 3. The teen will be back in school in 1 week.
- 4. Antibiotics will be given to prevent an infection.
- 5. A dressing will stay in place for 1 week.

**137.** A client receives morphine for postoperative pain. Which of the following assessments should the nurse include in the client’s plan of care?

- 1. Take apical heart rate after each dose of morphine.
- 2. Assess urinary output every 8 hours.
- 3. Assess mental status every shift.
- 4. Check for pedal edema every 4 hours.

**138.** When infusing total parenteral nutrition (TPN), the nurse should assess the client for which of the following complications?

- 1. Essential amino acid deficiency.
- 2. Essential fatty acid deficiency.
- 3. Hyperglycemia.
- 4. Infection.

**139.** When assessing for signs of a blood transfusion reaction in a client with dark skin, the nurse should assess for which of the following?

- 1. Hypertension.
- 2. Diaphoresis.
- 3. Polyuria.
- 4. Warm skin.

**140.** The nurse is caring for a child with a head injury. Place the following assessments in order of priority, starting with the nursing assessment the nurse should perform **first**.

1. Vital signs.

2. Decreased urine output.

3. Level of consciousness.

4. Motor strength.

**141.** After surgery to create a urinary diversion, the client is at risk for a urinary tract infection. The nurse should plan to incorporate which of the following interventions into the client's care?

- 1. Clamp the urinary appliance at night.
- 2. Empty the urinary appliance when one-third full.
- 3. Administer prophylactic antibiotics.
- 4. Change the urinary appliance daily.

**142.** When suctioning a client's tracheostomy tube, the nurse should incorporate which of the following steps into the procedure?

- 1. Oxygenate the client before suctioning.
- 2. Insert the suction catheter about 2 inches into the cannula.
- 3. Use a bolus of sterile water to stimulate cough.
- 4. Use clean gloves during the procedure.

**143.** A 14-month-old child has a severe diaper rash. Which of the following recommendations should the nurse provide to the parents?

- 1. Continue to use the baby wipes.
- 2. Change the diaper every 4 to 6 hours.
- 3. Wash the buttocks using mild soap.
- 4. Apply powder to the diaper area.

**144.** On entering a toddler's room, the nurse finds the mother sitting about 8 feet from the child and watching television while the toddler is screaming. Which of the following is the **most** appropriate response by the nurse?

- 1. "What happened between you and your child?"
- 2. "Why is your child screaming?"
- 3. "Did something cause your child to be upset?"
- 4. "Have you tried to calm down your child?"

**145.** A client has a total hip replacement. Which of the following client statements indicates a need for further teaching before discharge?

- 1. "I will implement my exercise program as soon as I get home."
- 2. "I will be careful not to cross my legs."
- 3. "I will need an elevated toilet seat."
- 4. "I can't wait to take a tub bath when I get home."

**146.** An adolescent tells the school nurse she thinks she has infectious mononucleosis. The nurse should **next** assess the client for?

- 1. Sore throat and malaise.
- 2. Fatigue and weight loss.
- 3. Coldlike symptoms and fever.
- 4. Skin rash and abdominal pain.

**147.** While assessing the fundus of a multiparous client on the first postpartum day, the nurse performs handwashing and dons clean gloves. Which of the following should the nurse do **next**?

- 1. Place the nondominant hand above the symphysis pubis and the dominant hand at the umbilicus.
- 2. Ask the client to assume a side-lying position with the knees flexed.
- 3. Perform massage vigorously at the level of the umbilicus if the fundus feels boggy.
- 4. Place the client on a bedpan in case the uterine palpation stimulates the client to void.

**148.** A nulligravid client with gestational diabetes tells the nurse that she had a reactive nonstress test 3 days ago and asks, "What does that mean?" The nurse explains that a reactive nonstress test indicates which of the following about the fetus?

- 1. Evidence of some compromise that will require delivery soon.
- 2. Fetal well-being at this point in the pregnancy.
- 3. Evidence of late decelerations occurring during the test.
- 4. No accelerations demonstrated within a 20-minute period.

**149.** A client has been diagnosed with right-sided heart failure. The nurse should assess the client further for:

- 1. Intermittent claudication.
- 2. Dyspnea.
- 3. Dependent edema.
- 4. Crackles.

**150.** To help prevent hip flexion deformities associated with rheumatoid arthritis, the nurse should help the client assume which of the following positions in bed several times a day?

- 1. Prone.
- 2. Very low Fowler's.
- 3. Modified Trendelenburg.
- 4. Side-lying.

**151.** Which of the following should be the nurse's priority assessment after an epidural anesthetic has been given to a nulligravid client in active labor?

- 1. Level of consciousness.
- 2. Blood pressure.
- 3. Cognitive function.
- 4. Contraction pattern.

**152.** Assessment of a nulligravid client in active labor reveals the following: complaints of moderate discomfort; cervix dilated 3 cm, 0 station and completely effaced; fetal heart rate of 136 bpm. Which of the following should the nurse plan to do **next**?

- 1. Assist the client with comfort measures and breathing techniques.
- 2. Turn the client from the left side-lying position to the right side-lying position.
- 3. Prepare the client for epidural anesthesia to relieve pain.
- 4. Instruct the client that internal fetal monitoring is necessary.

**153.** The nurse monitors the serum electrolyte levels of a client who is taking digoxin (Lanoxin). Which of the following electrolyte imbalances is a common cause of digoxin toxicity?

- 1. Hyponatremia.
- 2. Hypomagnesemia.
- 3. Hypocalcemia.
- 4. Hypokalemia.

**154.** After abdominal surgery, a client has an order for meperidine (Demerol) I.M. 100 mg every 3 to 4 hours and acetaminophen (Tylenol) with codeine 30 mg. The client has been taking meperidine every 4 hours for the past 48 hours, but she tells the nurse that the meperidine is no longer lasting 4 hours and she needs to have it every 3 hours. Which of the following nursing actions is **most** appropriate?

- 1. Realizing that the client is developing tolerance to the meperidine, the nurse administers the meperidine every 3 hours.
- 2. The nurse urges the client to take the acetaminophen with codeine to prevent addiction to the meperidine.
- 3. The nurse requests an order from the physician to change the dose to an equianalgesic dose of morphine.
- 4. The nurse encourages the client to do relaxation exercises to provide distraction from the pain.

**155.** The nurse assesses a 7-month-old infant's growth and development. Which behavior should the nurse consider unusual?

- 1. Drinking from a cup and spilling little of the liquid.
- 2. Raising the chest and upper abdomen off the bed with the hands.
- 3. Imitating sounds that the nurse makes.
- 4. Crying loudly in protest when the mother leaves the room.

**156.** A 13-year-old client is dying of cancer and struggling with the emotional aspects of this. When providing care for this client, the nurse should incorporate the developmental tasks for this age. According to Erikson's developmental model, the child normally is expected to be working on which of the following psychosocial issues?

- 1. Lifetime vocation.
- 2. Social conscience.
- 3. Personal values.
- 4. Sense of competence.

**157.** The physician has prescribed amiodarone (Cordarone) for a client with cardiomyopathy. The nurse should monitor the client's rhythm to determine the effectiveness of the medication in controlling:

- 1. Sinus node dysfunction.
- 2. Heart block.
- 3. Severe bradycardia.
- 4. Life-threatening ventricular dysrhythmias.

**158.** An 18-year-old female client who is sexually active with her boyfriend visits the clinic complaining of a purulent vaginal discharge that is sometimes frothy. The nurse interprets this as suggesting which of the following?

- 1. Sexually transmitted disease.
- 2. Normal variations in vaginal discharge.
- 3. Need for vaginal douching.
- 4. Change in birth control method.

**159.** An elderly client has been bedridden since a cerebrovascular accident that resulted in total right-sided paralysis. The client has become increasingly confused, is occasionally incontinent of urine, and is refusing to eat. In planning the client's care, which of the following factors should the nurse consider as most critical in contributing to skin breakdown in this client?

- 1. Nutritional status.
- 2. Urinary incontinence.
- 3. Episodes of confusion.
- 4. Right-sided paralysis.

**160.** Assessment of a client who has just been admitted to the inpatient psychiatric unit reveals an unshaven face, noticeable body odor, visible spots on the shirt and pants, slow movements, gazing at the floor, and a flat affect. Which of the following should the nurse interpret as indicating psychomotor retardation?

- 1. Slow movements.
- 2. Flat affect.
- 3. Unkempt appearance.
- 4. Avoidance of eye contact.

**161.** A nurse notices that a newborn has a swelling in the scrotal area. The nurse interprets this swelling as indicative of hydrocele if which of the following occurs?

- 1. The swollen bulge can be reduced.
- 2. The increase in scrotal size is bilateral.
- 3. The scrotal sac can be transilluminated.
- 4. The bulge appears during crying.

**162.** When cleaning the skin around an incision and drain site, which of the following procedures should the nurse follow?

- 1. Clean the incision and drain site separately.
- 2. Clean from the incision to the drain site.
- 3. Clean from the drain site to the incision.
- 4. Clean the incision and drain site simultaneously.

**163.** An Hispanic mother who does not speak English and is very upset brings her child to the clinic with bleeding from the mouth. Which of the following is the **most** appropriate action by the nurse who does not speak Spanish?

- 1. Call for the Spanish interpreter.
- 2. Grab the child and take the child to the treatment room.
- 3. Immediately apply ice to the child's mouth.
- 4. Give the ice to the mother and demonstrate what to do.

**164.** The nurse is instructing an unlicensed assistive personnel on the prevention of postoperative pulmonary complications. Which of the following statements indicates that the assistant has understood the nurse's instructions?

- 1. "I will turn the client every 4 hours."
- 2. "I will keep the client's head elevated."
- 3. "I should suction the client every 2 hours."
- 4. "I will have the client take 5 to 10 deep breaths every hour."

**165.** Which of the following outcomes is **most** appropriate for a nursing diagnosis of *Ineffective tissue perfusion* related to interruption of arterial flow? Select all that apply.

- 1. Extremities warm to touch.
- 2. Improved respiratory status.
- 3. Decreased muscle pain with activity.
- 4. Participation in self-care measures.
- 5. Lungs clear to auscultation.

**166.** The infusion rate of total parenteral nutrition is tapered before being discontinued. This is done to prevent which of the following complications?

- 1. Essential fatty acid deficiency.
- 2. Dehydration.
- 3. Rebound hypoglycemia.
- 4. Malnutrition.

**167.** While assessing the psychosocial aspects of a primigravid client at 30 weeks' gestation, which of the following feelings are expected?

- 1. Vulnerability.
- 2. Confirmation.
- 3. Ambivalence.
- 4. Body image disturbance.

**168.** The nurse teaches a client scheduled for an I.V. pyelogram what to expect when the dye is injected. The nurse knows that the client has correctly understood what was taught when he states that he may experience which of the following sensations when the dye is injected?

- 1. A metallic taste.
- 2. Flushing of the face.
- 3. Cold chills.
- 4. Chest pain.

**169.** To prevent development of peripheral neuropathies associated with isoniazid administration, the nurse should teach the client to:

- 1. Avoid excessive sun exposure.
- 2. Follow a low-cholesterol diet.
- 3. Obtain extra rest.
- 4. Supplement the diet with pyridoxine (vitamin B6).

**170.** A usually reliable interpreter called by the nurse to help communicate with a mother of a child who does not speak English and has brought her child in for a routine visit has yet to arrive in the clinic. The nurse has paged the interpreter several times. Which of the following should the nurse do **next**?

- 1. Continue with the examination.
- 2. Reschedule the infant's appointment for later in the week.
- 3. Ask the mother to stay longer in the hope that the interpreter arrives.
- 4. Page the interpreter one more time.

**171.** Before discharge from the hospital after a myocardial infarction, a client is taught to exercise by gradually increasing the distance walked. Which vital sign should the nurse teach the client to monitor to determine whether to increase or decrease the exercise level?

- 1. Pulse rate.
- 2. Blood pressure.
- 3. Body temperature.
- 4. Respiratory rate.

**172.** During an appointment with the nurse, a client says, "I could hate God for that flood." The nurse responds, "Oh, don't feel that way. We're making progress in these sessions." The nurse's statement demonstrates a failure to do which of the following?

- 1. Look for meaning in what the client says.
- 2. Explain to the client why he may think as he does.
- 3. Add to the strength of the client's support system.
- 4. Give the client credit for solving his own problems.

**173.** The nurse has just received the change of shift report on the following clients on the labor, delivery, recovery, and postpartum unit. Which of these clients should the nurse assess **first**?

- 1. An 18-year-old single primigravid client, in labor for 9 hours, with cervical dilation at 6 cm, 0 station, contractions occurring every 5 minutes, and receiving epidural anesthesia.
- 2. A 24-year-old primiparous client who delivered a 7 lb, 3 oz boy vaginally 1 hour ago, has a firm fundus and scant lochia rubra, and is attempting to breast-feed.
- 3. A 26-year-old multigravid client, in labor for 8 hours, with cervical dilation at 8 cm, 1 + station, contractions every 3 to 4 minutes, and receiving no anesthesia.
- 4. A 30-year-old multipara who delivered a 6 lb, 5 oz girl by cesarean section owing to fetal distress 3 hours ago, has a firm fundus and scant lochia rubra, and is receiving morphine by patient-controlled analgesia.

**174.** A client with type I diabetes mellitus is scheduled to have surgery. The client has been NPO since midnight. In the morning, the nurse notices that the client's daily insulin has not been ordered. Which action should the nurse do **first**?

- 1. Obtain the client's blood glucose at the bedside.
- 2. Contact the physician for further orders regarding insulin dosage.
- 3. Give the client's usual morning dose of insulin.
- 4. Inform the Post Anesthesia Care Unit (PACU) staff to obtain the insulin order.

**175.** A client's chest tube is to be removed by the physician. Which of the following items should the nurse have ready to be placed directly over the wound when the chest tube is removed?

- 1. Butterfly dressing.
- 2. Montgomery strap.
- 3. Fine mesh gauze dressing.
- 4. Petrolatum gauze dressing.

**176.** While visiting a client with multiple sclerosis, the community health nurse observes that the client looks untidy and sad. The client suddenly says, "I can't even find the strength to comb my hair," and bursts into tears. Which of the following responses by the nurse is **best**?

- 1. "It must be frustrating not to be able to care for yourself."
- 2. "How many days have you been unable to comb your hair?"
- 3. "Why hasn't your husband been helping you?"
- 4. "Tell me more about how you're feeling."

**177.** A client newly diagnosed with bulimia is attending a nurse-led group at the mental health center. She tells the group that she only came because her husband said he would divorce her if she didn't get help. Which of the following responses by the nurse is **most** appropriate?

- 1. "You sound angry with your husband. Is that correct?"
- 2. "You will find that you like coming to group. These people are a lot of fun."
- 3. "Tell me more about why you are here and how you feel about that."
- 4. "Tell me something about what has caused you to be bulimic."

**178.** A diabetic client has been diagnosed with hypertension and the physician has prescribed atenolol (Tenormin), a beta blocker. When performing discharge teaching, it is important for the client to recognize that the addition of Tenormin can cause:

- 1. A decrease in the hypoglycemic effects of insulin.
- 2. An increase in the hypoglycemic effects of insulin.
- 3. An increase in the incidence of ketoacidosis.
- 4. A decrease in the incidence of ketoacidosis.

**179.** The parent of a child who is taking an antibiotic for bilateral otitis media tells the nurse that he has stopped the medicine since his child is better, saving the rest of the medication to use the next time the child gets sick. Which of the following is the nurse's **best** response?

- 1. "It is important to give the medicine as ordered."
- 2. "How do you know your child's ears are cured?"
- 3. "Your child needs all of the medicine so that the infection clears."
- 4. "Stopping the medicine is not what's best for your child!"

**180.** The nurse is making rounds and observes a client who is unconscious (see figure). The nursing assistant has just turned the client from lying on her back. Before raising the side rail, the nurse should:

- 1. Elevate the head of the bed to 30 degrees.
- 2. Ask the nursing assistant to add a pillow under the right arm.
- 3. Inspect the skin at pressure points from the back-lying position.
- 4. Help the nursing assistant move the client closer to the head of the bed.



## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

**1. 2.** The nurse is responsible for maintaining confidentiality of this disclosure by the client.

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**2. 2.** Pets are discouraged when parents are trying to allergy-proof a home for a child with bronchial asthma, unless the pets are kept outside. Pets with hair or feathers are especially likely to trigger asthma attacks. A fish is a satisfactory pet for this child, but the parents should be taught to keep the fish tank clean to prevent it from harboring mold.

🔑 CN: Health promotion and maintenance;  
CL: Synthesize

**3. 2.** Under the policy for valuables, the nurse documents the description on an envelope with the client, the client and nurse sign the envelope, and the valuables envelope is locked in the safe. The other options increase the risk of loss or damage to the client's valuables.

🔑 CN: Management of care; CL: Synthesize

**4. 1.** Sucking provides the infant with a sense of security and comfort. It also is an outlet for releasing tension. The infant should not be discouraged from sucking on the pacifier. Fussiness after feeding may indicate that the infant's appetite is not satisfied. Sucking is not manipulative in the sense of seeking parental attention.

🔑 CN: Health promotion and maintenance;  
CL: Analyze

**5. 3.** Sexually transmitted diseases are communicable diseases that must be reported. The nurse is responsible for reporting these diseases to the appropriate public health agency, and to otherwise maintain the client's confidentiality. The client's family cannot request release of medical information without the client's consent. A physician's order is not a substitute for a client's consent to release medical information in the absence of a communicable disease.

🔑 CN: Management of care; CL: Synthesize




**6. 4.** In a life-threatening emergency where time is of the essence in saving life or limb, consent is not required. This client has a Glasgow Coma Scale score of 7, which means he is comatose. The client has deteriorated to a level where he cannot be aroused, withdraws in a purposeless manner from painful stimuli, exhibits decorticate posturing, and may or may not have brain stem reflexes intact. The placement of the ICP monitor is crucial to determine cerebral blood flow and prevent herniation. The client's fiancée cannot sign his consent because, until she is his wife or has designated power of attorney, she is not considered his next of kin. The physician should insert the catheter in this emergency. He does not need to get a consultation from another physician. When consent is needed for a situation that is not a true emergency, two nurses can receive a verbal consent by telephone from the client's next of kin.

 CN: Management of care; CL: Apply

**7. 4.** Follow-up generally involves semianual chest radiographs. Recurrence usually occurs locally in the lungs and may be identified on chest radiographs. Follow-up after cancer treatment is an important component of the treatment plan. Serum markers (liver function tests) have not been shown to detect recurrence of lung cancer. There are no data to support the need for an abdominal computed tomography scan.

 CN: Reduction of risk potential;  
CL: Synthesize

**8. 1.** All blood products should be administered through a micron mesh filter. Blood is never administered without a filter. Leukocytes can be removed by using leukocyte-poor filters, and this is recommended to decrease reactions in clients, such as hemophiliacs, who require frequent transfusions. Blood is too concentrated to administer through a microdrip set.

 CN: Pharmacological and parenteral therapies; CL: Apply


**9. 3.** One of the best strategies to help clients feel in control is to ask them their view of situations, and to respond to what they say. This technique acknowledges that clients' opinions have value and relevance to the interview. It also promotes an active role for clients in the process. Use of a questionnaire or written instructions is a means of obtaining information but promotes a passive client role. Asking whether clients have questions encourages participation, but alone it does not acknowledge their views.

 CN: Management of care; CL: Synthesize

**10. 2, 3, 4, 5.** Socialization and communication, in addition to increased activity, are all means to aid in prevention of self-injury. Education of family members may foster development of strategies to prevent self-injury; hence, mitten restraints could be avoided. Applying lotion after bathing may not be appropriate when the skin is broken and not intact.

 CN: Management of care; CL: Synthesize

**11. 3.** A client with severe depression may experience symptoms of psychosis such as hallucinations and delusions that are typically mood congruent. The statement, "My heart has stopped and my blood is black ash," is a mood-congruent somatic delusion. A delusion is a firm, false, fixed belief that is resistant to reason or fact. A hallucination is a false sensory perception unrelated to external stimuli. An illusion is a misinterpretation of a real sensory stimulus. Paranoia refers to suspiciousness of others and their actions.

 CN: Psychosocial adaptation;  
CL: Analyze

**12. 2.** The client should be allowed to see his chart. As a client advocate, the nurse should answer questions for the client. The nurse helps the client understand that he is a primary partner in the health team. The Bill of Rights for Patients has existed since the 1960s, and every client should be aware of this document. The doctor should not need to give permission for the client to see his chart. As a client advocate, the nurse should not make excuses to put the client off in regard to seeing his chart.

 CN: Management of care; CL: Apply

**13. 3.** The three-point gait, in which the client advances the crutches and the affected leg at the same time while weight is supported on the unaffected extremity, is the appropriate gait of choice. This allows for non-weight-bearing on the affected extremity. The two-point, four-point, and swing-to gaits require some weight bearing on both legs, which is contraindicated for this client.


 CN: Reduction of risk potential;  
CL: Evaluate

**14. 1.** When the client verbalizes that life isn't worth living anymore, the nurse needs to ask the client directly about suicide by saying, "Are you thinking about killing yourself?" Asking directly does not provoke suicide but conveys concern, understanding, and the worth of the client. Commonly, the client experiences a sense of relief that someone finally hears him. It also helps the nurse plan responsible care by identifying the client who is at risk for suicide. The nurse should then evaluate the seriousness of the suicidal ideation by inquiring about the intent and plan. Stating, "Things will get

better,” offers hope too soon without first evaluating the intent of the suicidal ideation. Asking, “Why do you think that way?” implies a lack of understanding and knowledge on the part of the nurse. Major depression usually is endogenous and biochemically based. Therefore, the client may not know why he doesn’t want to live. Saying, “You shouldn’t feel that way,” admonishes the client, decreases self-worth, and conveys a lack of understanding.

 CN: Psychosocial adaptation;  
CL: Synthesize

**15. 1, 4, 5.** Lamotrigine, an antiepileptic, is used as a mood stabilizer for clients with bipolar disorder and has been found to be effective for the depressive phase of bipolar disorder. Common adverse effects are dizziness, headache, sedation, tremors, nausea, vomiting, and ataxia. The development of a rash needs to be reported and evaluated by the physician because it could indicate the start of a severe systemic rash known as Stevens-Johnson syndrome, a toxic epidermal necrolysis, which would necessitate the discontinuation of lamotrigine. Hyperthermia in conjunction with muscle rigidity suggests the development of neuroleptic malignant syndrome, a life-threatening complication associated with olanzapine.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**16. 0.8 mL**

$$\frac{0.4 \text{ mg}}{X} = \frac{0.5 \text{ mg}}{1 \text{ mL}}$$


$$0.4 = 0.5X$$

$$\frac{0.4}{0.5} = X$$

$$0.8 \text{ mL} = X.$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**17. 4.** The nurse should instruct the client to increase her intake of calcium because there is a slight increase in the risk of osteoporosis with this medication. Weight-bearing exercises are also advised. The drug may also impair glucose tolerance in women who are at risk for diabetes.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**18. 1, 2, 5.** The first trimester is when the couple works through the psychological task of accepting the pregnancy. These statements describe the client and her partner coping with the pregnancy, how it feels, and how it will impact their lives.

The feelings include pleasure, excitement, and ambivalence. Wondering what the baby will look like and planning for the baby’s room occur later in the pregnancy.

 CN: Health promotion and maintenance;  
CL: Analyze


**19. 4.** The aminoglycoside antibiotic gentamicin sulfate should not be applied to large denuded areas because toxicity and systemic absorption are possible. The nurse should instruct the client to avoid excessive sun exposure because gentamicin sulfate can cause photosensitivity. The client should be instructed to apply the cream or ointment for only the length of time prescribed because a superinfection can occur from overuse. The client should contact the physician if the condition worsens after use.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**20. 2, 5, 6.** Hydrochlorothiazide is a thiazide diuretic used in the management of mild to moderate hypertension, and in the treatment of edema associated with: heart failure, renal dysfunction, cirrhosis, corticosteroid therapy, and estrogen therapy. It increases the excretion of sodium and water by inhibiting sodium reabsorption in the distal tubule of the kidneys. It promotes the excretion of chloride, potassium, magnesium, and bicarbonate. Side effects include: drowsiness, lethargy, and muscle weakness, but not muscle twitching. Although there may be abdominal cramping, there is not diarrhea. The client does not become confused as a result of taking this drug.

 CN: Health promotion and maintenance;  
CL: Analyze

**21. 3.** The nurse needs to inform the sister that it takes 2 to 4 weeks before a full clinical effect occurs with the drug. The nurse should let her know that her brother will gradually get better and symptoms of depression will improve. Telling the sister that her brother is experiencing a very serious depression does not give the sister important information about the medication. Additionally, this statement may cause alarm and anxiety. Conveying the sister’s concern to the physician does not provide her with the necessary information about the client’s medication. Telling the sister that the client’s medication may need to be changed is inappropriate because a full clinical effect occurs after 2 to 4 weeks.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**22. 1, 2, 3.** For the client with grandiose delusions, the nurse should accept the client but not argue with the delusion to build trust and the client’s self-esteem. Focusing on the underlying feeling


or meaning of the delusion helps to meet the client's needs. Focusing on events and topics based in reality distracts the client from the delusional thinking. Confronting the client's delusions or beliefs can lead to agitation in the client and the need to cling to the grandiose delusion to preserve self-esteem. Interacting with the client only when he is based in reality ignores the client's needs and therapeutic nursing intervention.

 CN: Psychosocial adaptation;  
CL: Synthesize

**23. 1.** Saying, "When you interrupt others, they leave the area," is most helpful because it serves to increase the client's awareness of how others view him by giving him specific feedback about his behavior. The other statements are punitive and authoritative, possibly threatening to the client, and likely to increase defensiveness, decrease self-worth, and increase feelings of guilt.

 CN: Psychosocial adaptation;  
CL: Synthesize

**24. 4.** To determine how low the gentamicin serum level drops between doses, the trough serum level should be drawn just before the administration of the next I.V. dose of gentamicin sulfate.

 CN: Pharmacological and parenteral therapies; CL: Apply


**25. 1.** Health-promoting strategies for clients with a history of cardiovascular disease require knowledge in three areas: diet, exercise, and medication. Pain management and management of social activities are not usually features of health promotion activities for these clients.

 CN: Health promotion and maintenance;  
CL: Apply


**26. 3.** The child is exhibiting signs and symptoms of possible epiglottitis. As a result the child is at high risk for laryngospasm and airway occlusion. Therefore, the nurse should have a tracheostomy tube and setup readily available should the child experience an airway occlusion. Although acetaminophen is an antipyretic, the dosage of 600 mg to be administered rectally is too high. A typical 4-year-old weighs approximately 40 lb. The recommended dose is 125 mg. When any type of respiratory illness, and especially epiglottitis, is suspected, putting any object, including a tongue depressor for inspection or a cotton-tipped applicator to obtain a throat culture, in the back of the mouth or throat or having the child open the mouth is inappropriate because doing so may predispose the child to laryngospasm or occlusion of the airway by a swollen epiglottis.

 CN: Reduction of risk potential;  
CL: Synthesize


**27. 3.** The client is exhibiting temporary side effects associated with lithium therapy. Therefore, the nurse should continue the lithium and explain to the client that he is experiencing temporary side effects of lithium that will subside. Common side effects of lithium are nausea, dry mouth, diarrhea, thirst, mild hand tremor, weight gain, bloating, insomnia, and light-headedness. Immediately notifying the physician about these common side effects is not necessary.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**28. 1.** Thyroid replacement is a lifelong maintenance therapy. The medication is usually given as one dose in the morning. It cannot be tapered or discontinued because the client needs thyroid supplementation to maintain health. The medication cannot be discontinued after the thyroid-stimulating hormone (TSH) level is normal; the dose will be maintained at the level that normalizes the TSH concentration.

 CN: Pharmacological and parenteral therapies; CL: Apply

**29. 4.** A client who is beginning training for a tennis team would most likely require an adjustment in lithium dosage because excessive sweating can increase the serum lithium level, possibly leading to toxicity. Adjustments in lithium dosage would also be necessary when other medications have been added, when an illness with high fever occurs, and when a new diet begins.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**30. 4.** Traveling is usually discouraged if preterm labor has been a problem, as it restricts normal movement. A client should be able to walk around frequently to prevent blood clots and to empty her bladder at least every 1 to 2 hours. Bladder infections often stimulate preterm labor and preventing them is of great importance to this client. Contractions that recur indicate the return of preterm labor and the health care provider needs to be notified. Dehydration is known to stimulate preterm labor and encouraging the client to drink adequate amounts of water helps to prevent this problem.

 CN: Reduction of risk potential;  
CL: Evaluate

**31. 3.** The most appropriate response is to continue all treatments and attempt to stabilize the client using fluid replacement without administering blood or blood products. It is imperative that the health care team respect the client's religious beliefs and wishes, even if they are not those of the health care team. Discontinuing all measures is not


an option. The health care team should continue to provide the best care possible and does not need to notify the attorney.

 CN: Management of care; CL: Synthesize


**32. 2.** Cystic fibrosis is the most common inherited disease in children. It is inherited as an autosomal recessive trait, meaning that the child inherits the defective gene from both parents. The chances are one in four for each of this couple's pregnancies.

 CN: Reduction of risk potential;  
CL: Apply

**33. 3.** Nitroglycerin in all dosage forms (sublingual, transdermal, or intravenous) should be shielded from light to prevent deterioration. The client should be instructed to keep the nitroglycerin in the dark container that is supplied by the pharmacy, and it should not be removed or placed in another container.

 CN: Pharmacological and parenteral therapies; CL: Apply


**34. 3.** Valproic acid causes sedation as well as nausea, vomiting, and indigestion. Sedation is important because the client needs to be cautioned about driving or operating machinery that could be dangerous while feeling sedated from the medication. Depakene does not cause increased urination, slowed thinking, or weight loss. However, some clients may experience weight gain.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**35. 1.** These effects and others when seen after birth are known as a cluster of symptoms called fetal alcohol syndrome. Vitamin B<sub>6</sub> and vitamin A deficiency can affect growth and development but not with these specific effects. Folic acid deficiency contributes to neural tube defects.

 CN: Reduction of risk potential;  
CL: Analyze


**36. 4.** NSAIDs irritate the gastric mucosa and should be taken with food. NSAIDs are usually taken once or twice daily. Joint exercise is not related to the drug administration. Antacids may interfere with the absorption of NSAIDs.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**37. 2.** The client who drinks alcohol while taking disulfiram experiences sweating, flushing of the neck and face, tachycardia, hypotension, a throbbing headache, nausea and vomiting, palpitations, dyspnea, tremor, and weakness.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**38. 3.** Holding the gauze pledget against an I.M. injection site while removing the needle from the muscle avoids the discomfort of the needle pulling on the skin.

 CN: Pharmacological and parenteral therapies; CL: Apply


**39. 3.** Physical activity is gradually increased after a myocardial infarction while the client is still hospitalized and through a period of rehabilitation. The client is progressing too rapidly if activity significantly changes respirations, causing dyspnea, chest pain, a rapid heartbeat, or fatigue. When any of these symptoms appears, the client should reduce activity and progress more slowly. Edema suggests a circulatory problem that must be addressed but doesn't necessarily indicate overexertion. Cyanosis indicates reduced oxygen-carrying capacity of red blood cells and indicates a severe pathology. It is not appropriate to use cyanosis as an indicator for overexertion. Weight loss indicates several factors but not overexertion.

 CN: Reduction of risk potential;  
CL: Analyze

**40. 1, 2, 4.** Telehealth is becoming an increasingly available way for nurses to conduct counseling sessions with clients who are at a distance from a health care provider or health care facility. The client saves travel time and can avoid precipitating symptoms associated with the stress disorder that might occur as a result of a visit to a health care facility. The client also can access care that might not otherwise be easily available. Treatment for PTSD is long-term, and there is no evidence to suggest that telehealth versus face-to-face counseling shortens recovery time. Counseling sessions using telehealth technology are conducted on an individual basis between one client and a health care provider, but group support may be available if required as a part of a treatment plan.

 CN: Management of care; CL: Evaluate

**41. 3.** When a client talks about not having a problem with alcohol, the nurse needs to point out how alcohol has gotten the client into trouble. Concrete facts are helpful in decreasing the client's denial that alcohol is a problem. The other approaches allow the client to use defense mechanisms, such as rationalization, projection, and minimization, to explain her actions. Therefore, these approaches are not helpful.

 CN: Psychosocial adaptation;  
CL: Synthesize

**42. 3.** Medicaid is state funded, with matching federal funds, and provides medical assistance for low-income persons without health insurance. The program for older adults is Medicare.

 CN: Management of care; CL: Apply

**43. 3.** Before development and implementation of the teaching plan, it is vital to determine what the client currently knows regarding diabetes and what the client needs to know.

 CN: Management of care; CL: Create

**44. 1.** The goal of the education program is to instruct the client to take his pulse; therefore, the expected outcome would be the ability to give a return demonstration of how to palpate the heart rate.

 CN: Reduction of risk potential;  
CL: Evaluate

**45. 3.** Percutaneous umbilical blood sampling is a useful procedure for diagnosing Rh disease, obtaining fetal complete blood count, and karyotyping chromosomes to evaluate for genetic disorders. Ultrasound commonly is used to detect twins. A lecithin-sphingomyelin ratio is the procedure of choice to diagnose fetal lung maturation. A maternal blood test is used to determine the alpha fetoprotein level.

 CN: Reduction of risk potential;  
CL: Apply

**46. 2.** The client should report tinnitus because vancomycin can affect the acoustic branch of the eighth cranial nerve. Vancomycin does not affect the vestibular branch of the acoustic nerve; vertigo and ataxia would occur if the vestibular branch were involved. Muscle stiffness is not associated with vancomycin.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**47. 4.** Caffeinated beverages and alcohol should be avoided because they stimulate gastric acid production and irritate gastric mucosa. The client should avoid foods that cause discomfort; however, there is no need to follow a soft, bland diet. Eating six small meals daily is no longer a common treatment for peptic ulcer disease. Milk in large quantities is not recommended because it actually stimulates further production of gastric acid.

 CN: Reduction of risk potential;  
CL: Evaluate

**48. 3.** When a client with a NG tube exhibits abdominal distention, the nurse should first check the suction machine. If the suction equipment is functioning properly, then the nurse should take other steps, such as repositioning the tube or checking tube patency by irrigating it. If these steps are not effective, then the physician should be called.

 CN: Reduction of risk potential;  
CL: Synthesize

**49. 4.** Increased, not decreased, body temperature resulting from occupations or infections can contribute to low sperm counts caused by decreased sperm production. Heat can destroy sperm. Varicocele, an abnormal dilation of the veins in the spermatic cord, is an associated cause of a low sperm count. The varicosity increases the temperature within the testes, inhibiting sperm production. Frequent use of saunas or hot tubs may lead to a low sperm count. The temperature of the scrotum becomes elevated, possibly inhibiting sperm production. Endocrine imbalances (thyroid problems) are associated with low sperm counts in men because of possible interference with spermatogenesis.

 CN: Reduction of risk potential;  
CL: Evaluate

**50. 4, 2, 1, 3.** First, the nurse should assess the client from the emergency department who is screaming because she may be anywhere along the labor continuum and her status will be unknown until she has a vaginal exam to determine cervical effacement and dilation. The nurse should next assess the client with right lower quadrant pain as she may be experiencing an ectopic pregnancy or appendicitis and may need further evaluation by the health care provider. The client with clear vesicles and brown vaginal discharge is experiencing a molar pregnancy and will need to have a D&C to evacuate the vesicles; this condition will not jeopardize the life of the mother if no intervention occurs within an hour. The client who is at term without fetal movement is a priority from an emotional concern if there is no heart beat when she is evaluated, but the physical status of the fetus with no fetal movement for 2 days will not change if not seen within the next half hour and the nurse can see this client last. The emotional care for this client will be extensive if there is a diagnosis of fetal demise and the nurse should plan the time to be available to support this client as needed.

 CN: Management of care; CL: Synthesize

**51. 1.** The clinical findings of edema are consistent with fluid excess in the interstitial compartment. The extracellular compartment consists of fluid in two locations, the interstitial (tissue) spaces and plasma (intravascular) spaces. Fluid shifts within the extracellular compartment can occur either from the plasma space to the interstitial space, or from the interstitial space to the plasma space. When fluid shifts from the plasma space into the interstitial space, usually as a result of abnormal retention of fluids in such conditions as heart failure or renal failure, edema results. The intracellular compartment consists of fluid within the cells.

 CN: Reduction of risk potential;  
CL: Analyze

**52. 1.** Low potassium can cause an imbalance at the cellular level that leads to dysrhythmias and cardiac arrest. Hyperglycemia is caused by elevated blood sugar. Hypertension is unrelated to potassium levels. Increased energy is unrelated to potassium levels.

 CN: Reduction of risk potential;  
CL: Analyze

**53. 2.** Handwashing with the correct technique is the best method for preventing cross-contamination. The hands serve as a source of infection. Waterless commercial products containing at least 60% alcohol are as effective at killing organisms as handwashing.

 CN: Management of care; CL: Synthesize

**54. 3.** The third maneuver is used to identify the presenting part. This maneuver is used to identify the part of the fetus that lies over the inlet to the pelvis. While facing the client, the nurse places the tips of the first three fingers on the side of the woman's abdomen above the symphysis pubis and palpates deeply around the presenting part to identify its contour and size. The first maneuver involves using the tips of the fingers of both hands to palpate the uterine fundus. The second maneuver identifies the back of the fetus, and the fourth maneuver identifies the cephalic prominence.

 CN: Reduction of risk potential;  
CL: Apply

**55. 2.** The stored glucose of muscle glycogen is the major fuel during sustained activity. Glucose production slows as the body begins to depend on fat stores for glucose and fatty acids. Protein is not the body's preferred energy source. Fat is a secondary source of energy. Water is not an energy source, although sufficient water is required to engage in aerobic activity without causing dehydration.

 CN: Health promotion and maintenance;  
CL: Apply

**56. 3.** Fluctuation of fluid with respirations in the water-seal column indicates that the system is functioning properly. If an obstruction were present in the chest tube, fluid fluctuation would be absent. Subcutaneous emphysema occurs when air pockets can be palpated beneath the client's skin around the chest tube insertion site. A leak in the system is indicated when bubbling occurs in the water-seal column.

 CN: Reduction of risk potential;  
CL: Apply

**57. 4.** It is important to dry the feet carefully after a bath to prevent a fungal infection. Diabetic clients should seek medical attention when they injure

their toes or feet to prevent complications. Iodine is highly toxic to the tissues. Diabetic clients should inspect their feet daily and should wear shoes that support their feet while in the house.

 CN: Reduction of risk potential;  
CL: Evaluate

**58. 2.** Diverticular rupture causes peritonitis from the release of intestinal contents (chemicals and bacteria) into the peritoneal cavity. A rigid abdominal wall results from a diverticular cavity. The inflammatory response of the peritoneal tissue produces severe abdominal rigidity and pain, diminished intestinal motility, and retention of intestinal contents (air, fluid, and stool). Hyperactive bowel sounds, explosive diarrhea, and excessive flatulence do not indicate peritonitis.

 CN: Reduction of risk potential;  
CL: Analyze

**59. 1, 2, 3, 5.** Pancreatitis, a chronic or acute inflammation of the pancreas, is a potentially life-threatening condition. Excessive alcohol intake and gallstones are the greatest risk factors. Abdominal trauma can potentiate inflammation. Hyperlipidemia is a risk factor for recurrent pancreatitis. Hypertension and hypothyroidism are not associated with pancreatitis.

 CN: Reduction of risk potential;  
CL: Analyze

**60. 3.** The client most in need of validating safety is the mother who has received Methergine 1 hour ago for increased bleeding. Her bleeding level needs to be documented as having been evaluated at the beginning of the shift and to determine if it has decreased to within normal limits (i.e., saturating less than 1 pad/hour). The 3 stable clients will need to have an initial assessment by the oncoming nurse but can wait until the nurse can first assess the mother who is receiving Methergine. The mother with the 4-hour-old infant is able to breast-feed to maintain the blood glucose level, and the mother with the 3-day-old infant in the "bili blanket" is stable at this point.

 CN: Management of care; CL: Synthesize

**61. 1.** The nurse should firmly yet gently strike the chest wall with the hand cupped to make a hollow popping sound. A slapping sound indicates that an incorrect technique is being used. The area over the rib cage is percussed to loosen mucus from the underlying lung passages. The child should wear a thin piece of clothing (T-shirt) over the chest area to protect the skin without diminishing the effect of the percussion.

 CN: Reduction of risk potential;  
CL: Analyze


**62. 1.** The nurse should call to the desk to ask for assistance. The nurse needs to notify the doctor of the client's death and the family must then be notified. A code should not be called. Nursing personnel should begin postmortem care so that the family does not walk in unannounced to find their loved one deceased and looking disarrayed.

 CN: Management of care; CL: Synthesize

**63. 2 lb.** One pound of weight is approximately equivalent to 3,500 calories. Removing 1,000 calories per day results in a 2-lb weight loss per week (7,000 calories divided by 7 days). If a client wanted to lose 1 lb in a 7-day period, he would need to cut out 500 calories per day (3,500 calories divided by 7 days). It is unsafe to try to lose more than 2 lb/week.

 CN: Health promotion and maintenance; CL: Apply

**64. 1.** The nurse should instruct the client to take the medication immediately or as soon as she remembers that she missed the medication. There is only a slight risk that the client will become pregnant when only one pill has been missed, so there is no need to use another form of contraception. However, if the client wishes to increase the chances of not getting pregnant, a condom can be used by the male partner. The client should not omit the missed pill and then restart the medication in the morning because there is a possibility that ovulation can occur, after which intercourse could result in pregnancy. Taking two pills is not necessary and also will result in putting the client off her schedule.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**65. 1.** Pain disorder is a somatoform disorder involving severe pain in one or more anatomic sites causing severe distress or impaired function. The statement, "I need to have a good cry about all the pain I've been in and then not dwell on it," indicates improvement because the client has a realistic view of the physical symptoms and pain and is willing to let them go and move on. The other statements indicate the continued presence of denial, lack of insight, and the need for symptoms to manage anxiety.

 CN: Psychosocial adaptation; CL: Evaluate

**66. 4.** The nurse needs to collect additional information about the client's complaint of hearing voices. Assessing the content of hallucinations is essential to determine whether they are command hallucinations that the client might act on. Asking about what the neighbor has been doing or telling the client that the neighbor won't visit indirectly

reinforces the delusion about the neighbor. Although determining the onset and duration of the voices is important, the nurse needs to assess the content of the hallucinations first.

 CN: Psychosocial adaptation; CL: Synthesize

**67. 3.** A client with severe diarrhea loses large amounts of bicarbonate, resulting in metabolic acidosis. Metabolic alkalosis does not result in this situation. Diarrhea does not affect the respiratory system.

 CN: Reduction of risk potential; CL: Analyze

**68. 4.** Serum osmolality indicates the water balance of the body. A normal plasma osmolality between 275 and 295 mOsm/kg indicates that the fluid volume excess has been resolved. A weight reduction of 10% may not necessarily return the client to a state of normal serum osmolality. Clients with excess fluid volume do not necessarily have pain or abnormal arterial blood gas values.

 CN: Reduction of risk potential; CL: Synthesize

**69. 3.** Exactly why rheumatic fever follows a streptococcal infection is not known, but it is theorized that an antigen-antibody response occurs to an M protein present in certain strains of streptococci. The antibodies developed by the body attack certain tissues such as in the heart and joints. Antistreptolysin O titer findings show elevated or rising antibody levels. This blood finding is the most reliable evidence of a streptococcal infection.


 CN: Reduction of risk potential; CL: Analyze

**70. 1.** The ability to communicate with a person of the same language would be an advantage, an opportunity for socialization and support for the new mother who speaks Spanish. If a Spanish-speaking mother were placed with the client who also had a baby in SCN, she would have no communication opportunity and the same would apply for rooming with the mother who has had a Caesarean section. The client who is non-English speaking does not identify the language spoken and the nurse cannot assume that it is Spanish.

 CN: Management of care; CL: Synthesize

**71. 3.** The nurse should call the surgeon's office so that arrangements can be made for the client to donate a unit of his blood for possible future autotransfusion. This must be done in sufficient time before surgery so that the client is not at risk for being anemic at the time of the scheduled procedure. The client's request must be scheduled through the surgeon's office because the surgeon has

ultimate responsibility for the client. The nurse can document that the surgeon's office was notified of the client's request. Notifying the hematology laboratory or blood bank is not an appropriate response.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**72. 1.** High colonic irrigation can increase the risk of perforation in a distended and inflamed colon. Tap water is hypotonic in the bowel and would draw increased fluid into the area. The other orders are part of standard preparation for intestinal surgery.

 CN: Reduction of risk potential; CL: Synthesize

**73. 1, 3.** When a client collects stool for occult blood, the nurse should instruct him to avoid eating meat, especially red meat, for 1 to 3 days before the sample collection because meat eliminated in the stool can lead to false-positive results. Eating foods high in fiber a few days before sample collection may be recommended because doing so improves the chances of finding occult blood if a lesion is present. The client should take stool samples from different sites of the stool for a better sample. The stool sample should be covered to protect everyone from body secretions. The specimen does not have to be sent to the laboratory immediately. Some medications, herbs, foods, and activities can lead to false results of the occult testing. For example, iron pills, turnips, and horseradish lead to false-positive results. Vitamin C leads to false-negative results. Some anti-inflammatory drugs and aspirin should be avoided due to antiplatelet properties that increase the risk of gastrointestinal bleeding.


 CN: Reduction of risk potential; CL: Evaluate

**74. 3.** The most appropriate intervention is to offer the client frequent mouth care to moisten the dry oral mucosa. Reexplaining why the client cannot drink may be helpful but will not relieve her thirst. Ice chips cannot be given to a client who is on nothing-by-mouth status. Diverting the client's attention does not treat her complaint.

 CN: Basic care and comfort; CL: Synthesize

**75. 2.** This client is demonstrating classic symptoms of hypothyroidism. Primary hypothyroidism results from pathologic changes in the thyroid gland. In this case, the thyroid gland cannot secrete sufficient amounts of thyroid hormone, leading to a decrease in cellular metabolic activity, decreased oxygen consumption, and decreased heat production. Cushing's disease is manifested by a buffalo hump, moonface, hypertension, fatigability, and weakness, resulting from the inappropriate release

of cortisol. Hyperthyroidism, or Graves' disease, is manifested by increased appetite with weight loss, increased anxiety, hand tremors, palpitations, heat intolerance, and insomnia. A pituitary tumor can have many symptoms, depending on the location.

 CN: Reduction of risk potential; CL: Analyze

**76. 3.** After the symptoms of puberty, such as increased hair growth and enlargement of the breasts, are noticed, menstruation typically begins within 30 months.

 CN: Health promotion and maintenance; CL: Apply

**77. 2.** Epstein's pearls are tiny, hard, white nodules found in the mouth of some neonates. They are considered normal and usually disappear without treatment. Koplik's spots, associated with measles in children, are patchy and bright red with a bluish-white speck in the middle. Precocious teeth are actual teeth that some neonates have at birth. Usually only one or two teeth are present. *Candida albicans*, or thrush, is not apparent in the mouth immediately after birth but may appear a day or two later. This infection is manifested by yellowish-white spots or lesions that resemble milk curds and bleed when attempts are made to wipe them away.

 CN: Health promotion and maintenance; CL: Analyze

**78. 1, 2.** The initial signs of esophageal atresia and TEF include lots of frothy mucus and unexplained episodes of cyanosis usually caused by overflow of mucus from the esophagus. Loose stools and poor gag reflex are not signs of TEF. Initial weight loss is common in newborns and not related to TEF.

 CN: Reduction of risk potential; CL: Analyze


**79. 1.** Adequate circulatory status is the most important factor in the healing process of an infected decubitus ulcer. Blood flow to the area must be present to bring nutrients and prescribed antibiotics to the tissues. Rest and a balanced diet are essential to health maintenance but are not the priority for healing an infected decubitus ulcer. A fluid intake of 2,000 to 3,000 mL/day, if not contraindicated, is recommended to provide hydration to the client's tissues.

 CN: Reduction of risk potential; CL: Synthesize

**80. 2.** The nurse's initial response should be to withhold the digoxin. The nurse should then notify the physician if the apical pulse is 60 bpm or lower because of the risk of digoxin toxicity. The charge



nurse does not need to be notified, but the nurse needs to document the notification and follow-up in the chart.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**81. 2.** In an emergency in which the neonate's head is already delivering, the first action by the nurse should be to check for the presence of a cord around the neonate's neck. If the cord is present, the nurse should gently remove it from around the neck. The mother should be told to breathe gently and avoid forceful bearing-down efforts, which could lead to lacerations. Although blood and bodily fluid precautions are always present in client care, this is an emergency. If possible, the nurse should put on gloves. Suctioning the mouth can be done after the nurse has checked that the cord is not around the neonate's neck. Telling the mother that help is on the way is not reassuring because emergency medical technicians may take some time to arrive. Delivery is imminent because the neonate's head is delivering.

 CN: Reduction of risk potential;  
CL: Synthesize

**82. 2.** The ulna heals in approximately 12 weeks. The femur takes approximately 24 weeks to heal because of the size of the bone and the muscle forces exerted on the femur. Skeletal traction does not delay healing but can actually promote healing by properly aligning the fracture.

 CN: Reduction of risk potential;  
CL: Synthesize

**83. 2.** The client needs to know that there is a cause for the delirium, that there is hope for treatment, and that medications can help decrease anxiety. Giving medications can help the anxiety, but the client also needs an explanation about the condition. Saying that the more the client worries, the worse the delirium will get is inappropriate and most likely would add to the client's anxiety.

 CN: Psychosocial adaptation;  
CL: Synthesize

**84. 1.** The client understands the instructions when she says she should avoid contact sports because they may result in injury to the client and the fetus. Learning to ski while pregnant is not recommended because injury may occur. Scuba diving should be avoided because depth pressures could cause fetal damage. Hot tubs should be avoided during the first trimester because sitting in them can result in fetal hyperthermia and fetal hypoxia. Mild exercises, such as walking, can help strengthen the muscles and prevent some discomforts such as backache.

 CN: Health promotion and maintenance;  
CL: Evaluate

**85. 4.** Third-degree heart block occurs when atrial stimuli are blocked at the atrioventricular junction. Impulses from the atria and ventricles are conducted independently of each other. The atrial rate is 60 to 100 bpm; the ventricular rate is usually 10 to 60 bpm.

 CN: Reduction of risk potential;  
CL: Analyze

**86. 1.** The nurse should call the oncology unit to institute a transfer. The nurse handling chemotherapy agents should be specially trained. It is an unwise use of nursing resources to send a nurse from one unit to administer medications to a client on another unit. It is better to centralize and send the client who needs chemotherapy to one unit. Even if the pharmacy mixes the agent, the drug must be administered by a specially trained nurse.

 CN: Management of care; CL: Synthesize

**87. 2.** After surgery, the most important nursing diagnosis is *Risk for infection*. Surgery involves an incision, which places the infant at risk for infection. The infant with this type of procedure does have discomfort, which can be relieved with acetaminophen (Tylenol). *Acute pain* is an important nursing diagnosis but not the priority. The infant may be in arm restraints or have the cuff of the sleeve pinned to the diaper or pants. It is important that the infant not touch the incision line or disrupt the sutures. There is no indication for a nursing diagnosis of *Impaired parenting*. The parents would be reacting normally with a first reaction of shock.


 CN: Reduction of risk potential;  
CL: Analyze

**88. 1.** An appropriate outcome for the client with rheumatoid arthritis is that he will adopt self-care behaviors to manage joint pain, stiffness, and fatigue and be able to perform activities of daily living. Range-of-motion (ROM) exercises can help maintain mobility, but it may not be realistic to expect the client to maintain full ROM. Depending on the disease progression, there may be further development of pain and joint deformity, even with appropriate therapy. It is important for the client to understand the importance of taking the prescribed drug therapy even if symptoms have abated.


 CN: Reduction of risk potential;  
CL: Synthesize

**89. 4.** Hydrotherapy wound cleaning is very painful for the client. The client should be medicated for pain about 30 minutes before the treatment in anticipation of the increased pain the client will experience. Wounds are debrided but excessive fluids are not lost during the hydrotherapy session. However, electrolyte loss can occur from open

wounds during immersion, so the sessions should be limited to 20 to 30 minutes. There is no need to limit food or fluids 45 minutes before hydrotherapy unless it is an individualized need for a given client. Topical antibiotics are applied after hydrotherapy.

 CN: Reduction of risk potential;  
CL: Create

**90. 1.** Hepatitis B immune globulin is given as prophylactic therapy to individuals who have been exposed to hepatitis B. Interferon has been approved to treat hepatitis B. Hepatitis B surface antigen is a diagnostic test used to detect current infection. Amphotericin B is an antifungal.

 CN: Pharmacological and parenteral therapies; CL: Apply

**91. 1.** When examining the tympanic membrane of a child younger than age 3 years, the nurse should pull the pinna down and back. For an older child, the nurse should pull the pinna up and back to view the tympanic membrane.

 CN: Reduction of risk potential;  
CL: Apply


**92. 3.** In the compensatory stage of shock, the client exhibits moderate tachycardia. If the shock continues to the progressive stage, decreased urinary output, hypotension, and mental confusion develops as a result of failure to perfuse and ineffective compensatory mechanisms. These findings are indications that the body's compensatory mechanisms are failing.

 CN: Reduction of risk potential;  
CL: Analyze


**93. 2.** Hydrochlorothiazide is a thiazide diuretic. Muscle weakness can be an indication of hypokalemia. Polyuria is associated with this diuretic, not urinary retention. Confusion and diaphoresis are not side effects of hydrochlorothiazide.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**94. 1.** The ability to remember an old song is related to long-term memory, which persists after short-term memory is lost. Therefore, the nurse should respond by providing the son with this information. Stating that the nurse is happy to hear about the change and that the client is getting better is inappropriate and inaccurate. This statement ignores the issue of long-term versus short-term memory. Telling the client not to get his hopes up because the improvement is only temporary is inappropriate. The information provided does not indicate that the client has expressive aphasia, which would be suggested by the statement that the client can't talk to the son.

 CN: Psychosocial adaptation;  
CL: Analyze

**95. 1.** A specimen for culture and sensitivity should be sent to the laboratory promptly so that a smear can be taken before organisms start to grow in the specimen.

 CN: Reduction of risk potential;  
CL: Apply


**96. 1.** The client is in a crisis and has a high anxiety level. Holding the client's hands and encouraging the client to slow down and take a deep breath conveys caring and helps decrease anxiety. Telling the client to calm down or stop worrying offers no concrete directions for accomplishing this task. It is unknown from the data who was at fault in the accident. Therefore, it is inappropriate for the nurse to state that it wasn't the client's fault.

 CN: Psychosocial adaptation;  
CL: Synthesize


**97. 3.** Many women who acquire gonorrhea are asymptomatic or experience mild symptoms that are easily ignored. They are not necessarily more reluctant than men to seek medical treatment, but they are more likely not to realize they have been affected. Gonorrhea is easily transmitted to all women and can result in serious consequences, such as pelvic inflammatory disease and infertility.

 CN: Management of care; CL: Create

**98. 4.** Tingling and numbness of the toes would be the earliest indication of circulatory impairment. Inability to move the toes and cyanosis are later indicators. Complaints of cast tightness should be investigated because cast tightness can lead to circulatory impairment; it is not, however, an indicator of impairment.

 CN: Reduction of risk potential;  
CL: Analyze

**99. 3.** The client should be encouraged to report painful urination or urinary retention. Lesions may appear 2 to 12 days after exposure. The client is capable of transmitting the infection even when asymptomatic, so a barrier contraceptive should be used. Drinking extra fluids will not stop the lesions from forming.

 CN: Management of care;  
CL: Synthesize

**100. 1.** The nurse should initiate fetal and contraction monitoring for this client upon arrival to the unit. This gives the nurse data regarding changes in fetal and maternal contraction status before completing the other orders. Next, the betamethasone would be given to begin the maturation process for the fetal lungs. Next, the nurse should start an intravenous infusion to provide a line for immediate

intravenous access, if needed, and provide hydration for the client. The nurse should obtain the urine specimen prior to administering any antibiotic therapy, if ordered.

 CN: Management of care; CL: Synthesize

**101. 2.** Severe hypoperfusion to all vital organs results in failure of the vital functions and then circulatory collapse. Hypotension, anuria, respiratory distress, and acidosis are other symptoms associated with irreversible shock. The client in irreversible shock will not be alert.

 CN: Reduction of risk potential;  
CL: Analyze

**102. 1.** Pulmonary embolism is a potentially life-threatening complication of deep vein thrombosis. The client's change in mental status, tachypnea, and tachycardia indicate a possible pulmonary embolism. The nurse should promptly notify the doctor of the client's condition. Administering a sedative without further evaluation of the client's condition is not appropriate. There is no need to elicit a positive Homans' sign; the client is already diagnosed with deep vein thrombosis. Increasing the I.V. flow rate may be an appropriate action, but not without first notifying the physician.

 CN: Reduction of risk potential;  
CL: Synthesize

**103. 2.** Coping with the chronic tinnitus of Ménière's disease can be very frustrating. Providing background sound, such as music, can help camouflage the low-pitched, roaring sound of tinnitus. Maintaining a quiet environment can make the sounds of tinnitus more pronounced. Avoiding caffeine and nicotine is recommended, because this can decrease the occurrence of the tinnitus. However, avoiding these substances does not help the client with coping with tinnitus when it occurs. Taking a sedative does not affect tinnitus.

 CN: Reduction of risk potential;  
CL: Synthesize

**104. 2.** The child's signs and symptoms in conjunction with the acute onset suggest possible croup or epiglottitis. The priority diagnosis at this time is *Risk for injury*. The airway may become completely occluded by the epiglottis at any time. Although the child is probably experiencing fear and anxiety, and impaired gas exchange may occur with continued respiratory distress, the immediate priority is a patent airway. No evidence is provided to support aspiration and ineffective airway clearance.

 CN: Reduction of risk potential;  
CL: analyze

**105. 3.** The nurse should first determine why the client wants to sit up, and then, if needed delegate someone to assist the client. Loosening the restraints will not keep the client safe in bed. Raising the side rails and elevating the head of the bed do not address the client's needs.

 CN: Management of care; CL: Synthesize

**106. 4.** Diabetic retinopathy involves background and proliferative retinopathy. Both forms are associated with vascular changes in the basement membrane of the arterioles and capillaries of the choroid and retina. Neuropathy is usually associated with the lower extremities.

 CN: Reduction of risk potential;  
CL: Analyze

**107. 2.** The 70-year-old woman with syncopal episodes is at greatest risk for falling. The nurse should assess the client's gait and balance and the syncopal episodes. The 22-year-old man with upper body fractures and the 50-year-old man with angina are not at risk for falling. The 30-year-old woman could be at risk for falling, but she is at less risk than the 70-year-old client with syncope.

 CN: Management of care; CL: Analyze

**108. 3.** The baseline laboratory data that are established before a client is started on tissue plasminogen activator or alteplase recombinant include hematocrit, hemoglobin level, and platelet count.


 CN: Reduction of risk potential;  
CL: Apply

**109. 3.** The most appropriate long-term goal for the client with hypertension is to commit to life-long therapy. A significant problem in the long-term management of hypertension is compliance with the treatment plan. It is essential that the client understand the reasons for modifying lifestyle, taking prescribed medications, and obtaining regular health care. Limiting stress, losing weight, and monitoring blood pressure are important aspects of care for the client with hypertension; however, the treatment plan must be individualized to include aspects of care that are appropriate for each client.

 CN: Health promotion and maintenance;  
CL: Synthesize

**110. 1.** The nurse should work with the client to individualize the plan of care for managing pain. Cancer pain is best managed with a combination of medications, and each client needs to be worked with individually to find the treatment regimen that works best. Cancer pain is commonly undertreated because of fear of addiction. The client who is in pain needs the appropriate level of analgesic and needs to be reassured that he will not become

addicted. Cancer pain is best treated with regularly scheduled doses of medication. Administering the medication only when the client asks for it will not lead to adequate pain control. As drug tolerance develops, the dosage of the medication can be increased.

 CN: Basic care and comfort;  
CL: Synthesize

**111. 4.** The client needs further instructions when she says, “I can continue to work at my job at the automobile factory until labor starts.” The goal is to avoid preterm labor. Because the client is experiencing severe hydramnios, she will most likely be maintained on bed rest to increase uteroplacental circulation and reduce pressure on the cervix. Hydramnios has been associated with increased weight gain caused by increased amniotic fluid volume. Hydramnios has been associated with gastrointestinal disorders in the fetus, such as tracheoesophageal fistula with stenosis or intestinal obstruction. The client should continue to eat high-fiber foods and should avoid straining, which could lead to ruptured membranes. Stool softeners may also be ordered. The client should report any symptoms of fluid rupture or labor.

 CN: Reduction of risk potential;  
CL: Evaluate

**112. 1.** The stationary bicycle is the most appropriate training modality because it is a non-weight-bearing exercise. Interval training involves rest and exercise. The time that the individual exercises on the stationary bicycle is increased with improved functional capacity, and the rest time is decreased.

 CN: Health promotion and maintenance;  
CL: Synthesize

**113. 1.** Nausea and anorexia, and in some situations weight loss, are symptoms experienced by clients with jaundice. Jaundice is associated with high levels of bilirubin in the blood. Causes include hepatitis, yellow fever, and alcoholism. The nursing diagnoses of *Acute pain* related to muscle spasms and *Ineffective health maintenance* are not supported by the data. *Adult failure to thrive* is a possible nursing diagnosis; however, more data is needed to support it.


 CN: Reduction of risk potential;  
CL: Analyze

**114. 1.** The protocol recommended by the Agency for Healthcare Research and Quality is that all clients who are at risk for pressure ulcer development be identified on admission to health care facilities so that preventive actions can be implemented by the nursing staff. These preventive actions need to be individualized to the client, so automatic placement

of all at-risk clients on an every-2-hour turning schedule, a specialty bed, or a high-protein, high-carbohydrate diet is not appropriate.

 CN: Reduction of risk potential;  
CL: Apply

**115. 3.** Visual disturbances are a symptom of digoxin (Lanoxin) toxicity. These disturbances can include double, blurred, or yellow vision. Cardiovascular manifestations of digoxin toxicity include bradycardia, other dysrhythmias, and pulse deficit. Gastrointestinal symptoms include anorexia, nausea, and vomiting.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**116. 2.** Irradiated skin can become dry and irritated, resulting in itching and discomfort. The client should be instructed to clean the skin gently and apply nonperfumed, nonirritating lotions to help relieve dryness. Taking an antihistamine does not relieve the skin dryness that is causing the itching. Heat should not be applied to the area because it can cause further irritation. Medicated ointments, especially corticosteroids, which is controversial, should not be applied to the skin without the order of the radiation therapist.

 CN: Reduction of risk potential;  
CL: Evaluate


**117. 1.** The mask is appropriate because it covers the nose and mouth and fits snugly against the cheeks and chin. Masks that are too large may cover the eyes. Masks that are too small obstruct the nose. The mask does not need to be covered with a cloth.

 CN: Management of care; CL: Evaluate

**118. 4.** In preparation for a thoracentesis, the client should be asked to sit forward and place his arms on the bedside table for support. This position provides access to the chest wall and intercostal spaces for insertion of the needle. The supine, Sims', or prone position would not provide adequate access to the chest wall or separate the intercostal spaces sufficiently for needle insertion.


 CN: Reduction of risk potential;  
CL: Apply

**119. 4.** The antidote for heparin is 1% protamine sulfate. Vitamin K is the antidote for warfarin, an oral anticoagulant. Thrombin is a topical anticoagulant.


 CN: Pharmacological and parenteral therapies; CL: apply

**120. 1.** At this time, the client's anger is not out of control, so empathy and talking are appropriate to diffuse the anger. Using time-out is appropriate when the client's anger is escalating and the client can

no longer talk about the anger rationally. Restraints are appropriate only when there is imminent risk of harm to the client or others. Future strategies are discussed after the initial incident is resolved.

 CN: Psychosocial adaptation;  
CL: Synthesize

**121. 1.** The nurse's first action after the removal of a NG tube is to provide the client with oral hygiene. Then it is appropriate to give the client liquids to drink if the client is no longer on nothing-by-mouth status. There is no association between removal of an NG tube and having the client cough and deep-breathe. Auscultating the client's bowel sounds should be done before removal of the NG tube.

 CN: Basic care and comfort;  
CL: Synthesize

**122. 3.** Heat applications cause vasodilation, which promotes circulation to the area, and increase tissue metabolism and leukocyte mobility. Heat applications do not prevent swelling; applications of cold are used to prevent swelling by causing vasoconstriction. Moist heat applications do not reduce bruising or scaling on the skin.

 CN: Reduction of risk potential;  
CL: Evaluate

**123. 1.** Thick, cloudy amniotic fluid indicates an intrauterine infection. Typically, the client has a fever, lethargy, and malaise. Greenish-colored amniotic fluid is associated with meconium staining. A strong yellowish color is associated with erythroblastosis fetalis because of the presence of bilirubin and hemolyzed red blood cells. The normal color of amniotic fluid is clear or with a very slight yellow tint later in pregnancy.

 CN: Reduction of risk potential;  
CL: Analyze

**124. 3.** When finishing a 24-hour urine collection, the final voided urine is saved and added to the collection container. The first urine specimen, voided at 7 a.m. Monday, is discarded. The urine is not sent for a urine culture. It is not necessary to separate each day's collection of urine.

 CN: Reduction of risk potential;  
CL: Apply

**125. 2.** Hypoalbuminemia occurs in cirrhosis because the liver cannot synthesize albumin. This causes a decrease in colloidal osmotic pressure, resulting in ascites. Hyperkalemia is not an expected electrolyte imbalance of cirrhosis. The aspartate aminotransferase and alanine aminotransferase values are increased in liver disease.

 CN: Reduction of risk potential;  
CL: Analyze

**126. 2.** At this time, the infant can be given the vaccines. The fact that the child's sibling is immunosuppressed because of chemotherapy is not a reason to withhold the vaccines. The fact that the child has a cold is not grounds for delaying the immunizations. However, if the child had a high fever, the immunizations would be delayed.

 CN: Health promotion and maintenance;  
CL: Synthesize

**127. 3.** The primary cause of disability and death in children is injury from accidents. Teaching safety measures to children and their parents is the best way to decrease injury and accidents.

 CN: Management of care;  
CL: Synthesize

**128. 1.** A major goal of postoperative care for the client who has had an incisional cholecystectomy is the prevention of respiratory complications. Because of the location of the incision, the client has a difficult time breathing deeply. Use of incentive spirometry promotes chest expansion and decreases atelectasis. Performing leg exercises each shift is not frequent enough; they should be performed hourly. Maintaining a weight reduction diet may be appropriate for the client, but it is not the highest priority in the immediate postoperative phase. Promoting wound healing is important, but respiratory complications are most common after a cholecystectomy.

 CN: Reduction of risk potential;  
CL: Synthesize

**129. 1.** In response to hearing a noise, normally hearing infants blink or startle and stop body movements. Shy and withdrawn behaviors are characteristic of older children with hearing impairment. Squealing occurs in 90% of infants by age 4 months. Most infants can say "da-da" by age 9 months.

 CN: Health promotion and maintenance;  
CL: Evaluate

**130. 3.** Continuous irrigation, usually consisting of sterile normal saline, is used after TURP to keep blood clots from obstructing the catheter and impeding urine flow. Antibiotics may be instilled in the bladder with the use of an irrigating solution, but this is not the primary reason for using continuous irrigation in TURP. The irrigating solution may secondarily help prevent bladder distention because it keeps the catheter from becoming obstructed.


 CN: Reduction of risk potential;  
CL: Apply

**131. 3.** A distended bladder produces dullness when percussed because of the presence of urine. Hyperresonance is a percussion sound that is

present in hyperinflated lungs. Tympany, a loud drumlike sound, occurs over gas-filled areas such as the intestines. Flat sounds occur over very dense tissue that has no air present.

 CN: Reduction of risk potential;  
CL: Analyze

**132. 2.** Major accidents can induce feelings similar to those of victims of other kinds of disasters and crime. Therefore, the nurse calls the crisis nurse to assist the passengers with their feelings of victimization. Passengers may mourn the loss of a vacation, but, with no fatalities, major grief reactions are not expected. Other personnel can take calls from relatives while the crisis nurse helps the passengers. Psychiatric hospitalization is a premature assumption.

 CN: Psychosocial adaptation;  
CL: Analyze

**133. 1.** When placed on the abdomen, a neonate pulls the legs up under the body, which puts tension on the perineum. Therefore, after surgery, the neonate should be positioned either supine with the legs suspended at a 90-degree angle or on either side with the hips elevated.

 CN: Reduction of risk potential;  
CL: Apply

**134. 1.** The child with meningococcal meningitis requires droplet precautions for at least the first 24 hours after effective therapy is initiated to reduce the risk of transmission to others on the unit. After the child has been placed on droplet precautions, other actions, such as taking the child's vital signs, asking about medication allergies, and inquiring about the health of siblings at home, can be performed.

 CN: Management of care; CL: Synthesize


**135. 1.** Teenagers usually enjoy activities with peers in preference to socializing with their parents or siblings. Peer relationships help the adolescent develop self-identity.

 CN: Health promotion and maintenance;  
CL: Synthesize


**136. 2, 3.** Teens are very concerned about their body image and knowing about the size of the scar is important to them. Typically, teens return to school in 1 week. While hospitalized, friends can visit during visiting hours. Clients are usually hospitalized for an uncomplicated appendectomy for about 24 hours. Antibiotics are not routinely given to prevent an infection. The dressing is removed within a few days.

 CN: Reduction of risk potential;  
CL: Synthesize


**137. 2.** Morphine can cause urinary retention. The nurse should assess the client for urinary hesitancy or retention, and note the urinary output. It is not necessary to take the apical heart rate after each dose of morphine. Mental status should be assessed after each dose because morphine can cause such effects as sedation, delirium, and disorientation. Assessing for pedal edema is not necessary.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**138. 4.** Infection is the greatest concern to the nurse. Infection occurs more frequently because of the number of procedures performed on clients that require this therapy and people they come in contact with in the hospital. Infection can be reduced if proper infection control techniques are used and human contact is reduced. Deficiencies and toxicities of nutrients are rare because of the use of standard protocols and orders for TPN formulas. Hyperglycemia can occur with TPN administration; however, all clients receiving TPN have their serum glucose concentration monitored frequently, and the hyperglycemia can easily be managed by adding insulin to the TPN solution. An infection is a much more serious complication.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**139. 2.** The nurse should assess for signs of impending shock such as diaphoresis. The client would have hypotension, dysuria, and cool skin.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**140.**

3. Level of consciousness.

4. Motor strength.


1. Vital signs.

2. Decreased urine output.

In order of priority, the nurse would assess level of consciousness, motor strength, vital signs, and then decreased urine output. Level of consciousness is the best indication of brain function. If the child's condition deteriorates, the nurse would observe changes in level of consciousness before any other changes. Motor strength is primarily assessed as a voluntary action. With a change in level of consciousness, there may be changes in motor function. If the client's fluids are restricted, then the urine output would decrease. In children, the usual urine output is 1 mL/kg/hour.

 CN: Reduction of risk potential;  
CL: Synthesize


**141. 2.** The urinary appliance should be emptied before the pouch is one-third full to prevent urinary reflux. The appliance should be attached to a leg bag at night to allow for adequate drainage. It is not appropriate to administer prophylactic antibiotics when incorporating positive self-care activities into the client's routine can prevent most urinary tract infections. The urinary appliance is not changed daily. If no leakage occurs and the client's skin remains free from irritation, the appliance can be left in place for 1 week or more.

 CN: Basic care and comfort;  
CL: Synthesize

**142. 1.** Preoxygenating the client before suctioning helps prevent the development of hypoxia during the procedure. The suction catheter is inserted about 5 to 6 inches into the cannula. A bolus of 3 to 5 mL of sterile normal saline solution may be inserted into the cannula before suctioning to stimulate coughing and loosen secretions. The nurse uses sterile technique when suctioning a client.

 CN: Reduction of risk potential;  
CL: Apply

**143. 3.** Because the toddler has a severe diaper rash, it may be best to change all that the parents are doing. The buttocks need to be washed thoroughly with mild soap and dried well. In fact, it is helpful to leave the diaper off and expose the buttocks to the air. Baby wipes commonly contain additives and perfumes that may be irritating to the baby's sensitive skin. The diaper needs to be changed more often than every 4 to 6 hours. Otherwise, the moist diaper environment will continue to irritate the skin, causing the rash to worsen. Powder has limited absorbing ability and will most likely irritate the area more. In addition, some powders contain perfumes or are scented and can irritate the skin.

 CN: Basic care and comfort;  
CL: Synthesize

**144. 2.** The toddler is screaming for a reason, so it is most therapeutic to ask the mother why the child is screaming. This type of question is nonaccusatory, just seeking information. Asking the mother what happened between her and the child makes the assumption that something did happen and limits the amount of information to be gained from the question. Asking whether something caused the child to be upset makes an assumption that something happened and limits the answer to a yes or no response, cutting off communication. Asking whether the mother has tried to calm the child is accusatory and also limits the response to yes or no, thus cutting off communication.

 CN: Health promotion and maintenance;  
CL: Synthesize

**145. 4.** The client will need to avoid extremes of motion in the hip to avoid dislocation. The hip should not be flexed more than 90 degrees, internally rotated, or legs crossed. It is not possible to safely sit in the bathtub without flexing the hip beyond the recommended 90 degrees. The client can implement the prescribed exercise program at the time of discharge home. The client should take care not to stress the hip for 3 to 6 months after surgery. An elevated toilet seat will be necessary during the recovery from surgery.

 CN: Reduction of risk potential;  
CL: Evaluate

**146. 1.** The common presenting symptoms of infectious mononucleosis vary greatly but commonly include fever, malaise, sore throat, and lymphadenopathy. Skin rash, cold symptoms, abdominal pain, and weight loss are less common symptoms.

 CN: Reduction of risk potential;  
CL: Analyze

**147. 1.** The nurse should place the nondominant hand above the symphysis pubis and the dominant hand at the umbilicus to palpate the fundus. This prevents uterine inversion and trauma, which can be very painful to the client. The nurse should ask the client to assume a supine, not side-lying, position with the knees flexed. The fundus can be palpated in this position and the perineal pads can be evaluated for lochia amounts. The fundus should be massaged gently if the fundus feels boggy. Vigorous massaging may fatigue the uterus and cause it to become firm and then boggy again. The nurse should ask the client to void before fundal evaluation. A full bladder can cause discomfort to the client, the uterus to be deviated to one side, and postpartum hemorrhage.

 CN: Health promotion and maintenance;  
CL: Apply


**148. 2.** A reactive nonstress test is a positive sign indicating that the fetus is doing well at this point in the pregnancy. For a nonstress test to be a reactive test, at least two accelerations (15 beats or more) of the fetal heart rate lasting at least 15 seconds must occur after movement. If the fetus were compromised, the nonstress test would demonstrate no accelerations in fetal heart rate; a contraction stress test would show fetal heart rate decelerations during simulated labor. Late decelerations are associated with a positive or abnormal contraction stress test. No accelerations in a 20-minute period during a nonstress test may mean that the fetus is sleeping; however, this is interpreted as a nonreactive nonstress test.

 CN: Reduction of risk potential;  
CL: Apply


**149. 3.** Right-sided heart failure causes venous congestion resulting in such symptoms as peripheral (dependent) edema, splenomegaly, hepatomegaly, and neck vein distention. Intermittent claudication is associated with arterial occlusion. Dyspnea and crackles are associated with pulmonary edema, which occurs in left-sided heart failure.

 CN: Reduction of risk potential;  
CL: Analyze

**150. 1.** To help prevent flexion deformities, a client with rheumatoid arthritis should lie in a prone position in bed for about ½ hour several times a day. This positioning helps keep the hips and knees in an extended position and prevents joint flexion. Low Fowler's, modified Trendelenburg, and side-lying positions do not prevent hip flexion.

 CN: Basic care and comfort;  
CL: Synthesize


**151. 2.** Administration of an epidural anesthetic can result in a hypotensive effect on maternal blood pressure. Therefore, the priority assessment is the mother's blood pressure. Ephedrine or wedging the client to a position to keep pressure off the vena cava, such as on the left side, can be used to elevate maternal blood pressure should it drop too low. Epidural anesthesia has no effect on the level of consciousness or the client's cognitive function. Although the client's contraction pattern may decrease in frequency after administration of the anesthesia, the priority assessment is the client's blood pressure. After blood pressure is maintained, contractions can be assessed.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**152. 1.** The client's assessment findings indicate that the client is in the latent phase of the first stage of labor. Therefore, the nurse should plan to assist the client with comfort measures and breathing techniques to relieve discomfort. The client can move around, walk, or ambulate at this phase of labor. If the client chooses to remain in bed, a left side-lying position provides the greatest perfusion. It is too early for the client to have an epidural anesthetic. Epidural anesthesia is usually administered when the cervix is dilated 4 to 5 cm. The fetal heart rate is normal, so internal fetal monitoring is not warranted at this time.

 CN: Health promotion and maintenance;  
CL: Synthesize

**153. 4.** Hypokalemia is one of the most common causes of digoxin (Lanoxin) toxicity. It is essential that the nurse carefully monitor the potassium levels of clients taking digoxin to avoid toxicity. Low serum potassium levels can cause cardiac dysrhythmias.

 CN: Pharmacological and parenteral therapies; CL: Apply


**154. 3.** Current pain guidelines recommend the removal of meperidine from formularies and the substitution of morphine commonly administered by patient-controlled analgesia. Meperidine can be ordered for severe pain but its use is limited by the high incidence of neurotoxicity (seizures) associated with the accumulation of its metabolite, normeperidine. It is contraindicated in clients with acute pain lasting more than 2 days and in those for whom large daily doses (more than 600 mg) are needed. It would be inappropriate to urge the client to take the acetaminophen and codeine to prevent addiction. Addiction is a psychological condition in which a client is driven to take drugs for reasons that are not therapeutic. The client is in pain and her need for the morphine is therapeutic. Although the client may obtain some relief from relaxation exercises, this alone is not sufficient to provide pain relief.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**155. 1.** Infants at age 7 months are not capable of drinking from a cup without spilling. At age 6 months, infants can partially lift their weight on the hands, enjoy imitating sounds, and are developing separation anxiety.

 CN: Health promotion and maintenance;  
CL: Analyze

**156. 3.** According to Erikson, a child of 13 years is normally seeking to meet the need to develop personal identity. Personal values are a component of this identity. Developing a conscience is a component of achieving initiative during the preschool years. Developing a sense of competence is a component of achieving industry in the school-age years. Developing a lifetime vocation is a component of achieving generativity in adulthood.

 CN: Psychosocial adaptation;  
CL: Analyze

**157. 4.** Cardiomyopathy means that the myocardium is weak and irritable. Amiodarone is an antiarrhythmic and acts directly on the cardiac cell membrane. In this situation, amiodarone is used to increase the ventricular fibrillation threshold. Amiodarone is contraindicated in sinus node dysfunction, heart block, and severe bradycardia.

 CN: Reduction of risk potential;  
CL: Evaluate

**158. 1.** A frothy, purulent vaginal discharge in a sexually active female client is typically caused by a sexually transmitted disease such as trichomonas. Other diseases, such as chlamydia, may also be present. Both the client and the boyfriend need treatment after the disease is determined. Normal variations in female vaginal discharge should be clear to white, not frothy or purulent. The client




should be instructed to wear cotton underwear and avoid pantyhose, wet gym clothes, and tight-fitting garments, such as jeans, so that air can circulate.

 CN: Management of care; CL: Analyze

**159. 4.** The most common factor in skin breakdown is immobility. Right-sided paralysis, in which the client cannot perceive the need to change position and lacks control over movement of the extremities, is the condition most likely to lead to skin breakdown. It is essential that the nurse plan to change the client's position at least every 2 hours. Nutritional status and urinary incontinence can contribute to skin breakdown, but neither is the most critical factor. Confusion does not directly influence skin breakdown.

 CN: Reduction of risk potential;  
CL: Analyze

**160. 1.** Psychomotor retardation refers to a general slowdown of motor activity commonly seen in a client with depression. Movements appear lethargic, energy is absent or lacking, and performance of activity is slow and difficult. A flat affect reflects a lack of emotion. An unkempt appearance reflects lack of self-care. Avoiding eye contact reflects low self-esteem or suspiciousness.

 CN: Psychosocial adaptation;  
CL: Analyze

**161. 3.** A hydrocele, defined as fluid in the processus vaginalis, is determined when the scrotal sac can be transilluminated. A swelling in the scrotal area that can be reduced indicates an inguinal hernia. Both hydroceles and hernias can enlarge the scrotal sac, and both can be either unilateral or bilateral. A hernia typically is more obvious during crying.


 CN: Reduction of risk potential;  
CL: Analyze

**162. 1.** When cleaning the skin around an incision and drain, the nurse should clean the incision and drain separately to avoid contaminating either wound. This is applying the principle of working from the least contaminated area to the most contaminated area. In this case, both areas are fresh wounds and should be kept separate.

 CN: Management of care; CL: Apply

**163. 4.** Any injury to the mouth results in copious amounts of blood because the mouth is a highly vascular area. Because the nurse does not know the mother and does not speak Spanish, the most appropriate action is to give the mother the ice and demonstrate what she is to do. The child will be less fearful if the ice is applied by the mother. Calling for an interpreter is appropriate after caring for the immediate need of the child. Grabbing the child

away will probably upset the mother more, further adding to the stress experienced by the child.

 CN: Psychosocial adaptation;  
CL: Synthesize


**164. 4.** Having the client deep-breathe hourly is the most appropriate action for the assistant to take to help prevent pulmonary complications. The client should be turned at least every 2 hours. Keeping the client's head elevated will not prevent pulmonary complications. Suctioning the client is not an assistant's responsibility, nor does it prevent pulmonary complications.

 CN: Management of care; CL: Evaluate


**165. 1, 3.** The outcomes to achieve for a nursing diagnosis of *Ineffective tissue perfusion* involve evidence of adequate blood flow to the area. The temperature of the involved extremity is an important indicator for a client with peripheral vascular disease. The temperature will indicate the degree to which the blood supply is getting to the extremity. Warmth indicates adequate blood flow. Pain is also an indicator of blood flow. Pain, such as muscle pain, suggests ischemia and lack of oxygen that results when the oxygen demand becomes greater than the supply. Thus, a decrease in muscle pain with activity would suggest improvement in blood flow to the area. Improved respiratory status and clear lungs are unrelated to ineffective tissue perfusion. Although participation in self-care measures is always helpful, this outcome is more appropriate for a nursing diagnosis of *Activity intolerance*, *Fatigue*, or *Self-care deficit*.

 CN: Reduction of risk potential;  
CL: Evaluate


**166. 3.** When dextrose is abruptly discontinued, rebound hypoglycemia can occur. The nurse should assess the client for symptoms of hypoglycemia. Essential fatty acid deficiency is very unlikely to occur because some of these fatty acids are stored. Preventing dehydration or malnutrition is not the reason for tapering the infusion rate; the client's hydration and nutritional status and ability to maintain adequate intake must be established before total parenteral nutrition is discontinued.

 CN: Pharmacological and parenteral therapies; CL: Apply


**167. 1.** During the third trimester, particularly in the seventh month of pregnancy, the client typically exhibits feelings of vulnerability and fear that the baby will be lost. Confirmation that the fetus is real occurs during the second trimester. Ambivalence is typically seen and resolved during the first trimester. Body image disturbance commonly occurs during the second trimester because of the profound changes that occur to the body during this time.

 CN: Health promotion and maintenance;  
CL: Analyze

**168. 2.** As the dye is injected, the client may experience a feeling of warmth, flushing of the face, and a salty taste in the mouth. The client should not experience chest pain or cold chills; these would be adverse reactions warranting close monitoring of the client.

 CN: Reduction of risk potential;  
CL: Evaluate

**169. 4.** Isoniazid competes for the available vitamin B<sub>6</sub> in the body and leaves the client at risk for developing neuropathies related to vitamin deficiency. Supplemental vitamin B<sub>6</sub> is routinely prescribed to address this issue. Avoiding sun exposure is a preventive measure to lower the risk of skin cancer. Following a low-cholesterol diet lowers the individual's risk of developing atherosclerotic plaque. Rest is important in maintaining homeostasis but has no real impact on neuropathies.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**170. 2.** The interpreter may have been delayed. Therefore, the nurse's best action would be to reschedule the child's appointment when the interpreter can be scheduled as well. Because the mother does not speak English, there is no point in examining the infant because history information is needed and most likely would be too difficult to obtain. Asking the mother to stay longer is rude to her. Also, doing so would probably be difficult because of the communication gap. If the interpreter is delayed, paging one more time will not help.

 CN: Management of care; CL: Synthesize


**171. 1.** The client who is on a progressive exercise program at home after a myocardial infarction should be taught to monitor his pulse rate. The pulse rate can be expected to increase with exercise, but exercise should not be increased if the pulse rate increases more than about 25 bpm from baseline or exceeds 100 to 125 bpm. The client should also be taught to decrease exercise if chest pain or dyspnea occurs.

 CN: Basic care and comfort; CL: Analyze

**172. 1.** The nurse's response fails to identify the meaning in what the client has said. The nurse needs to explore the client's statement about hating God for that flood because the meaning of the client's statement is unclear. Also, clichés such as, "Don't feel that way," are not helpful because they ignore the client's feelings and his interpretation of the situation in which he finds himself. Explaining to the client why he may think as he does (offering a rationale) is inappropriate. The nurse's response fails to identify the meaning in what the client has said and is not supportive. There is no evidence that the client is solving his problems.

 CN: Psychosocial adaptation;  
CL: Analyze

**173. 3.** The client who should be assessed first is the multigravid client who has been in labor for 8 hours and whose cervix is 8 cm dilated at 1 + station with contractions every 3 to 4 minutes. A multigravid client typically has a shorter labor than a primigravid, and this client's station is 1+, which means that delivery of the fetus is imminent.

 CN: Management of care; CL: Synthesize


**174. 1.** The nurse should contact the physician and clarify whether the client's usual insulin dose should be given before surgery; having the blood glucose level is objective information that the physician may need to know before making a final decision as to the insulin dosage. The nurse should not assume that the usual insulin dose is to be given. It is not appropriate for the nurse to defer decision-making on this issue until after the surgery.

 CN: Reduction of risk potential;  
CL: Synthesize

**175. 4.** Immediately after chest tube removal, a petrolatum gauze is placed over the wound and covered with a dry sterile dressing. This serves as an airtight seal to prevent air leakage or air movement in either direction. Bandages or straps are not applied directly over wounds. Mesh gauze allows air movement.

 CN: Management of care; CL: Apply

**176. 4.** By asking the client to tell more about how she is feeling, the nurse is not making any assumptions about what is troubling the client. The nurse should acknowledge the client's feelings and encourage her to discuss them. Saying that this situation must be frustrating involves assumptions by the nurse about why the client is crying and is not a therapeutic response. Asking how long the client has been unable to comb her hair takes the focus off her feelings and inhibits therapeutic communication. Inquiring why the client's husband hasn't helped insinuates that the husband is not helping enough, which is inappropriate, takes the focus off the client's feelings, and inhibits therapeutic communication.


 CN: Psychosocial adaptation;  
CL: Synthesize

**177. 3.** Encouraging the client to talk about why she is here and about her feelings may reveal more information about what led her to come to the group and what led to her diagnosis. It also provides the nurse with valuable information needed to develop an appropriate plan of care. The comment that the client sounds angry presumes what the client is feeling and asks her to talk about her husband. The focus here should be on the client, not the husband. Telling the client that she will like coming


to group imposes the nurse's view onto the client. The statement stresses that the group is fun instead of giving its therapeutic value. Having the client tell the nurse something about the cause of her bulimia ignores the client's original statement. Additionally, this statement requires the client to have insight into the cause of her disease, which may not be possible at this time. Also, it may be too early in the relationship to discuss the disorder.

 CN: Psychosocial adaptation;  
CL: Synthesize

**178. 2.** There is a direct interaction between the effects of insulin and those of beta blockers. The nurse must be aware that there is a potential for increased hypoglycemic effects of insulin when a beta blocker is added to the client's medication regimen. The client's blood sugar should be monitored. Ketoacidosis occurs in hyperglycemia. Although a decrease in the incidence of ketoacidosis could occur when a beta blocker is added, the direct result is an increase in the hypoglycemic effect of insulin.

 CN: Pharmacological and parenteral therapies; CL: Apply

**179. 3.** Commonly, when a child appears better, the parents stop the medication. Unfortunately, the infection remains. Therefore, the nurse needs to explain that all of the medication is needed to clear up the infection. Explaining why the medicine should be continued is more helpful to parents than saying it needs to be given. Asking how the mother knows that her child's ears are better blames the mother and diminishes her self-esteem. Telling the mother that stopping the medication is not what is best for the child implies blame and is condescending.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**180. 3.** The client is positioned correctly in the side-lying position. The pillows support the client's joints and do not cause unnecessary pressure on the joints or skin. It is not necessary to add another pillow under the arm or to elevate the head of the bed. The nurse should assess the client's skin for signs of breakdown, particularly at the elbows, back, hips, and heels where there were pressure points from the position in which the client was previously lying.

 CN: Reduction of Risk Potential;  
CL: Evaluate

COMPREHENSIVE

TEST

2

1. The unit secretary who transcribes the physicians' orders asks the nurse to interpret an illegible order. The nurse should:

- 1. Interpret the order according to the client's previous medication record.
- 2. Clarify the order with the pharmacist.
- 3. Clarify the order by calling the physician.
- 4. Clarify the client's medications with the client's family.

2. A client with cholecystitis is taking Propantheline bromide (Pro-Banthine). The expected outcome of this drug is:

- 1. Increased bile production.
- 2. Decreased biliary spasm.
- 3. Absence of infection.
- 4. Relief from nausea.

3. The nurse refers the parents of a child with cystic fibrosis to the local chapter of the National Cystic Fibrosis Foundation. The Foundation has been especially beneficial for parents of children with cystic fibrosis by helping them:

- 1. Find tutors to educate their children at home.
- 2. Obtain genetic counseling.
- 3. Meet with other parents of children with cystic fibrosis for mutual support.
- 4. Obtain financial assistance to purchase medications for their children.

4. After a bronchoscopy with biopsy, the nurse assesses the client. Which of the following signs should be reported immediately to the physician?

- 1. Green sputum.
- 2. Dry cough.
- 3. Hemoptysis.
- 4. Laryngeal stridor.

5. A client complains that "the hospital food is horrible." Which of the following is the **most** appropriate response by the nurse?

- 1. "The staff is doing the best they can to cook in such large quantities."
- 2. "I'll report this to the physician."
- 3. "Would you like to speak with the dietitian about the food and meal selection?"
- 4. "I don't like the hospital cafeteria food either."

6. The nurse must be aware that adverse drug reactions in the elderly client may be underestimated because:

- 1. Adverse reactions rarely have an atypical presentation.
- 2. Cognitive impairment is an expected finding in the elderly client.
- 3. Physical or psychological symptoms are attributed to the effects of aging.
- 4. Excess sedation is difficult to assess in the elderly client.

7. An elderly man experiences a thrombotic cerebrovascular accident and subsequent flaccid hemiplegia of his right side. When planning his care, rehabilitation begins:

- 1. As soon as anticoagulant therapy is started.
- 2. When the client is admitted to the hospital.
- 3. When the client can first work cooperatively with health care personnel.
- 4. As directed by the physical therapist.

8. An unmarried pregnant teenager tells the nurse that she is undecided about having an abortion or giving the baby up for adoption. The **best** response for the nurse to offer is which of the following?

- 1. "You should give the baby up so that it can have a better home and opportunities."
- 2. "Research studies show that babies do better with their natural mothers."
- 3. "It must be a difficult decision. What have you thought about so far?"
- 4. "Why don't you try keeping the baby. You can always give it up for adoption later."

9. When administering blood, the nurse must check the name on the label of the blood with the name on the client's:

- 1. Wristband with a family member present.
- 2. Wristband in the presence of another nurse.
- 3. Medical chart with the unit clerk.
- 4. Medication administration record with the pharmacist.

10. A client is diagnosed with syndrome of inappropriate antidiuretic hormone (SIADH). The nurse should assess the client for which alteration in fluid and electrolyte balance?

- 1. Increased osmolality of the plasma.
- 2. Decreased serum sodium level.
- 3. Increased urine output.
- 4. Decreased blood pressure.

**11.** A client is admitted to the emergency department with crushing chest injuries sustained in a car accident. Which of the following signs indicates a possible pneumothorax?

- 1. Cheyne-Stokes respirations.
- 2. Increased fremitus.
- 3. Diminished or absent breath sounds on the affected side.
- 4. Decreased sensation on the affected side.

**12.** Which of the following statements by a client taking valproic acid (Depakene) for bipolar disorder indicates that further teaching about this medication is necessary?

- 1. "I need to take the pills at the same time each day."
- 2. "I can chew the pills if necessary."
- 3. "I can take the pills with food."
- 4. "I need to call my doctor if I start bruising easily."

**13.** A nurse is obtaining the history of an infant with suspected acute otitis media. What should the nurse ask the parent about?

- 1. Position of the infant when taking a bottle.
- 2. Covering of the infant's ears when out in the cold.
- 3. Thorough drying of the infant's ears after a bath.
- 4. Immunization status of the infant.

**14.** A client is having elective surgery under general anesthesia. Who is responsible for obtaining the informed consent?

- 1. The nurse.
- 2. The surgeon.
- 3. The anesthesiologist.
- 4. The nurse anesthetist.

**15.** The family of an elderly client with terminal cancer inquires about hospice services. The nurse explains that hospice care:

- 1. Focuses only on the needs of the client.
- 2. Can only be provided in the inpatient setting.
- 3. Is staffed exclusively by professional health care workers.
- 4. Focuses on supportive care for the client and family.

**16.** A primigravid client at 8 weeks' gestation tells the nurse that she doesn't like milk. To ensure that the client consumes an adequate intake of milk products, the nurse should instruct the client that an 8-oz glass of milk is equal to which of the following?

- 1. 2 tablespoons of Parmesan cheese.
- 2. 1½ cup of a milkshake.
- 3. 1½ to 2 slices of presliced American cheese.
- 4. ½ cup of cottage cheese.

**17.** A primigravid client at 35 weeks' gestation is scheduled for a biophysical profile. After instructing the client about the test, which of the following, if stated by the client as one of the parameters of this test, indicates effective teaching?

- 1. Amniotic fluid volume.
- 2. Placement of the placenta.
- 3. Amniotic fluid color.
- 4. Fetal gestational age.

**18.** When caring for a child who has been receiving long-term steroid therapy, the nurse should assess the child for:

- 1. Usual behavior and temperament.
- 2. Loss of weight from baseline.
- 3. Development of truncal obesity.
- 4. Demonstration of a growth spurt.

**19.** The nurse manager has assigned a nurse as the circulating nurse for a surgical abortion. The nurse is Roman Catholic and wishes to refuse to participate in an abortion. The nurse manager of the operating room should:

- 1. Require the nurse to do this assignment.
- 2. Change the assignment, and record the behavior on the nurse's evaluation.
- 3. Change the assignment without comment.
- 4. Change the assignment to circulate, but have the nurse prepare the equipment.

**20.** An 86-year-old man in a retirement community has few health problems, manages his own self-care, plays cards, and talks about "the good old days." He says he wants to make "final" arrangements, such as completing an advance directive and planning and paying for his funeral and burial. The nurses recognize that this represents which of the following?

- 1. He is depressed and should be watched for further signs of depression.
- 2. He is responding in an appropriate manner for his age.
- 3. He is potentially suicidal and should be placed on suicide precautions and seen by a psychiatrist.
- 4. He has a premonition that he is going to die soon.

**21.** A client is taking phenytoin (Dilantin) as an antiepileptic medication. The nurse should instruct the client to obtain:

- 1. Increased iron.
- 2. Increased calcium.
- 3. Frequent dental examinations.
- 4. Frequent eye examinations.

**22.** The nurse should establish baseline data on a client who is starting on long-term gentamicin sulfate (Garamycin) therapy. Which of the following is **least** important for assessment screening in this client?

- 1. Visual acuity.
- 2. Vestibular function.
- 3. Renal function.
- 4. Auditory function.

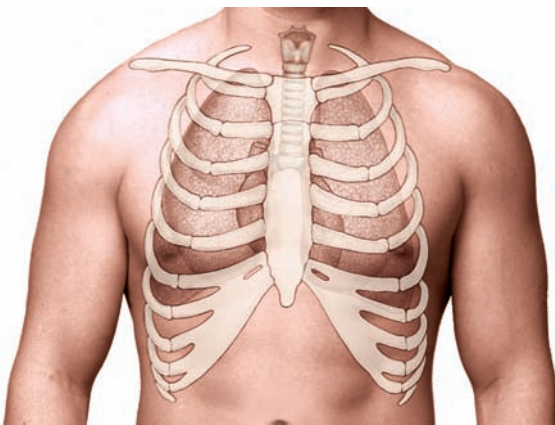
**23.** The nurse prepares to discharge a 5-year-old child from the 1-day surgery unit. The nurse leaves the room to get supplies and then, on returning, finds that the child is not breathing. The client is pulseless, and the nurse begins chest compressions. Because effective chest compressions depend on proper technique, the nurse should apply pressure:

- 1. On the lower sternum with the heel of one hand.
- 2. Midway on the sternum with the tips of two fingers.
- 3. Over the apex of the heart with the heel of one hand.
- 4. On the upper sternum with the heels of both hands.

**24.** When developing a nutritional plan for a child who needs to increase protein intake, the nurse should suggest which of the following foods? Select all that apply.

- 1. Bacon.
- 2. Cooked dry beans.
- 3. Peanut butter.
- 4. Yogurt
- 5. Apple

**25.** The nurse is auscultating  $S_1$  and  $S_2$  in a client. Identify the area where the nurse should hear  $S_1$  the loudest.



**26.** The nurse instructs a client with coronary artery disease in the proper use of nitroglycerin (Nitrostat). At the onset of chest pain, the client should:

- 1. Call 911 when three nitroglycerin tablets taken every 5 minutes are ineffective.
- 2. Call 911 when five nitroglycerin tablets taken every 5 minutes are ineffective.
- 3. Take three nitroglycerin tablets, 10 minutes apart, and call 911.
- 4. Go to the emergency department if three nitroglycerin tablets are ineffective.

**27.** A diet high in which of the following food substances contributes to increases in serum cholesterol?

- 1. Polyunsaturated fat.
- 2. Saturated fat.
- 3. Monounsaturated fat.
- 4. Phospholipids.

**28.** During the health history, a client bluntly states, "I think I'm better off dead." The **best** response by the nurse is which of the following?

- 1. "Has a family member ever committed suicide?"
- 2. "When did these feelings begin?"
- 3. "Do you have someone at home to help you?"
- 4. "Are you thinking about suicide?"

**29.** A client is taking methotrexate (Rheumatrex) for severe rheumatoid arthritis. The nurse instructs the client that it will be necessary to monitor her:

- 1. Serum glucose.
- 2. Serum electrolytes.
- 3. Complete blood count (CBC) with differential and platelet count.
- 4. Sedimentation rate.

**30.** Which of the following meals would be appropriate for the child with osteomyelitis to choose?

- 1. Beef and bean burrito with cheese, carrot and celery sticks, and an orange.
- 2. Buttered wheat bread, cream of broccoli soup, tossed salad with dressing, and an apple.
- 3. Potato soup; bacon, lettuce, and tomato sandwich; and an orange.
- 4. Tomato soup, grilled cheese sandwich, and banana.

**31.** An elderly client complains to the nurse about constipation and reports that he has never been constipated before. The **best** response for the nurse to make is which of the following?

- 1. "Constipation is an expected problem at your age."
- 2. "You need to eat more fiber."
- 3. "You need to drink more water."
- 4. "The new onset of constipation may be a sign of a more serious problem."

**32.** A nurse is interviewing a client who will begin rehabilitation for alcohol dependency. Which approach by the nurse is **most** helpful to the client before starting the program?

- 1. "You need to be very serious about this program."
- 2. "You need to want to be alcohol free before we can help you."
- 3. "This program requires you to do a lot of hard work."
- 4. "We'll help you be successful so that you can stay alcohol free."

**33.** A newly diagnosed type 1 diabetic client asks the nurse, "Why do I have to take two shots of insulin? Shouldn't one shot be enough?" The **best** response for the nurse to make is which of the following?

- 1. "A single shot of long-acting insulin would be preferable."
- 2. "You might be able to change to oral medications soon."
- 3. "Two shots will give you better control and decrease complications."
- 4. "I'll ask the physician to change your insulin schedule."

**34.** The nurse reviews the peak and trough serum levels from a client who is receiving gentamicin sulfate (Garamycin) in order to:

- 1. Adjust the dosage to the therapeutic range.
- 2. Avoid allergic reactions.
- 3. Prevent side effects.
- 4. Reach therapeutic levels more quickly.

**35.** A client with a history of diabetes mellitus and chronic obstructive pulmonary disease should have which of the following immunizations?

- 1. Influenza.
- 2. Hepatitis A.
- 3. Measles-mumps-rubella.
- 4. Varicella.

**36.** A parent confides to the nurse that she thinks her 8-month-old infant is anxious. Which of the following suggestions by the nurse is **most** appropriate to help the mother lessen her anxiety about her infant?

- 1. Limit holding the infant to feeding times.
- 2. Talk quietly to the infant while he is awake.
- 3. Play music in his room for most of the day and night.
- 4. Have a close friend keep the infant for a few days.

**37.** The parent of a 2-week-old infant brings the child to the clinic for a checkup. The parent expresses concern about the baby's breathing because the infant breathes quickly for a while and then breathes slowly. The nurse interprets this finding as an indication of which of the following?

- 1. A normal pattern in infants of this age.
- 2. The need for an apnea monitor.
- 3. A need for close monitoring for the mother.
- 4. The need for a chest radiograph.

**38.** Which of the following complications is associated with a tracheostomy?

- 1. Decreased cardiac output.
- 2. Damage to the laryngeal nerve.
- 3. Pneumothorax.
- 4. Acute respiratory distress syndrome.

**39.** The nurse who is caring for a client with type 1 diabetes mellitus should use which of the following to determine how well the child's insulin, diet, and exercise are balanced?

- 1. Fasting serum glucose level.
- 2. One-week dietary recall.
- 3. Home log of blood glucose levels.
- 4. Glycosylated hemoglobin level.

**40.** The nurses on a medical surgical unit have instituted a falls prevention program. Which of the following strategies will have the **highest** likelihood of preventing falls?

- 1. Putting a falls risk sign on the clients' doors.
- 2. Having the client wear a color-coded armband.
- 3. Making rounds of the unit and clients' rooms.
- 4. Keeping all beds in low position.

**41.** A client is receiving a unit of packed red blood cells. Before the transfusion started, the client's blood pressure was 90/50 mm Hg, pulse rate 100 bpm, respirations 20 breaths/minute, and temperature 98° F (36.7° C). Fifteen minutes after the transfusion starts, the client's blood pressure is 92/54 mm Hg, pulse 100 bpm, respirations 18 breaths/minute, and temperature is 101.4° F (38.6° C). The nurse should **first**:

- 1. Stop the transfusion.
- 2. Raise the head of the bed.
- 3. Obtain an order for antibiotics.
- 4. Offer the client a cool washcloth.

**42.** Which of the following findings in a client receiving opioid epidural analgesia would lead the nurse to notify the physician? Select all that apply.

- 1. Blood pressure of 80/40 mm Hg; baseline blood pressure of 110/60 mm Hg.
- 2. Respiratory rate of 14 breaths/minute; baseline respiratory rate of 18 breaths/minute.
- 3. Report of crushing headache.
- 4. 1.5 cc of blood aspirated from the catheter before the bolus injection.
- 5. Pain rating of 3 on a scale of 1 to 10.

**43.** Which of the following dietary strategies **best** meets the nutritional needs of a client with acquired immunodeficiency syndrome (AIDS)?

- 1. Tell the client to eat large meals frequently.
- 2. Encourage megadoses of nutritional supplements.
- 3. Instruct the client to cook foods thoroughly and adhere to safe food-handling practices.
- 4. Tell the client to prepare food in advance and leave it out to eat small amounts throughout the day.

**44.** Before an incisional cholecystectomy is performed, the nurse instructs the client in the correct use of an incentive spirometer. Why is incentive spirometry essential after surgery in the upper abdominal area?

- 1. The client will be maintained on bed rest for several days.
- 2. Ambulation is restricted by the presence of drainage tubes.
- 3. The operative incision is near the diaphragm.
- 4. The presence of a nasogastric tube inhibits deep breathing.

**45.** The nurse is examining a 6-week-old African American infant. There are large spots of deep blue pigmentation across the infant's buttocks. The nurse should identify this sign as characteristic of:

- 1. Vascular disease.
- 2. Telangiectatic nevi.
- 3. Infant milia.
- 4. Mongolian spots.

**46.** A nulliparous client has been given a prescription for oral contraceptives. Which of the following should the nurse instruct the client to report to her health care provider immediately?

- 1. Blurred vision.
- 2. Nausea.
- 3. Weight gain.
- 4. Mild headache.

**47.** A client experienced a pneumothorax after the placement of a central venous pressure line. Which of the following assessments supports a medical diagnosis of pneumothorax?

- 1. Sudden, sharp pain on the affected side.
- 2. Tracheal deviation toward the affected side.
- 3. Bradypnea and elevated blood pressure.
- 4. Presence of crackles and wheezes.

**48.** A client is experiencing a flashback from the use of lysergic acid diethylamide. The nurse should:

- 1. Confront the client's misperceptions.
- 2. Reassure the client while presenting reality.
- 3. Seclude the client until the flashback ends.
- 4. Challenge the client's unrealistic statements.

**49.** The nurse should dispose of a used needle and syringe by:

- 1. Cutting the needle at the hilt in a needle cutter before disposing of it in the universal precaution container in the client's room.
- 2. Placing uncapped, used needles and syringes immediately in the universal precaution container in the client's room.
- 3. Recapping the needle and placing the needle and syringe in the universal precaution container in the client's room.
- 4. Separating the needle and syringe and placing both in the universal precaution container in the client's room.

**50.** The nurse is planning a health promotion education session for a community health fair. The nurse reviews health data for the community (see below) prior to planning the session. To develop a program which is appropriate for the residents of this community and is cost-effective, the nurse should plan to? Select all that apply.

- 1. Focus on information about preventing heart disease.
- 2. Appeal to college graduates.
- 3. Present the program in Spanish and English.
- 4. Develop content which is culturally appropriate for members of all ethnic/racial groups in the community.
- 5. Provide printed materials for each participant.

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#### Deaths by Cause

Deaths by Accident	28
Deaths by Homicide	2
Deaths by Heart Disease	238
Deaths by Suicide	12
Deaths by Cancer	203
Deaths by Motor Vehicle Accident	10

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#### Educational Attainment

High School Dropouts	6,604
No High School Diploma	101,596
High School Diploma Only	163,995
High School Diploma or More	451,863
Some College	147,330
Associate Degree or More	171,410
Bachelor Degree or More	140,550

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#### Race/Ethnicity

African American	54,083
American Indian	294
Asian	2,047
Caucasian	78,122
Hispanic	2,459
Multiracial	7,073



**51.** An 80-year-old client is admitted with nausea and vomiting. He has a history of heart failure and is being treated with digoxin (Lanoxin). He tells the nurse he has been nauseated for a week and began vomiting 2 days ago. Laboratory values indicate that he has hypokalemia. Because of these clinical findings, the nurse should assess the client carefully for signs of which of the following conditions?

- 1. Chronic renal failure.
- 2. Exacerbation of heart failure.
- 3. Digoxin toxicity.
- 4. Metabolic acidosis.

**52.** The nurse instructs the client with osteoporosis that food products high in calcium include:

- 1. Rice.
- 2. Broccoli.
- 3. Apples.
- 4. Meat.

**53.** A woman is using progestin injections (Depo-Provera) for contraception. The nurse instructs the client to return for an appointment in:

- 1. 1 month.
- 2. 3 months.
- 3. 4 months.
- 4. 6 months.

**54.** A client exhibits increased restlessness. The results of the arterial blood gas test are as follows: pH, 7.52; partial pressure of carbon dioxide, 38 mm Hg; bicarbonate, 34 mg/L. The nurse should plan care based on the fact that these findings indicate which of the following acid-base imbalances?

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

**55.** While the nurse is caring for a multigravid client at 39 weeks' gestation in active labor whose cervix is dilated to 7 cm and completely effaced at +1 station, the client says, "I need to push!" Which of the following should the nurse do **next**?

- 1. Turn the client to her left side.
- 2. Tell her to push when she has the urge.
- 3. Have her pant quickly during the contraction.
- 4. Tell her to focus on an object in the room to relax.

**56.** When teaching a client with chronic renal failure who is taking antibiotics about signs and symptoms of potential nephrotoxicity to report, the nurse should encourage the client to promptly report which of the following changes in the urine? Select all that apply.

- 1. Straw-colored.
- 2. Cloudy.
- 3. Smoky.
- 4. Pink.

**57.** The nurse is assessing a child with suspected juvenile hypothyroidism. Which of the following should the nurse expect this child to manifest?

- 1. Short attention span and weight loss.
- 2. Weight loss and flushed skin.
- 3. Rapid pulse and heat intolerance.
- 4. Dry skin and constipation.

**58.** A 10-year-old diagnosed with attention deficit hyperactivity disorder (ADHD) has been switched from a stimulant to atomoxetine (Strattera) 40 mg two times a day. The nurse is instructing the client and her mother about the change in medication. Which statement indicates that the client's mother needs further education about the medication? Select all that apply.

- 1. "I have to give her both doses before lunch."
- 2. "I'll have to make sure she's gaining weight appropriately."
- 3. "She may have nausea or dizziness for 1 or 2 months."
- 4. "If she has mood swings, I should call her psychiatrist."
- 5. "She can't take monoamine oxidase inhibitors while on Strattera."
- 6. "If her ADHD symptoms don't improve in 2 to 3 weeks, I should stop the Strattera."

**59.** Which of the following interventions will be most effective in reducing a client's fluid volume excess?

- 1. Low-sodium diet.
- 2. Monitoring serum electrolytes daily.
- 3. Restricting fluid intake.
- 4. Elevation of the client's feet.

**60.** The nurse observes a darkish blue pigment on the buttocks and back of an African American neonate. Which of the following actions is **most** appropriate?

- 1. Ask the obstetrician to assess the child.
- 2. Assess the child for other areas of cyanosis.
- 3. Document this observation in the child's record.
- 4. Advise the mother that laser therapy is needed.

**61.** During a physical examination, the nurse observes a copper bracelet on a client's wrist. The client states that she is wearing it to treat her arthritis. The nurse should:

- 1. Recognize that the client is wearing a protective object she believes wards off illness.
- 2. Inform the client that this is not a helpful practice and ask her to remove the bracelet.
- 3. Tell the client that wearing the bracelet is a form of quackery and not to use the bracelet as a treatment.
- 4. Continue to wear the copper bracelet because this is a medically supported treatment for arthritis.

**62.** The heart rate of a newly delivered term neonate is regular at 142 bpm. Which of the following should the nurse do **next**?

- 1. Notify the neonate's pediatrician.
- 2. Check for the presence of cyanosis.
- 3. Assess the heart rate again in 3 hours.
- 4. Document this as a normal neonatal finding.

**63.** The fetus of a multigravid client at 38 weeks' gestation is determined to be in a frank breech presentation. The nurse describes this presentation to the client as which of the following fetal parts coming in contact with the cervix?

- 1. Buttocks.
- 2. Head.
- 3. Both feet.
- 4. Shoulder.

**64.** The therapeutic effects of desmopressin nasal spray (DDAVP) are obtained when the client no longer has:

- 1. Polydipsia.
- 2. Nasal congestion.
- 3. Headache.
- 4. Blurred vision.

**65.** The nurse advises a 42-year-old client to have a screening mammogram. The client asks why this is necessary since she performs a breast self-examination (BSE) monthly. The nurse's **best** response is:

- 1. "All women over 35 should have an annual mammogram."
- 2. "A mammogram can identify breast cancer before it's detectable by BSE."
- 3. "Most women don't perform BSE thoroughly enough to detect cancer."
- 4. "A mammogram can detect other endocrine abnormalities as well."

**66.** A client is recovering from an infected abdominal wound. Which of the following foods should the nurse encourage the client to eat to support wound healing and recovery from the infection?

- 1. Chicken and orange slices.
- 2. Cheeseburger and french fries.
- 3. Cheese omelet and bacon.
- 4. Gelatin salad and tea.

**67.** The nurse teaches the client with iron deficiency anemia that food sources with high iron content include:

- 1. Cheese.
- 2. Squash.
- 3. Eggs.
- 4. Beef.

**68.** The mother of a toddler diagnosed with iron deficiency anemia asks what foods she should give her child. The nurse should evaluate the teaching as successful when the mother later reports that she feeds the toddler which of the following?

- 1. Milk, carrots, and beef.
- 2. Raisins, chicken, and spinach.
- 3. Beef, lettuce, and juice.
- 4. Eggs, cheese, and milk.

**69.** A toddler admitted in respiratory distress keeps pulling at the oxygen mask, trying to remove it. The nurse should? Select all that apply.

- 1. Restrain the child.
- 2. Have the parent read to the child.
- 3. Administer a sedative.
- 4. Encourage the parent to hold the child.
- 5. Tell the child the mask will help him breathe better.
- 6. Ask the parent to leave the child's bedside.

**70.** Four hours after a cast has been applied for a fractured ulna, the nurse assesses that the client's fingers are pale and cool and capillary refill is delayed for 4 seconds. How should the nurse interpret these findings?

- 1. Nerve impairment is developing in the fingers.
- 2. Arterial blood supply to the fingers is decreased.
- 3. Venous stasis is occurring in the fingers.
- 4. The finding is normal for this recovery period.

**71.** The nurse is developing a plan of care for a client who has joint stiffness due to rheumatoid arthritis. Which of the following interventions is **most** effective in relieving stiffness?

- 1. A warm shower before performing activities of daily living.
- 2. Aspirin after activity to decrease inflammation.
- 3. A 10-lb weight loss to limit stress on joints.
- 4. Cold compresses to joints for 30 minutes to relieve stiffness.

**72.** The nurse walks into the room and finds that a client who has just had surgery is diaphoretic, appears to have no respirations, and has a barely palpable pulse. What is the **most** appropriate immediate response?

- 1. Call a code.
- 2. Open the airway.
- 3. Start rescue breathing.
- 4. Start cardiac compressions.

**73.** A client with obsessive-compulsive disorder washes her hands multiple times daily and is late for meals and milieu activities. Which of the following is **most** appropriate for the nurse to do initially?

- 1. Totally eliminate the client's ritual.
- 2. Allow the client to decide whether she wants to attend meals and activities.
- 3. Inform the client that absence from meals and activities is not permitted.
- 4. Remind the client about meal and activity times so that the ritual can be completed on time.

**74.** After discussing preconception needs with an Asian-American nulliparous client, which of the following client statements indicates the need for further instruction?

- 1. "I should take folic acid supplements before I get pregnant."
- 2. "If I become pregnant, I can continue to eat sushi twice a week."
- 3. "I should continue to steam my vegetables rather than cooking them for a long time."
- 4. "Eating soy products can increase my protein levels once I'm pregnant."

**75.** A client with osteoarthritis purchased a copper bracelet to wear. He tells the nurse that he feels better since he started wearing it. Which response by the nurse is **most** appropriate?

- 1. Tell the client to remove the bracelet because it does not have any therapeutic value.
- 2. Warn the client not to spend any more money on quackery such as bracelets.
- 3. Instruct the client to remove the bracelet because the copper in it can interfere with salicylate metabolism.
- 4. Acknowledge that the client feels better, but encourage the client to continue with the prescribed therapy.

**76.** The client is started on simvastatin (Zocor) as a component of cholesterol management. Which of the following laboratory tests needs to be monitored while on this therapy?

- 1. Complete blood count.
- 2. Serum glucose.
- 3. Total protein.
- 4. Liver function tests.

**77.** A man of Chinese descent is admitted to the hospital with multiple injuries after a motor vehicle accident. His pain is not under control. The client states, "If I could be with my people, I could receive acupuncture for this pain." The nurse should understand that acupuncture in the Asian culture is based on the theory that it:

- 1. Purges evil spirits.
- 2. Promotes tranquility.
- 3. Restores the balance of energy.
- 4. Blocks nerve pathways to the brain.

**78.** A client is taking large doses of aspirin daily to treat her rheumatoid arthritis. Which of the following side effects should the nurse instruct her to report?

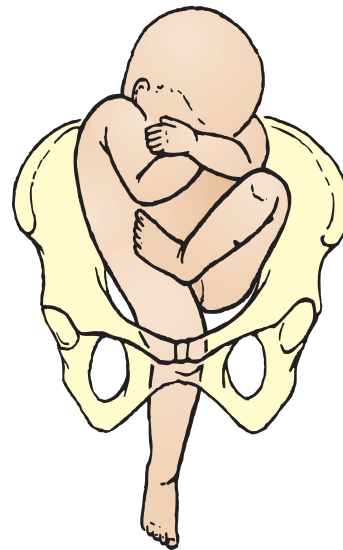
- 1. Abdominal cramps.
- 2. Tinnitus.
- 3. Rash.
- 4. Hypotension.

**79.** A client is transferred from the coronary care unit to the step-down unit. Which of the following is **not** necessary in the transfer report?

- 1. The client needs oxygen at 2 L/minute.
- 2. The client has a do not resuscitate order.
- 3. The client uses the bedpan.
- 4. The client has four grandchildren.

**80.** The nurse is assessing fetal presentation in a multiparous client. The figure below indicates which of the following types of presentations?

- 1. Frank breech.
- 2. Complete breech.
- 3. Footling breech.
- 4. Vertex.



**81.** A multigravid client at 26 weeks' gestation with a history of pregnancy-induced hypertension (PIH) asks the nurse about traveling from the United States to a village in India by airplane to visit her father, who wishes to see her before she delivers. Which of the following responses by the nurse is **most** appropriate?

- 1. "Air travel at this point in your pregnancy can lead to preterm labor."
- 2. "You can travel by airplane as long as you take frequent walks during the trip."
- 3. "You need to avoid traveling because of your history of PIH."
- 4. "You'd be placing yourself and your fetus at risk for communicable diseases common in India."

**82.** To which national food assistance program should the nurse refer a low-income, pregnant client for help in obtaining food for herself and later her infant?

- 1. Home-delivered meals.
- 2. Congregate meals.
- 3. Women, Infants, and Children Supplemental Food Program (WIC).
- 4. Food bank.

**83.** The nurse is caring for a client who has severe burns on the head, neck, trunk, and groin areas. Which position would be **most** appropriate for preventing contractures?

- 1. High Fowler's.
- 2. Semi-Fowler's.
- 3. Prone.
- 4. Supine.

**84.** The client sustained an open fracture of the femur from an automobile accident. For which of the following types of shock should the client be assessed?

- 1. Cardiogenic.
- 2. Hypovolemic.
- 3. Neurogenic.
- 4. Anaphylactic.

**85.** The client has various sensory impairments associated with diabetic disease. The nurse determines that the client needs further instruction when he states which of the following?

- 1. "I'll carefully test the temperature of my bath-water."
- 2. "I'll avoid kitchen activities."
- 3. "I'll avoid hot water bottles or heating pads."
- 4. "I'll inspect my skin daily for pressure points and injury."

**86.** The nurse is providing discharge instructions to the client with peripheral vascular problems. Which of the following instructions should be included in the discussion with this client? Select all that apply.

- 1. Avoiding prolonged standing and sitting.
- 2. Limiting walking so as not to activate the "muscle pump."
- 3. Keeping extremities elevated on pillows.
- 4. Keeping the legs in a dependent position.
- 5. Using a heating pad to promote vasodilation.

**87.** A father tells the nurse that his adolescent son spends lots of time in his room, his grades are falling, and he has given away a few of his most favorite compact disks. Which of the following is the **most** appropriate action for the nurse?

- 1. Give the father the telephone number for the local crisis hotline.
- 2. Have the father take the adolescent to the nearest mental health outpatient facility now.
- 3. Make a same-day appointment for the adolescent with his usual health care provider.
- 4. Obtain more history information from the distraught father before making a decision.

**88.** A 7-year-old child is admitted to the hospital with the medical diagnosis of acute rheumatic fever. If the child develops chorea-like movements, which of the following eating utensils should the nurse suggest the parents not allow the child to use?

- 1. Fork.
- 2. Spoon.
- 3. Plastic cup.
- 4. Drinking straw.

**89.** The nurse should prepare the client for which of the following during the immediate post-operative care after reversal of a colostomy? Select all that apply.

- 1. Nasogastric (NG) tube attached to low intermittent suction.
- 2. Administration of I.V. fluids.
- 3. Daily measurement of abdominal girth.
- 4. Calculation of intake and output every 8 hours.
- 5. Assessment of vital signs every 6 hours.

**90.** A client's catheter is removed 4 days after a transurethral resection of the prostate (TURP). He is experiencing urinary dribbling. Which one of the following nursing interventions is appropriate in this situation?

- 1. Teach the client Kegel exercises.
- 2. Obtain a urine culture and sensitivity analysis to screen for a urinary infection.
- 3. Encourage voiding every hour to prevent dribbling.
- 4. Inform him that the dribbling will stop after a few days.

**91.** An adolescent primigravid client at 26 weeks' gestation who has gained 25 lb since becoming pregnant visits the prenatal clinic for a routine visit. Which of the following is the recommended amount of weight gain during the third trimester?

- 1. 1 lb/week.
- 2. 2 lb/week.
- 3. 7 lb/month.
- 4. 5 to 6 lb for the trimester.

**92.** The nurse is preparing to administer 0.1 mg of digoxin (Lanoxin) intravenously. Digoxin comes in a concentration of 0.5 mg/2 mL. How many milliliters should the nurse administer?  
\_\_\_\_\_ mL.

**93.** The mother of a 2-month-old infant with colic states, "I don't know what to do anymore. She's up in the middle of the night crying all the time." The nurse should tell the mother to:

- 1. Walk the floor with the baby at night.
- 2. Take the infant for a short drive in the car.
- 3. Allow the infant to cry it out in her crib.
- 4. Offer cereal to fill the baby's stomach.

**94.** After the application of an arm cast, the client complains of pain on passive stretching of his fingers, finger swelling and tightness, and loss of function. Based on these data, the nurse anticipates that the client may be developing which of the following?

- 1. Delayed bone union.
- 2. Compartment syndrome.
- 3. Fat embolism.
- 4. Osteomyelitis.

**95.** Which of the following is a priority for a client who has just had a myocardial infarction?

- 1. Low-back training program.
- 2. Risk modification education.
- 3. Strength training program.
- 4. Jogging exercise program.

**96.** While assessing a 4-day-old neonate delivered at 28 weeks' gestation, the nurse cannot elicit the neonate's Moro reflex, which was present 1 hour after birth. The nurse notifies the physician because this may indicate which of the following?

- 1. Postnatal asphyxia.
- 2. Skull fracture.
- 3. Intracranial hemorrhage.
- 4. Facial nerve paralysis.

**97.** After transurethral resection of the prostate, the nurse notices that the client's urine is bright red, has numerous clots, and is viscous. Which nursing action is **most** appropriate?

- 1. Irrigate the catheter to remove clots.
- 2. Milk the catheter tube vigorously.
- 3. Increase the client's fluid intake.
- 4. Assess vital signs and notify the surgeon.

**98.** The nurse is teaching the client about the appropriate use of lorazepam (Ativan) to manage anxiety. Which of the following statements indicates that the client understands the nurse's teaching?

- 1. "I can take my medicine whenever I feel anxious."
- 2. "It's okay to double my dose if I need to."
- 3. "My medicine isn't for the everyday stress of life."
- 4. "It's safe to have a glass of wine while taking this medicine."

**99.** The physician orders a maternal blood test for alpha fetoprotein for a nulligravid client at 16 weeks' gestation. When developing the teaching plan, the nurse bases the explanations on the understanding that this test is used to detect which of the following?

- 1. Neural tube defects.
- 2. Chromosomal anomalies.
- 3. Inborn errors of metabolism.
- 4. Lecithin-sphingomyelin ratio.

**100.** A client with end stage cancer who is receiving chemotherapy tells her husband that she feels useless now and wants to die. Prioritize, starting with first priority, the following statements the nurse should make to the husband.

1. "I will assess your wife to determine if she is suicidal."

2. "She may feel differently when her chemotherapy is completed."

3. "Thanks for telling me this; it must be scary to have her tell you this."

4. "Let's discuss what you can say to her that may help."

**101.** A nursing assistant recorded a client's 6 a.m. blood glucose level as 126 instead of 216. The nursing assistant did not recognize the error until 9 a.m. but reported it to the nurse right away. The nurse should next:

- 1. Reassign the nursing assistant to another client.
- 2. Wait and observe the client for symptoms of hyperglycemia.
- 3. Reprimand the nursing assistant for the error.
- 4. Call the physician and completing an incident report.

**102.** A client recovering from an abdominal hysterectomy has pain in her right calf. The nurse should:

- 1. Palpate the calf to note pain.
- 2. Measure the circumference of both calves and note the difference.
- 3. Have the client flex and extend her leg and note the presence of pain.
- 4. Raise the right leg and lower it to detect changes in skin color.

**103.** The nurse is caring for an elderly client who has experienced a sensorineural hearing loss. The nurse anticipates that the client will exhibit which one of the following symptoms?

- 1. Difficulty hearing high-pitched sounds.
- 2. Difficulty with speaking clearly.
- 3. Inability to assign meaning to sound.
- 4. Vertigo when changing positions.

**104.** A client recently diagnosed with lung cancer tells the nurse that she has been having difficulty sleeping and is often preoccupied with thoughts about how her life has changed. She says, "I wish my life could just go on the way it was." Which of the following nursing diagnoses is **most** appropriate for this client?

- 1. *Ineffective coping* related to cancer diagnosis.
- 2. *Insomnia* related to fear of the unknown.
- 3. *Grieving* related to cancer diagnosis.
- 4. *Anxiety* related to the need for chemotherapy treatment.

**105.** The physician orders I.V. nalbuphine (Nubain) for a primigravid client in early active labor. After administering the drug, which of the following should the nurse do **first**?

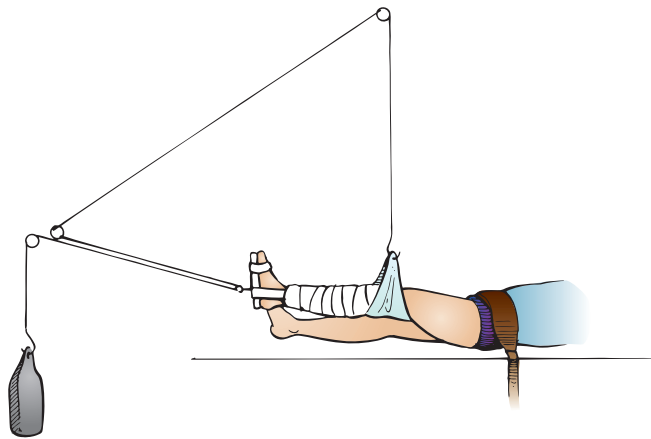
- 1. Elevate the head of the bed.
- 2. Cover the client with a blanket.
- 3. Pull the side rails up.
- 4. Dim the lights in the room.

**106.** A client with emphysema has been admitted to the hospital. The nurse should assess the client further for:

- 1. Frequent coughing.
- 2. Bronchospasms.
- 3. Underweight appearance.
- 4. Copious sputum.

**107.** A 12-year-old boy has a fractured femur and is immobilized in traction as shown in the figure. The nurse should:

- 1. Add additional weight until the foot is only 2 inches from the bed.
- 2. Offer foods that are easy to eat.
- 3. Place a pillow under the fractured leg to provide support.
- 4. Provide opportunities for age-appropriate activities.



**108.** The nurse is participating in a blood pressure screening event. After three separate readings taken at least 2 minutes apart, the nurse determines that a client has a blood pressure of 160/90 mm Hg. The nurse should advise the client to:

- 1. Have blood pressure evaluated within 1 month.
- 2. Begin an exercise program.
- 3. Examine lifestyle to decrease stress.
- 4. Schedule a complete physical immediately.

**109.** Which of the following activities is **least** effective in preventing sensory deprivation during a client's stay in the cardiac care unit?

- 1. Watching television.
- 2. Visiting with family.
- 3. Reading the newspaper.
- 4. Keeping the door closed to provide privacy.

**110.** The nurse is teaching a client who is taking dexamethasone (Decadron) for cerebral edema about early symptoms of Cushing's disease. The nurse should advise the client to report which of the following is a symptom of hyperadrenocorticism?

- 1. Hypotension.
- 2. Increased urinary frequency.
- 3. Increased muscle mass.
- 4. Easy bruising.

**111.** A client's wife arrives on the unit 6 hours after her husband's car accident, explaining that she has been out of town. She is distraught because she was not with her husband when he was admitted. What is the **most** appropriate initial intervention for the nurse to make?

- 1. Allow her to verbalize her feelings and concerns.
- 2. Describe her husband's medical treatment since admission.
- 3. Explain the nature of the injury and reassure her that her husband's condition is stable.
- 4. Reassure her that the important fact is that she is here now.

**112.** A client is scheduled to have a graded exercise test. The nurse explains to the client that the test will determine how:

- 1. Well he thinks under pressure.
- 2. Well his body reacts to controlled exercise stress.
- 3. Far he can walk.
- 4. Long he can walk.

**113.** A client who has asthma is taking albuterol (Ventolin) to treat bronchospasms. The nurse should assess the client for which of the following adverse effects that can occur as a result of taking this drug? Select all that apply.

- 1. Lethargy.
- 2. Nausea.
- 3. Headache.
- 4. Nervousness.
- 5. Constipation.

**114.** A client tells the nurse that she is afraid to undergo chemotherapy because of what she has heard about the side effects. What is the nurse's **best** response to the client's concerns?

- 1. "Your health has been excellent. It's unlikely that you'll experience serious side effects."
- 2. "We'll give you medications to prevent the side effects, so you shouldn't be too concerned."
- 3. "Each person responds differently to chemotherapy treatments. We'll monitor your responses closely."
- 4. "It's important for you to accept this treatment. If you refuse your chemotherapy treatments, you'll die."

**115.** The mother of an infant with hemophilia tells the nurse that she is planning to do home teaching when the child reaches school age. She does not want her child in school because the teacher will not watch the child as well as she would. The mother's comments represent what common parental reaction to a child's chronic illness?

- 1. Overprotection.
- 2. Devotion.
- 3. Mistrust.
- 4. Insecurity.

**116.** A mother tells a nurse that her child has been exposed to roseola. After teaching the mother about the illness, which of the following, if stated by the mother as the **most** characteristic sign of roseola, indicates successful teaching?

- 1. Fever and sore throat.
- 2. Normal temperature followed by a low-grade fever.
- 3. High fever followed by a drop and then a rash.
- 4. Coldlike signs and symptoms and a rash.

**117.** A client with acute psychosis, not otherwise specified, has been taking haloperidol (Haldol) for 3 days. When evaluating the client's response to the medication, which of the following comments reflects the **greatest** improvement?

- 1. "I know these voices aren't really real, but I'm still scared of them."
- 2. "I'm feeling so restless, and I can't sit still."
- 3. "Boy, do I need a shower. I think it has been days since I've had one."
- 4. "I'll be fine if you just let me out of here today."

**118.** A 58-year-old homeless male is brought to the emergency department by the police after being found unconscious on the street. Following examination and evaluation of laboratory test results, a diagnosis of diabetic ketoacidosis is confirmed. Which of the following information is **most** crucial to document on the client's chart? Select all that apply.

- 1. Size of pupils and reaction of pupils to light.
- 2. Response to verbal and painful stimuli.
- 3. Skin condition and presence of any rashes, lesions, or ulcers.
- 4. Blood pressure.
- 5. Length of time the client has had diabetes.
- 6. Hourly urine output.

**119.** A 78-year-old client who experienced a brief delirium knows that the condition was caused by prescription medication intoxication. Which of the following statements indicates the need for further education?

- 1. "I never realized that taking a little extra medication now and then could cause such a problem."
- 2. "I get medicines from three different doctors and they don't all know what I'm taking."
- 3. "I thought that the herbal medicines would help me. I never realized they would make me sick."
- 4. "I didn't know that cold and flu medicines might not mix with my regular medicines."

**120.** During an emergency, a physician has asked for I.V. calcium to treat a client with hypocalcemia. The nurse should:

- 1. Hand the physician calcium chloride for I.V. use.
- 2. Check with the physician for his complete order.
- 3. Hand the physician calcium gluconate for I.V. use.
- 4. Hand the physician the kind of calcium available on the unit.

**121.** The nurse is administering an I.V. potassium chloride supplement to a client who has heart failure. When developing a plan of care for this client, which of the following should the nurse incorporate?

- 1. Hyperkalemia will intensify the action of the client's digoxin (Lanoxin) preparation.
- 2. The client's potassium levels will be unaffected by his potassium-sparing diuretic.
- 3. The administration of the I.V. potassium chloride should not exceed 10 mEq/hour or a concentration of 40 mEq/L.
- 4. Metabolic alkalosis will increase the client's serum potassium levels.

**122.** A client is receiving morphine sulfate by a patient-controlled analgesia (PCA) system after a left lower lobectomy about 4 hours ago. The client reports moderately severe pain in his left thorax that worsens when he coughs. The nurse's **first** course of action is to:

- 1. Reassure the client that the PCA system is working and will relieve his pain.
- 2. Encourage the client to rest; no further assessment is needed.
- 3. Assess the pain systematically with the hospital-approved scale.
- 4. Encourage the client to ignore the pain and sleep because pain is expected after this type of surgery.

**123.** Which of the following factors can alter tissue tolerance and lead to the development of a pressure ulcer?

- 1. The client's age.
- 2. Exposure to moisture.
- 3. Presence of hypertension.
- 4. Smoking.

**124.** The nurse is screening clients for cancer prevention. Which of the following is the recommended screening protocol for colon cancer in asymptomatic clients who have a low-risk profile?

- 1. Guaiac testing of stools should be performed annually after age 50 years.
- 2. Digital rectal examinations are recommended every 5 years after age 40 years.
- 3. Sigmoidoscopy is recommended if symptoms of colon problems are present.
- 4. A low-fat diet should be implemented by age 50 years.

**125.** The nurse is evaluating the effectiveness of antipsychotic medications in a client with severe Alzheimer's disease. Which of the following changes indicates improvement resulting from medications?

- 1. Adjustment to the structured daily routine.
- 2. Return of the client's short-term memory.
- 3. Decrease in verbal and physical aggression.
- 4. Diminished resistance with activities of daily living done one step at a time.

**126.** After vaginal delivery of a term neonate, the nurse determines that the placenta is about to separate when which of the following occurs?

- 1. The uterus becomes oval shaped.
- 2. The uterus enlarges.
- 3. A sudden gush of dark blood occurs.
- 4. The client expends efforts pushing.

**127.** The nurse should complete which of the following assessments on a client who has received tissue plasminogen activator or alteplase recombinant (Activase) therapy?

- 1. Neurologic signs frequently throughout the course of therapy.
- 2. Excessive bleeding every hour for the first 8 hours.
- 3. Blood glucose level.
- 4. Arterial blood gas values.

**128.** During the emergent stage of burn management for a client with burns of 30 percent of the body the nurse should assess the client for which of the following? Select all that apply.

- 1. Hyponatremia.
- 2. Hyperkalemia.
- 3. Hypoglycemia.
- 4. Increased hematocrit.
- 5. "Fever spikes."

**129.** A 6-year-old child is to have a cardiac catheterization and asks the nurse if it will hurt. Which of the following statements provides the nurse with the **best** guide for responding to the child's question?

- 1. "The medication used to numb the insertion site will sting."
- 2. "A momentary sharp pain usually occurs when the catheter enters the heart."
- 3. "Most 6-year-olds feel some discomfort during the procedure."
- 4. "It's a painless procedure, although a tingling sensation may be felt in the extremities."

**130.** A 10-year-old with a history of recent respiratory infection has swelling around the eyes in the morning and dark urine. Which of the following should the nurse ask **first**?

- 1. "Has the child had a rash and fever?"
- 2. "Has the child had a sore throat?"
- 3. "Does the child have any allergies?"
- 4. "Does the child drink lots of liquids?"

**131.** After a nasogastric (NG) tube has been inserted, the nurse can **most** accurately determine that the tube is in the proper place if which of the following can be demonstrated?

- 1. The client is no longer gagging or coughing.
- 2. The pH of the aspirated fluid is measured.
- 3. Thirty milliliters of normal saline can be injected without difficulty.
- 4. A whooshing sound is auscultated when 10 mL of air is inserted.



**132.** A client at 40 + weeks' gestation visits the emergency department because she thinks she is in labor. Which of the following is the **best** indication that the client is in true labor?

- 1. Fetal descent into the pelvic inlet.
- 2. Cervical dilation and effacement.
- 3. Painful contractions every 3 to 5 minutes.
- 4. Leaking amniotic fluid clear in color.

**133.** Which of the following should be considered the **highest** priority during the first 24 hours postoperatively for the client who had a total laryngectomy due to cancer of the larynx?

- 1. Provide adequate nourishment.
- 2. Prevent skin breakdown.
- 3. Maintain proper bowel elimination.
- 4. Maintain a patent airway.

**134.** It has been 5 months since a client lost his wife and child in a car-train accident. The nurse should determine that the client needs continuing counseling if he makes which of the following statements?

- 1. "I'm sleeping, eating, and working pretty well, but I still get so sad at times."
- 2. "I miss them so much, but I can tell I'm getting better day by day."
- 3. "I wish I didn't have to sleep. I hate the nightmares about what the car looked like."
- 4. "I never thought I'd get over this, but I'm working with my congressman for train crossing safety."

**135.** A client is hearing voices that are telling her to kill herself. She is demanding a knife to use on her wrists. Which of the following is **most** appropriate at this time?

- 1. Put the client in restraints after giving an I.M. dose of p.r.n. medication.
- 2. Ask the client to talk about her anger and what is causing it.
- 3. Give oral p.r.n. doses of haloperidol (Haldol) and lorazepam (Ativan) as ordered.
- 4. Search the client's room for potential weapons after locking the unit kitchen.

**136.** The nurse should adjust a client's heparin dose according to a prescribed anticoagulation order based on maintaining which laboratory value at what therapeutic level for anticoagulant therapy?

- 1. Partial thromboplastin time, 1.5 to 2.5 times the normal control.
- 2. Prothrombin time, 1.5 to 2.5 times the normal control.
- 3. International Normalized Ratio, 2 to 3 seconds.
- 4. Thrombin clotting time, 10 to 15 seconds.

**137.** Which of the following measures is contraindicated when the nurse assists a child who has leukemia with oral hygiene?

- 1. Applying petroleum jelly to the lips.
- 2. Cleaning the teeth with a toothbrush.
- 3. Swabbing the mouth with moistened cotton swabs.
- 4. Rinsing the mouth with a nonirritating mouthwash.

**138.** The nurse realizes that a medication error has been made and a client has received the wrong medication. What should be the nurse's **first** action when realizing an error has been made?

- 1. Assess the client's condition.
- 2. Notify the physician of the error.
- 3. Complete an incident report.
- 4. Report the error to the unit manager.

**139.** The nurse has been assigned to a client who has had diabetes for 10 years. The nurse gives the client's usual dose of Humulin Regular insulin at 7 a.m. At 10:30 a.m., the client complains of light-headedness and sweating. The nurse should contact the physician, report the situation, background, and assessment, and recommend intervention for:

- 1. Metabolic acidosis.
- 2. Hyperglycemia.
- 3. Hypoglycemia.
- 4. Ketoacidosis.

**140.** A 6-year-old boy is being treated in the emergency department for injuries inflicted by his stepfather. The client's mother says, "This never happened before. Jim got fired today. He got drunk and came home in a tirade. I'm so sorry that Jason got hurt, but I don't think it will ever happen again." Which of the following responses is **most** appropriate initially?

- 1. "I'm sorry too, but I agree it probably won't happen again."
- 2. "I'm not as forgiving as you are. I think you need to file charges on Jim."
- 3. "This is child abuse and I have to file a report with Child Protective Services."
- 4. "I want to know more about your situation. Let's sit and talk."

**141.** The nurse administers a tap water enema to a client. While the solution is being infused, the client has abdominal cramping. What should be the nurse's **first** response?

- 1. Clamp the tubing and carefully withdraw the tube.
- 2. Temporarily stop the infusion and have the client take deep breaths.
- 3. Raise the height of the enema container.
- 4. Rub the client's abdomen gently until the cramps subside.

**142.** In preparing for insertion of a peripheral I.V. catheter, the nurse must select an appropriate site. Which of the following areas should the nurse try **first** if an appropriate vein is found?

- 1. Back of the hand.
- 2. Inner aspect of the elbow.
- 3. Inner aspect of the forearm.
- 4. Outer aspect of the forearm.

**143.** The nurse administers lactulose (Duphalac) to a client with cirrhosis. What is the expected outcome from the administration of the lactulose?

- 1. Stimulation of peristalsis of the bowel.
- 2. Reduced peripheral edema and ascites.
- 3. Reduced serum ammonia levels.
- 4. Prevention of hemorrhage.

**144.** A 12-month-old child is seen in the neighborhood clinic for a regular checkup. The child's mother states that the child is caught up with immunizations. The nurse interprets this statement as indicating that the toddler has already received which of the following?

- 1. Diphtheria, tetanus and acellular pertussis (DTaP) #1 and 2; hepatitis B (HepB) #1 and 2; inactivated poliovirus (IPV) #1 and 2.
- 2. DTaP #1, 2, and 3; HepB #1, 2, and 3; IPV #1 and 2.
- 3. DTaP #1 and 2; HepB #1, 2, and 3; oral polio vaccine (OPV) #1 and 2.
- 4. DTaP #1, 2, and 3; *Haemophilus b* #1 and 2; OPV #1 and 2.

**145.** When planning a health promotion class with a group of women, the nurse should include which of the following strategies to help reduce the risk of developing osteoarthritis?

- 1. Follow a high-protein diet.
- 2. Exercise at least three times per week.
- 3. Prevent obesity.
- 4. Take a multivitamin supplement daily.

**146.** A deficiency of which of the following vitamins is thought to be the first step in the formation of plaque and oxidative changes in the arteries?

- 1. Vitamin C.
- 2. Vitamin A.
- 3. Vitamin E.
- 4. Vitamin B<sub>6</sub>.

**147.** A neonate circumcised with a Plastibell 1 hour ago is brought to his mother for feeding. The nurse should instruct the mother to do which of the following?

- 1. Read a pamphlet about circumcision care.
- 2. Remove the petroleum jelly gauze in 24 hours.
- 3. Tell the nurse when the neonate voids.
- 4. Place petroleum jelly over the site every 2 hours.

**148.** A client has been diagnosed with early alcoholic cirrhosis. The client should be taught that incorporating which of the following behaviors into his lifestyle could potentially reverse the pathologic changes occurring in the liver?

- 1. Avoid overexertion and fatigue.
- 2. Avoid drinking alcohol.
- 3. Eliminate smoking.
- 4. Eat a high-carbohydrate, low-fat diet.

**149.** A child is to receive dexamethasone (Decadron) intravenously at the ordered dosage of 7.6 mg. The drug concentration in the vial is 4 mg/mL. The nurse should administer?

\_\_\_\_\_ mL.

**150.** A 40-year-old primigravid client with AB-positive blood visits the outpatient clinic for an amniocentesis at 16 weeks' gestation. The nurse determines that the **most** likely reason for the client's amniocentesis is to determine if the fetus has which of the following?

- 1. Cri du chat syndrome.
- 2. ABO incompatibility.
- 3. Erythroblastosis fetalis.
- 4. Down syndrome.

**151.** The nurse is assessing a client who has benign prostatic hypertrophy (BPH). The nurse should ask the client if he has:

- 1. Impotence.
- 2. Flank pain.
- 3. Difficulty starting the urinary stream.
- 4. Hematuria.

**152.** Which of the following is the **most** helpful strategy to use for anger management when dealing with a verbally aggressive client?

- 1. Role-playing assertive statements with the nurse.
- 2. Watching a videotape about assertiveness.
- 3. Describing feelings that occur after aggressive outbursts.
- 4. Discussing situations that appear to be threatening.

**153.** Which of the following actions should the nurse anticipate using when caring for a term neonate diagnosed with transient tachypnea at 2 hours after birth?

- 1. Monitoring the neonate's color and cry every 4 hours.
- 2. Feeding the neonate with a bottle every 3 hours.
- 3. Obtaining extracorporeal membrane oxygenation equipment.
- 4. Providing warm, humidified oxygen in a warm environment.

**154.** The skin tone of a client of Vietnamese descent with dark skin who has early signs of iron deficiency anemia appears:

- 1. Reddish-brown.
- 2. Yellowish-brown.
- 3. Black-brown.
- 4. Whitish-brown.

**155.** Which of the following laboratory findings is present in nephrotic syndrome?

- 1. Decreased total serum protein.
- 2. Hypercalcemia.
- 3. Hyperglycemia.
- 4. Decreased hematocrit.

**156.** While caring for several preterm infants in the special care nursery, which of the following actions is **most** important for preventing nosocomial infections in these neonates?

- 1. Using sterile supplies for all treatments.
- 2. Performing thorough handwashing before giving infant care.
- 3. Donning cover gowns for nurses and visitors to the unit.
- 4. Wearing a mask, and changing it frequently when giving care.

**157.** Which of the following types of restraints is **best** for the nurse to use for a child in the immediate postoperative period after cleft palate repair?

- 1. Safety jacket.
- 2. Elbow restraints.
- 3. Wrist restraints.
- 4. Body restraints.

**158.** When preparing to present a community program about women who are victims of physical abuse, which of the following should the nurse stress about the incidence of battering?

- 1. Death from battering is rare.
- 2. Battering is a major cause of injury to women.
- 3. Lower socioeconomic groups are primarily affected.
- 4. Battering rarely involves pregnant women.

**159.** A client undergoes a nephrectomy. In the immediate postoperative period, which nursing intervention has the **highest** priority?

- 1. Monitoring blood pressure.
- 2. Encouraging the use of the incentive spirometer.
- 3. Assessing urine output hourly.
- 4. Checking the flank dressing for urine drainage.

**160.** A nulliparous client tells the nurse that during her last pelvic examination the physician said that her uterus was in a severe retroverted position. The nurse determines that the client may experience which of the following?

- 1. Frequent vaginal infections.
- 2. Pain from endometriosis.
- 3. Severe menstrual cramping.
- 4. Difficulty conceiving a child.

**161.** A mother tells the nurse that she wants her 4-year-old to stop sucking her thumb. When developing the teaching plan, which of the following should the nurse suggest?

- 1. Apply a special medicine that tastes terrible on the thumb.
- 2. Get the child to agree to stop the thumb sucking.
- 3. Remind the child every time the mother sees the thumb in her mouth.
- 4. Put the child in time-out every time the mother observes thumb sucking.

**162.** A client in severe respiratory distress is admitted to the hospital. When assessing the client, the nurse should:

- 1. Conduct a complete health history.
- 2. Complete a comprehensive physical examination.
- 3. Delay assessment until client's respiratory distress is resolved.
- 4. Focus assessment on the respiratory system and distress.

**163.** A client has had a total hip replacement. Which of the following signs most likely indicates that the hip has dislocated?

- 1. Abduction of the affected leg.
- 2. Loosening of the prosthesis.
- 3. External rotation of the affected leg.
- 4. Shortening of the affected leg.

**164.** A client with paranoid schizophrenia is withdrawn and suspicious of others and projects blame. The client's behavior reflects problems in which of the following stages of development as identified by Erikson?

- 1. Trust versus mistrust.
- 2. Autonomy versus shame and doubt.
- 3. Initiative versus guilt.
- 4. Intimacy versus isolation.

**165.** During the initial interview, a client with a compulsive eating disorder remarks, "I can't stand myself and the way I look." Which of the following statements by the nurse is most therapeutic?

- 1. "Everyone who has the same problem feels like you do."
- 2. "I don't think you look bad at all."
- 3. "Don't worry. You'll soon be back in shape."
- 4. "Tell me more about your feelings."

**166.** A client with a new ileal conduit asks the nurse when he needs to wear his appliance. Which of the following responses by the nurse is correct?

- 1. "You need to wear your appliance all the time."
- 2. "You need to wear your appliance after you irrigate."
- 3. "It is only necessary to wear your appliance at night."
- 4. "The appliance must be worn after your meals."

**167.** A child who is admitted after having suffered trauma has also been exposed to varicella. Which of the following should the nurse institute for infection control?

- 1. Airborne precautions.
- 2. Droplet precautions.
- 3. Contact precautions.
- 4. Indirect contact precautions.

**168.** Which of the following goals/outcomes is appropriate for a client with multiple myeloma?

- 1. Achieve effective management of bone pain.
- 2. Recover from the disease with minimal disabilities.
- 3. Decrease episodes of nausea and vomiting.
- 4. **Avoid** hyperkalemia.

**169.** A client with major depression is completing his morning care independently. When the nurse approaches the client with his medication, he tells the nurse that he is a failure as a husband and a father and is worthless. His wife told the nurse previously that the client is a good provider and a wonderful father and husband. Which of the following responses by the nurse is most appropriate?

- 1. "You were able to shower and dress without help this morning."
- 2. "Your wife told me that you are a good husband and father."
- 3. "You don't have any reason why you should feel that way."
- 4. "This medication will help your thinking."

**170.** The nurse uses Montgomery straps **primarily** to achieve which of the following client outcomes?

- 1. The client is free from falls.
- 2. The client is free from bruises.
- 3. The client is free from skin breakdown.
- 4. The client is free from wandering.

**171.** After an episode of severe pain, a client says to the nurse, "The pain really frightened me. I thought I was going to die." Which statement is the **most** appropriate response from the nurse?

- 1. "I understand that pain can be a frightening experience."
- 2. "Why were you frightened? You have had pain before."
- 3. "There's no need to be frightened of pain."
- 4. "Pain can't cause you to die. Try to relax."

**172.** A child returns to the pediatric unit after a bowel resection. Which of the following actions has the **highest** priority?

- 1. Administer I.V. fluids.
- 2. Keep the child on nothing-by-mouth status.
- 3. Monitor vital signs frequently.
- 4. Assess the child's pain level.

**173.** During a health history, a 59-year-old male client is being evaluated for possible type 2 diabetes mellitus. Which of the following client statements supports the diagnosis of type 2 diabetes?

- 1. "I have some shortness of breath when I exercise."
- 2. "No matter how much I drink, I'm still thirsty all the time."
- 3. "I wake up early in the morning and can't return to sleep."
- 4. "In the past couple of weeks, I've been having a lot of trouble urinating."

**174.** A 25-year-old has been diagnosed with hypertrophic cardiomyopathy. The nurse should assess the client for:

- 1. Angina.
- 2. Fatigue and shortness of breath.
- 3. Abdominal pain.
- 4. Hypertension.

**175.** The nurse should advise the mother of a toddler suspected of having pinworms to do the cellophane tape test at which of the following times?

- 1. Before bathing.
- 2. After a bowel movement.
- 3. While the child is asleep.
- 4. After a meal.

**176.** Which of the following conditions occurring in a mother's pregnancy provides a clue that the newborn might have a gastrointestinal tract anomaly?

- 1. Meconium in the amniotic fluid.
- 2. Low implantation of the placenta.
- 3. Increased amount of amniotic fluid.
- 4. Toxemia in the last trimester.

**177.** As part of the treatment plan, a client is prescribed steroids to treat ulcerative colitis. The nurse should assess the client for which of the following common complications related to steroid therapy?

- 1. Peptic ulcer.
- 2. Hypoglycemia.
- 3. Tachycardia.
- 4. Renal failure.

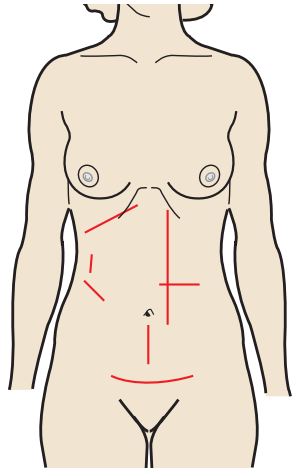
**178.** A client's abdominal incision eviscerates. The nurse should:

- 1. Take the client's vital signs and call the physician.
- 2. Lower the client's head and elevate the feet.
- 3. Cover the incision with a dressing moistened with sterile normal saline solution.
- 4. Start an emergency infusion of I.V. fluids.

**179.** What is the **priority** nursing intervention for a client who is admitted to the emergency department with burns over an estimated 27% of the body surface area?

- 1. Insert a large-caliber I.V. line.
- 2. Administer morphine intramuscularly.
- 3. Establish an airway.
- 4. Administer tetanus toxoid.

**180.** The client is to have a gastrectomy. The surgeon will use a transverse incision. Prior to surgery the nurse is checking to be sure the client has marked the correct site. Identify the site the client should have marked.



## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

**1. 3.** Illegible writing is one of the most common reasons for medication errors. The physician should be called to clarify the order. The previous medication record should not be used as a substitute for the exact order written by the physician. The pharmacist or the client's family cannot interpret an order written by a physician.

🔑 CN: Management of care; CL: Synthesize

**2. 2.** Propantheline bromide is an anticholinergic used to decrease biliary spasm. Decreasing biliary spasm helps to reduce pain in cholecystitis. Propantheline does not increase bile production or

have an antiemetic effect, and it is not effective in treating infection.

🔑 CN: Pharmacological and parenteral therapies; CL: Apply

**3. 3.** An important function of the National Cystic Fibrosis Foundation is to put parents of children with cystic fibrosis in touch with each other. Other parents can commonly offer support and help. In some instances, the Foundation gives parents financial assistance for equipment required for home care of their child with cystic fibrosis (but not for medications). The Foundation does not obtain tutors for children or provide genetic counseling for parents.

🔑 CN: Management of care; CL: Apply

**4. 4.** Laryngeal stridor is characteristic of respiratory distress from inflammation and swelling after bronchoscopy. It must be reported immediately. Green sputum indicates infection and would occur 3 to 5 days after bronchoscopy. A mild cough or hemoptysis is typical after bronchoscopy. If a tissue biopsy specimen was obtained, sputum may be blood-streaked for several days.

🔑 CN: Reduction of risk potential; CL: Analyze

**5. 3.** Strategies for meeting client satisfaction include involving hospital department personnel to improve service. Saying, “The staff is doing the best they can,” or, “I will report this to the physician,” does not offer a practical resolution to the client's complaint. Expressing a personal dislike for the food negates the client's complaint and does not offer a solution.

🔑 CN: Management of care; CL: Synthesize

**6. 3.** The elderly client commonly has vague or atypical responses to medications and diseases that are erroneously attributed to aging. A new cognitive change needs to be investigated and is not an expected change with aging. Changes in a client's behavior should be investigated to see whether there is a relation to excessive sedation. The nurse can interview the family members to obtain information.

🔑 CN: Health promotion and maintenance; CL: Apply


**7. 2.** Rehabilitation for a client who has sustained a cerebrovascular accident begins at the time he is admitted to the hospital. The first goal of rehabilitation should be to help prevent deformities. This goal is achieved through such techniques as positioning the client properly in bed, changing his position frequently, and supporting all parts of his body in proper alignment. Passive range-of-motion exercises may also be started, unless contraindicated.

🔑 CN: Management of care; CL: Synthesize


**8. 3.** The nurse's response should suggest exploration of the difficult decision-making process the client must go through. The client should be encouraged to verbalize the various options in order to make the choice that is right for her. Telling the client that she should give the baby up so it can have a better home or that research shows babies do better with their birth mothers is judgmental and does not place the control of the decision with the client. Suggesting that the client try keeping the baby at first minimizes the situation and also does not put the control of the decision with the client.

 CN: Psychosocial adaptation;  
CL: Synthesize


**9. 2.** Two nurses must verify the name and label of the blood with the client's wristband.

 CN: Pharmacological and parenteral therapies; CL: Apply


**10. 2.** SIADH is characterized by excess antidiuretic hormone (ADH, vasopressin) secretion, despite low plasma osmolality. Excess ADH causes water to be retained. As blood volume expands, plasma becomes diluted resulting in dilutional hyponatremia. Aldosterone is suppressed, resulting in increased renal sodium excretion. Water moves from the hypotonic plasma and the interstitial spaces into the cells.

 CN: Physiological adaptation;  
CL: Analyze

**11. 3.** Accumulation of air in the pleural cavity after a crushing chest injury may be assessed by unilateral diminished or absent breath sounds. Cheyne-Stokes respirations with periods of apnea commonly precede death. They indicate heart failure or brain death. Fremitus is increased with lung consolidation and decreased with pleural effusion or pneumothorax. Pain occurs at the injury site and increases with inspiration.

 CN: Physiological adaptation;  
CL: Analyze

**12. 2.** Chewing the pill or capsule form of valproic acid can cause mouth and throat irritation and is contraindicated. Taking the pills at the same time each day is important to maintain therapeutic effectiveness of the drug. Taking the pills with food is appropriate if the client is experiencing gastrointestinal upset. Valproic acid may cause clotting problems; therefore, bruising should be reported.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**13. 1.** A significant association between feeding position and otitis media exists. Children fed in a supine position have a high incidence of

otitis media because of the reflux of milk into the eustachian tubes during feedings. Keeping the infant's ears covered when out in the cold or thoroughly drying the ears after a bath has not been identified as a contributing factor to an infant's development of ear infections. Although the infant's immunization status is always important to ascertain, other factors, such as the position of the infant when taking a bottle, have more impact.

 CN: Reduction of risk potential;  
CL: Analyze


**14. 2.** It is the role of the surgeon or the person performing the procedure to obtain the informed consent. This consists of informing the client about the procedure, the risks of treatment, the side effects, other types of treatments available, and the effects without the procedure.

 CN: Management of care; CL: Apply


**15. 4.** Hospice care focuses on supportive care for the client and family. Care for the family may continue throughout the bereavement period. Hospice care involves care of the client at home as well as in an inpatient setting. Although professional care is provided in hospice, family members, volunteers, and unlicensed nursing personnel also participate in the care of the client.

 CN: Basic care and comfort; CL: Apply


**16. 3.** An 8 oz glass of milk is equivalent to 1½ to 2 slices of presliced American cheese. Two tablespoons of Parmesan cheese or ½ cup of milkshake is equivalent to 4 oz of milk, and ½ cup of cottage cheese is equivalent to 2 oz of milk.

 CN: Health promotion and maintenance;  
CL: Apply

**17. 1.** The biophysical profile typically measures five parameters to assess the fetus: fetal breathing, movement, and tone; amniotic fluid volume; and fetal heart reactivity. The test uses a scale of 0 to 2 for each parameter with a maximum score of 10.

 CN: Physiological adaptation;  
CL: Evaluate


**18. 3.** One of the side effects of steroid therapy is fat deposition on the trunk and face, producing classic Cushingoid signs. Therefore, the nurse should expect to find truncal obesity. Steroids also can cause altered moods or mood swings. Typically, long-term steroid use results in weight gain. Steroids may inhibit the action of growth hormone. Therefore, a growth spurt is not likely.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**19. 3.** The nurse should not be required to participate in an abortion if it contradicts the nurse's religious beliefs. The behavior should not be reflected negatively on the nurses' evaluation. Preparing equipment and supplies for the case may be viewed as the same as circulating for the case. The nurse has a right not to participate in an abortion unless it is an absolute emergency and no one else is available to care for the client.

 CN: Management of care; CL: Synthesize


**20. 2.** Given the client's age, making final plans is age appropriate. The absence of any signs of ill health, depression, or suicidal ideation makes the other options inappropriate.

 CN: Psychosocial adaptation;  
CL: Analyze


**21. 3.** Phenytoin causes hyperplasia of the gums, and the client needs frequent dental examinations and meticulous oral hygiene. Phenytoin therapy may contribute to a folic acid deficiency, but it is not related to iron or calcium metabolism. A need for frequent eye examinations is not related to the side effects of phenytoin.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**22. 1.** Visual acuity is not affected by long-term gentamicin sulfate therapy. The nurse should establish baseline data for vestibular, renal, and auditory function because gentamicin sulfate is ototoxic and causes renal toxicity.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**23. 1.** The chest is compressed with the heel of one hand positioned on the lower sternum, two fingerbreadths above the sternal notch. Fingertips are used to compress the sternum in infants, and the heels of both hands are used in adult cardiopulmonary resuscitation.

 CN: Safety and infection control;  
CL: Apply

**24. 2, 3, 4.** Yogurt, dry beans, and peanut butter all contain protein in amounts that make them good sources of protein for the child. Bacon is high in fat; an apple is a carbohydrate.


 CN: Basic care and comfort; CL: Apply

**25.**  $S_1$  is loudest at the mitral area.

 CN: Health promotion and maintenance;  
CL: Apply

**26. 1.** Nitroglycerin (Nitrostat) tablets should be taken 5 minutes apart for three doses; if this is ineffective, 911 should be called to obtain an ambulance


to take the client to the emergency department. The client should not drive or have a family member drive the client to the hospital.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**27. 2.** Saturated fats raise blood cholesterol. Polyunsaturated fats maintain blood cholesterol. Monounsaturated fats may help to maintain or lower blood cholesterol. Phospholipids do not have an effect on cholesterol but act as emulsifiers, keeping fats dispersed in water.

 CN: Health promotion and maintenance;  
CL: Apply


**28. 4.** The client who voices death wishes must be asked directly about thoughts of suicide and specific suicide plans. The other questions are important history questions but are not crucial to address the follow-up needed when the client verbalizes a death wish.

 CN: Psychosocial adaptation;  
CL: Synthesize

**29. 3.** This client should be monitored for blood dyscrasias, evidenced by decreased platelet count and white blood cell count with changes in the CBC differential.

 CN: Pharmacological and parenteral therapies; CL: Apply


**30. 1.** Children with osteomyelitis need a diet that is high in protein and calories. Milk, eggs, cheese, meat, fish, and beans are the best sources of these nutrients.

 CN: Physiological adaptation;  
CL: Synthesize


**31. 4.** The new onset of constipation may be a sign of a tumor from colon cancer. Constipation is not an expected change of aging. Increased fiber and fluid intake is helpful with constipation, but in this case the client needs to be seen by a health care provider to rule out colon cancer.

 CN: Reduction of risk potential;  
CL: Synthesize


**32. 4.** Saying, "We'll help you be successful so that you can stay alcohol-free," conveys interest in the client as a worthwhile individual who needs help and treatment. This statement also helps to build trust and enhances self-esteem. The other statements confront the client and may result in the client's feeling belittled, judged, and rejected.

 CN: Psychosocial adaptation;  
CL: Synthesize


**33. 3.** Research has shown that at least two injections daily provide improved blood glucose control and decreased incidence of target end-organ damage. Type 1 diabetes requires insulin replacement and cannot be managed with oral medications alone. It would be inappropriate to ask the physician to change the insulin schedule.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**34. 1.** Peak and trough serum levels are used to adjust the dosage within a therapeutic range.

 CN: Pharmacological and parenteral therapies; CL: Apply

**35. 1.** The client with diabetes and a chronic respiratory condition is most at risk for influenza and should receive the vaccine yearly. Diabetes and chronic respiratory conditions do not increase the risk of hepatitis A. An adult client is not as likely to need the measles-mumps-rubella or varicella immunizations, but titers can be checked if the client has not had childhood immunizations or the disease.

 CN: Reduction of risk potential; CL: Apply

**36. 2.** Infants are sensitive to stress in their caretakers. The best way to handle an anxious infant is to talk quietly to him, thereby soothing the infant. Limiting holding of the infant to feeding periods interferes with meeting the infant's needs for close contact, possibly compromising his ability to develop trust. Playing music in the room for most of the day and night will make it difficult for the infant to differentiate days from nights. Having a friend take the infant for several days will not necessarily take care of the problem because when the infant returns to the mother the same behaviors will recur unless the mother makes some changes.

 CN: Psychosocial adaptation; CL: Synthesize

**37. 1.** The infant is exhibiting periodic breathing, which is normal in infants of this age. The infant typically alternates short periods of rapid, louder respirations with periods of slower, quieter respirations.

 CN: Health promotion and maintenance; CL: Analyze


**38. 2.** Tracheostomy tubes are associated with several potential complications, including laryngeal nerve damage, bleeding, and infection. Tracheostomy tubes do not cause decreased cardiac output, pneumothorax, or acute respiratory distress syndrome.

 CN: Physiological adaptation; CL: Analyze


**39. 4.** A glycosylated hemoglobin level gives the nurse data about the average blood glucose concentration over 2 to 3 months, providing a picture of the client's overall glucose control. A fasting serum glucose level gives a picture of the child's recent glucose level, not the overall effectiveness of the child's therapeutic regimen. A 1-week diet recall is not always accurate. Although a home log would provide some information about the child's overall control and compliance, the log may not have all of the glucose levels recorded.

 CN: Reduction of risk potential; CL: Evaluate


**40. 3.** When making rounds, nurses can note a variety of risks in the clients' rooms, in the hallways, and other areas where clients might be at risk. Using signs, color-coded armbands, and keeping the bed in a low position are also useful, but making rounds offers the opportunity for nurses to intervene immediately and teach the client, family, and staff when risks are noted.

 CN: Safety and infection control; CL: Synthesize

**41. 1.** The nurse's first action should be to clamp off the transfusion because the client is having a transfusion reaction. It is most important that the client not receive any more blood. Other measures may be appropriate after the blood has been stopped. The nurse should raise the head of the bed if the client becomes short of breath. There is no need for antibiotic therapy for a blood transfusion related to a temperature spike. The nurse can provide a cool washcloth for a headache or fever; however, this is not a priority.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**42. 1, 3, 4.** A drop in blood pressure to 80/40 mm Hg is significant and should be reported to the physician. Hypotension and vasodilation may occur as a result of sympathetic nerve blockage along with the pain nerve blockage. A report of a crushing headache suggests that the epidural catheter may be dislodged and in the subarachnoid space rather than the epidural space. The physician also should be notified anytime more than 1 mL of fluid or blood is aspirated from the catheter before a bolus injection. A respiratory rate of 14 breaths/minute, although somewhat decreased from baseline, is within acceptable parameters. However, if the rate drops to 10 breaths/minute or less, the physician should be notified. A pain rating of 3 out of 10 suggests that pain is being relieved with the epidural analgesia.


 CN: Pharmacological and parenteral therapies; CL: Synthesize



**43. 3.** A client with AIDS is immunocompromised, and food safety is an important concern. Food-borne illnesses and infections can be devastating to the client with AIDS. Large, frequent meals are not necessary. Megadoses of vitamins can result in toxicities that may aggravate the client's clinical condition. Leaving food out encourages growth of microorganisms.

 CN: Safety and infection control;  
CL: Synthesize


**44. 3.** The incisions made for upper abdominal surgeries, such as cholecystectomies, are near the diaphragm and make deep breathing painful. Incentive spirometry, which encourages deep breathing, is essential to prevent atelectasis after surgery. The client is not maintained on bed rest for several days. The client is encouraged to ambulate by the first postoperative day, even with drainage tubes in place. Nasogastric tubes do not inhibit deep breathing and coughing.

 CN: Physiological adaptation;  
CL: Apply


**45. 4.** This finding describes Mongolian spots, which are common in newborns of African, Asian, or Latin descent. Telangiectatic nevi, or "stork bites," are pink lesions commonly found on the back of the neck. Milia are small white papules over the nose and cheek that indicate blocked sebaceous glands.

 CN: Health promotion and maintenance;  
CL: Analyze


**46. 1.** Blurred vision is a serious adverse effect of oral contraceptives, possibly because of severe hypertension as a result of the medication. If the client experiences blurred vision, she needs to contact her health care provider immediately. Nausea, weight gain, and mild headache are common and possibly bothersome side effects and should be noted. However, they do not need to be reported immediately unless they are severe, prolonged, or accompanied by other symptoms.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**47. 1.** Signs and symptoms of a pneumothorax include sudden, sharp pain with breathing or coughing on the affected side, tachypnea, dyspnea, diminished or absent breath sounds on the affected side, tachycardia, anxiety, and restlessness. Tracheal deviation away from the affected side indicates a tension pneumothorax, which is a medical emergency.

 CN: Physiological adaptation;  
CL: Analyze


**48. 2.** When a client is experiencing a flashback, the nurse should stay with the client, offer reassurance, and present reality in a nonthreatening manner to minimize the client's anxiety and agitation. The client needs to be told that she is experiencing an effect from lysergic acid diethylamide and that she is safe and the flashback will end. Confronting the client's misperceptions or challenging her unrealistic statements could increase her anxiety and agitation, possibly leading to aggressive behavior. Secluding the client until the flashback ends usually is not necessary or appropriate unless the client threatens or demonstrates aggression toward herself or others.

 CN: Psychosocial adaptation;  
CL: Apply


**49. 2.** The nurse should dispose of any used needle and syringe by immediately placing uncapped, used needles and syringes in the universal precaution container.

 CN: Pharmacological and parenteral therapies; CL: Apply

**50. 1, 4.** The greatest cause of death in this community is from heart disease and, therefore, the education session should focus on heart health and prevention of heart disease. This community has a diverse racial/ethnic mix and the session should be planned to be culturally appropriate for all members of the community. The majority of this community does not have a college education; the session should be planned for those with an education level of high school or less. There is not a sufficient number of Hispanics in this community to justify having the session presented in a language other than English. While printed materials enhance educational sessions, particularly for visual learners, there is no indication that this is necessary or would be cost effective.

 CN: Management of care;  
CL: Synthesize


**51. 3.** Nausea and vomiting, along with hypokalemia, are likely indicators of digoxin toxicity. Hypokalemia is a common cause of digoxin toxicity; therefore, serum potassium levels should be carefully monitored if the client is taking digoxin. The earliest clinical signs of digoxin toxicity are anorexia, nausea, and vomiting. Bradycardia, other dysrhythmias, and visual disturbances are also common signs. Chronic renal failure usually causes hyperkalemia. With persistent vomiting, the client is more likely to develop metabolic alkalosis than metabolic acidosis.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**52. 2.** Food sources high in calcium include steamed broccoli, dairy products, and fortified cereals. Rice, apples, and meat are not calcium-rich sources. Menopausal women need 1,500 mg of calcium daily.

 CN: Reduction of risk potential;  
CL: Apply

**53. 2.** At the time a client receives a Depo-Provera injection, a follow-up appointment should be made for 3 months later. The nurse should emphasize the need to adhere to the medication schedule to prevent an unplanned pregnancy. One of the most common reasons for failure of this contraceptive is lack of adherence to the appointment schedule for injections every 3 months.

 CN: Pharmacological and parenteral therapies; CL: Apply


**54. 4.** The pH of 7.52 indicates that the body is in a state of alkalosis. The partial pressure of carbon dioxide value is normal and the bicarbonate value is elevated. The increased bicarbonate value indicates that the acid-base imbalance is metabolic alkalosis. Restlessness can be a clinical finding in metabolic alkalosis.

 CN: Physiological adaptation;  
CL: Analyze


**55. 3.** Panting will alleviate the client's urge to push. The client risks edema or tearing of the cervix if pushing begins before complete cervical dilation (10 cm) is achieved. Although turning the client to her left side improves uteroplacental blood flow, it will have no effect on diminishing the client's urge to push. Although focusing on an object in the room may help the client to relax, it will have no effect on diminishing the client's urge to push due to the pressure of a fetus at +1 station.

 CN: Health promotion and maintenance;  
CL: Synthesize


**56. 2,3,4.** The client who is taking potentially nephrotoxic antibiotics should notify the health care provider iff the urine is cloudy, smoky, or pink; early signs of nephrotoxicity are manifested by changes in urine color. Straw-colored urine is normal.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**57. 4.** Clinical manifestations of juvenile hypothyroidism include dry skin, constipation, sparse hair, and sleepiness. Short attention span, weight loss, moist flushed skin, rapid pulse, and heat intolerance suggest hyperthyroidism.

 CN: Physiological adaptation;  
CL: Analyze

**58. 1, 6.** Atomoxetine is a selective norepinephrine reuptake inhibitor antidepressant, not a stimulant. Therefore, a two-times-a-day dosing schedule is appropriate, with a dose given in the morning and late afternoon. It may take more than 2 to 3 weeks to see the full effects of this medication. Nausea and dizziness are transient side effects. Monoamine oxidase inhibitors are contraindicated with atomoxetine.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**59. 1.** In clients with excess fluid volume, sodium restriction may be necessary to promote fluid loss. Monitoring electrolytes daily may be appropriate but will not reduce the excess fluid. Restricting fluid intake will not reduce retained fluids; increased fluids will increase urine output and promote improved fluid balance. Elevating the client's feet helps promote venous return and fluid reabsorption but in itself will not reduce the volume of excess fluid.

 CN: Reduction of risk potential;  
CL: Synthesize

**60. 3.** The bluish pigment on the buttocks and back of an African American infant is a common finding and should be documented as Mongolian spots in the child's record. These spots typically fade by the time the child is 5 or 6 years. Additional assessment by the physician is not indicated. Laser therapy is not used. Rather, laser therapy is useful for port wine stains, which are dark purple and disfiguring.

 CN: Health promotion and maintenance;  
CL: Synthesize

**61. 1.** The client might wear objects as a protection against specific medical disorders. Typically these practices bring no harm to the client and should not be discouraged. The client should continue to be encouraged to follow the medical guidance of her health care provider. If the practice is not harming the client, it is inappropriate to label it quackery and demand that the client discontinue it. There is no medical evidence to support the wearing of a copper bracelet.

 CN: Health promotion and maintenance;  
CL: Synthesize

**62. 4.** Normally, a neonate's heart rate should be between 120 and 160 bpm shortly after birth. The nurse should document this as a normal neonatal finding. The physician does not need to be notified. Assessing for cyanosis is a routine assessment at birth, but with the neonate's heart rate at 142 bpm, cyanosis should be minimal and typically located in the hands and feet. Heart rate assessments are


performed routinely according to facility protocol. For example, the heart rate is assessed soon after birth, every 15 minutes for 1 hour, every 30 minutes for 1 hour, and then every 4 hours.

 CN: Health promotion and maintenance;  
CL: Synthesize

**63. 1.** In a frank breech, the buttocks alone are at the cervix, while the knees are extended to rest on the chest. In a cephalic presentation, the head is the fetal body part first coming in contact with the cervix. Both feet at the cervix is termed double footling breech. In a shoulder presentation, one of the shoulders (actually the acromion process) presents to the cervix. Typically, the fetus is lying horizontally (transverse lie).

 CN: Health promotion and maintenance;  
CL: Apply

**64. 1.** The therapeutic effects of desmopressin nasal spray are relief from polydipsia and control of polyuria and nocturia in the client with diabetes insipidus. Side effects include nasal congestion and headache. Blurred vision is not related to desmopressin.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**65. 2.** A mammogram can detect a lesion the size of a pinhead, and a lump is about 2 cm before it can be detected by a BSE. The American Cancer Society guidelines recommend a mammogram yearly after age 40. A mammogram will not detect other endocrine abnormalities.

 CN: Health promotion and maintenance;  
CL: Synthesize

**66. 1.** Protein and vitamin C are particularly important in promoting wound healing and recovery from infection. A diet high in carbohydrates is also essential. Because the client with an infection commonly does not feel like eating, it is important that what he is encouraged to eat should be nutritious. Chicken and orange slices would help meet the client's protein and vitamin needs. A meal of cheeseburger and fries or cheese omelet and bacon is high in fat and low in vitamins. Gelatin salad and tea contain minimal nutrients.

 CN: Basic care and comfort; CL: Apply

**67. 4.** Beef, liver, iron-fortified cereals, and spinach are iron-rich foods. Cheese, squash, and eggs are not significant sources of iron.


 CN: Reduction of risk potential;  
CL: Apply

**68. 2.** Good sources of dietary iron include red meats, poultry, green leafy vegetables, and dried


fruits such as raisins. Milk products are poor sources of iron. Carrots are high in vitamin A.

 CN: Reduction of risk potential;  
CL: Evaluate


**69. 2, 4.** Children in respiratory distress need to be kept as quiet as possible to decrease respiratory and heart rates. Toddlers need a parent with them for security. The best way to quiet toddlers is to read to or hold them. Restraints increase heart and respiratory rates. A sedative will mask the signs of further respiratory distress. Although telling toddlers that a mask will help with breathing, they cannot understand the rationale and thus fully comprehend its importance. Asking the parents to leave the bedside will most likely result in greater upset, further contributing to respiratory distress.

 CN: Basic care and comfort;  
CL: Synthesize


**70. 2.** The pallor and cool temperature of the fingers and the decreased return time for capillary refill indicate decreased arterial blood supply to the fingers. These findings are not normal for any time in the recovery process. Nerve impairment includes numbness, tingling, and impaired movement of the fingers. Signs of venous stasis include edema and reddening of the fingers, not pallor and cool temperature.

 CN: Physiological adaptation;  
CL: Analyze


**71. 1.** Warm showers, baths, or hand soaks can help relieve joint stiffness and allow the client to more comfortably perform activities of daily living. Aspirin or other anti-inflammatory drugs should be taken before activity to help decrease inflammation and reduce joint pain and inflammation. Although weight loss may decrease stress on joints, pain and stiffness will continue to be a problem. Cold compresses are most effective for relieving joint pain, whereas moist heat is useful for decreasing pain and stiffness. When cold compresses are applied, their use should be limited to 10 to 15 minutes at a time to decrease the risk of tissue damage.

 CN: Basic care and comfort;  
CL: Synthesize

**72. 2.** The most appropriate immediate response is to open the airway. The nurse then should look, listen, and feel for respirations. Noting none, the nurse calls a code and attempts ventilations with a bag mask or mask with a one-way valve until the full code team responds. Using standard precautions with the mask protects the nurse from exposure to possible client microorganisms.

 CN: Physiological adaptation;  
CL: Synthesize

**73. 4.** The nurse should remind the client about meal and activity times so that the ritual can be completed beforehand and not interfere with meals and activities. The client must be allowed to complete her ritual because it keeps anxiety in check. Totally eliminating the client's ritual will increase her anxiety and the need for the handwashing. Allowing the client to decide whether she wants to attend meals and activities is not appropriate or in the client's best interest because she must perform the ritual to assuage anxiety. Informing the client that absence from meals and activities is not permitted scolds the client, increasing her anxiety and her need for the ritual.

 CN: Psychosocial adaptation;  
CL: Synthesize

**74. 2.** The client needs further instructions when she says, "If I become pregnant, I can continue to eat sushi twice a week." Raw fish, including tuna, should be avoided while the client is pregnant because of the risk of contamination with mercury and other potential teratogens. Folic acid supplements taken before the client gets pregnant and during pregnancy can help reduce the risk of neural tube defects. Steaming vegetables reduces the risk that vitamins will be lost in the cooking water. Soy products can increase the client's protein levels.

 CN: Health promotion and maintenance;  
CL: Evaluate

**75. 4.** The nurse should acknowledge that the client feels better, but should also remind the client to continue his drug therapy and other self-care activities of rest, exercise, joint protection, and adequate nutrition. Wearing the bracelet is not harmful, and the nurse should not instruct the client to remove it or label it quackery. Copper bracelets do not interfere with salicylate metabolism.

 CN: Psychosocial adaptation; CL: Synthesize

**76. 4.** Liver function tests, including aspartate transaminase (AST) should be monitored before therapy, 6 to 12 weeks after initiation of therapy or after dose elevation, and then every 6 months. If AST levels increase to three times normal, therapy should be discontinued. Simvastatin does not influence serum glucose, complete blood count, or total protein. Serum cholesterol and triglyceride levels should be evaluated before initiating therapy, after 4 to 6 weeks of therapy, and periodically thereafter.


 CN: Health promotion and maintenance;  
CL: Analyze

**77. 3.** Acupuncture, like acupressure and acupressure, is performed in certain Asian cultures to restore the energy balance within the body. Pressure, massage, and fine needles are applied to

energy pathways to help restore the body's balance. Acupuncture is not based on a belief in purging evil spirits. Although pain relief through acupuncture can promote tranquility, acupuncture is performed to restore energy balance. In the Western world, many researchers think that the gate-control theory of pain may explain the success of acupuncture, acupressure, and acupressure.

 CN: Basic care and comfort; CL: Apply

**78. 2.** Tinnitus or ringing in the ears is a sign of aspirin toxicity and should be reported. Clients should be instructed to take aspirin as prescribed and to avoid overdosage. Gastrointestinal symptoms associated with aspirin include nausea, heartburn, and epigastric discomfort caused by gastric irritation. Abdominal cramps, rash, and hypotension are not related to aspirin therapy.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**79. 4.** The nurse does not need to know that the client has four grandchildren in the transfer report because this is not information needed to help with the client's continuity of care.

 CN: Management of care; CL: Apply

**80. 3.** Although breech presentations are rare, footling breech occurs when there is an extension of the fetal knees and one or both feet protrude through the pelvis. In frank breech, there is flexion of the fetal thighs and extension of the knees. The feet rest at the sides of the fetal head. In complete breech, there is flexion of the fetal thighs and knees; the fetus appears to be squatting. Vertex position occurs in 95% of deliveries; in such cases, the head is engaged in the pelvis.

 CN: Health promotion and maintenance;  
CL: Apply

**81. 3.** Traveling is not advised because of the client's history of PIH. The client may be in jeopardy if complications occur and medical care is not available. In some cases, insurance companies will not cover costs of medical care in foreign countries. Air travel is not associated with preterm labor, although some airlines advise clients who are at 28 weeks' gestation or beyond not to travel by air. Any travel that causes fatigue should be avoided. Additionally, any pregnant client should get frequent exercise while traveling to avoid venous stasis from prolonged sitting. The client is not at greater risk for communicable diseases. The priority is the client's history of PIH, which, if it occurs, could lead to complications.

 CN: Reduction of risk potential;  
CL: Synthesize


**82. 3.** WIC is the best option. Home-delivered and congregate meals are for adults older than age 60 years. The food bank does not ensure adequate intake of the appropriate nutrients during pregnancy.

 CN: Management of care; CL: Apply


**83. 4.** A supine position in extension is the position most likely to prevent contractures. Clients who have experienced burns will find a flexed position most comfortable. However, flexion promotes the development of contractures. The high Fowler's and semi-Fowler's positions create hip flexion. The prone position is contraindicated because of head and neck burns. In clients with head and neck burns, pillows should not be used under the head or neck because it promotes neck flexion contractures.

 CN: Reduction of risk potential;  
CL: Synthesize

**84. 2.** A fractured femur, especially an open fracture, can cause much soft tissue damage and lead to significant blood loss. Hypovolemic shock can develop. Cardiogenic shock occurs when cardiac output is decreased as a result of ineffective pumping. Neurogenic shock occurs as a result of an impaired autonomic nervous system function. Anaphylactic shock is the result of an allergic reaction.

 CN: Physiological adaptation;  
CL: Analyze

**85. 2.** Safety concerns are essential for a client with sensory impairment. Water temperature should be tested carefully, hot water bottles should be avoided, and the skin should be inspected regularly. Independence and self-care are also important; the client should not be instructed to avoid kitchen activities out of fear of injury.


 CN: Safety and infection control;  
CL: Evaluate

**86. 1, 3.** Elevating the extremities counteracts the forces of gravity and promotes venous return and reduces venous stasis. Walking is encouraged to activate the muscle pump and promote collateral circulation. Prolonged sitting and standing leads to venous stasis and should be avoided. Although heat promotes vasodilation, use of a heating pad is to be avoided to reduce the risk of thermal injury secondary to diminished sensation.


 CN: Reduction of risk potential;  
CL: Create

**87. 3.** These behaviors suggest that the adolescent is thinking of suicide. Because of these behaviors, it is imperative for the adolescent to see his health care professional as soon as possible to


determine whether he has suicidal thoughts. After the nurse makes the appointment, then obtaining more information would be appropriate. Giving the father the telephone number for the local crisis hotline is appropriate after the appointment is made, to ensure that the father has additional support should the adolescent's behavior escalate and an emergency arises. Taking the adolescent to the nearest mental health outpatient facility now is not warranted unless the adolescent's behavior escalates.

 CN: Psychosocial adaptation;  
CL: Synthesize

**88. 1.** For a child with chorea-like movements, safety is of prime importance. Feeding the child may be difficult. Forks should be avoided because of the danger of injury to the mouth and face with the tines.

 CN: Safety and infection control;  
CL: Synthesize

**89. 1, 2, 4.** After bowel surgery, an NG tube attached to low intermittent suction is used to remove gastric fluids. The amount of fluid from the NG tube suction is important because it contributes to the client's overall fluid and electrolyte balance. I.V. fluids are used to maintain hydration, and intake and output is measured to determine hydration status. Postoperative vital signs are assessed more frequently than every 6 hours. Bowel sounds will be auscultated to determine when they return. Measuring abdominal girth is not necessary following colostomy reversal.

 CN: Physiological adaptation;  
CL: Synthesize


**90. 1.** After TURP, sphincter tone is poor, resulting in dribbling or incontinence. Kegel exercises can increase sphincter tone and decrease dribbling. Voiding every hour will not prevent dribbling or improve sphincter tone. It may take up to 12 months for urinary continence to be regained.

 CN: Reduction of risk potential;  
CL: Synthesize

**91. 1.** The pattern of weight gain is commonly more important than the amount. Clients should be advised to gain a total of 25 to 35 lb if they are of average weight when becoming pregnant. The recommended pattern is 1 lb/month in the first trimester, then 1 lb/week in the second and third trimesters. A sudden increase in weight gain is associated with pregnancy-induced hypertension, whereas a sudden weight loss may indicate an illness.

 CN: Health promotion and maintenance;  
CL: Evaluate


**92. 0.4 mL.** The nurse should administer 0.4 mL to administer 0.1 mg of digoxin I.V. if it comes in a concentration of 0.5 mg/2 mL, or 0.25 mg/mL.

 CN: Pharmacological and parenteral therapies; CL: Apply


**93. 2.** Numerous things have been tried by mothers with babies crying with colic. However, research has identified that the motion of a car is soothing to a baby with colic, commonly quieting the infant. The more the infant cries, the more air is swallowed, adding to the colic pain. Cereal should not be offered until the infant is age 4 to 6 months because of the increased risk of food allergies. Additionally, cereal has not been found to help with colic.

 CN: Health promotion and maintenance; CL: Synthesize

**94. 2.** Compartment syndrome, caused by compression of blood vessels and nerves, can lead to irreversible muscle and nerve damage if not detected early. Common signs of compartment syndrome in the arm include pain unrelieved by analgesics, pain on passive extension of fingers, loss of function, numbness and tingling, pallor, coolness of the extremity, and decreased or absent peripheral pulse. Delayed bone union does not cause symptoms of neurovascular impairment. Fat embolism is characterized primarily by confusion and respiratory symptoms. Osteomyelitis is a bone infection and is manifested by signs and symptoms of inflammation and infection.


 CN: Reduction of risk potential; CL: Analyze

**95. 2.** Cardiac rehabilitation includes client and family education and individualized activity counseling. Generally, the educational programs focus on presenting all of the risk factors associated with coronary artery disease. Low-back training is associated with a back injury recovery program. A strength training or jogging exercise program is not appropriate immediately after a cardiac event.


 CN: Basic care and comfort; CL: Synthesize

**96. 3.** When the nurse cannot elicit the Moro reflex of a 4-day-old preterm infant and the Moro reflex was present at birth, intracranial hemorrhage or cerebral edema should be suspected. Other symptoms include lethargy, bulging fontanel, and seizure activity. Confirmation can be made by ultrasound. Postnatal asphyxia is suggested by respiratory distress, grunting, nasal flaring, and cyanosis. A skull fracture can be confirmed by radiography. However, it is unlikely to occur in a preterm neonate. Rather, it is more common in the large-for-gestational-age neonate. Facial nerve paralysis is


indicated when there is no movement on one side of the face. This condition is more common in the large-for-gestational-age neonate.

 CN: Reduction of risk potential; CL: Analyze

**97. 4.** Blood clots are normal after transurethral resection of the prostate, but bright red urine can indicate a hemorrhage. The nurse should assess the client's vital signs and notify the surgeon. Irrigation of the catheter may help remove clots, but it does not decrease bleeding. Milking a urinary catheter or increasing fluid intake is not effective for controlling bleeding or decreasing clots.

 CN: Reduction of risk potential; CL: Synthesize


**98. 3.** The statement, "My medicine is not for the everyday stress of life," indicates an accurate understanding of the nurse's teaching about the use of lorazepam. Antianxiety agents like the benzodiazepines are used to treat anxiety that is unmanageable by other means and beyond the client's ability to cope. For the drug to be effective, it must be taken as prescribed. Lorazepam can cause physical and psychological dependence. Tolerance can occur, and doubling the dose of lorazepam may increase the risk of tolerance. Lorazepam is a central nervous system depressant. When it is taken in combination with alcohol, the depressant effect increases, posing a danger to the client.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**99. 1.** A blood test for alpha fetoprotein is recommended at 15 to 20 weeks' gestation to screen for neural tube defects such as spina bifida. Chorionic villi sampling is used to detect chromosomal anomalies. Amniotic fluid amino acid determination is used to detect inborn errors of metabolism such as phenylketonuria. An amniocentesis is used to determine the lecithin-sphingomyelin ratio for fetal lung maturity, indicated by a ratio of 2:1, or chromosomal abnormalities.

 CN: Reduction of risk potential; CL: Apply

**100. 3, 4, 1, 2.** The nurse should first acknowledge the husband's feelings as the first step to developing trust. The nurse can then help the husband learn how to talk to his wife. Assuring the husband that the nurse will assess the client's potential to commit suicide may help the husband believe positive action is being taken. Acknowledging that the client's desperation is likely related to her physical condition and may improve as her condition improves can give the husband hope for improvement in her mood.

 CN: Psychosocial adaptation; CL: Synthesize


**101. 4.** The error should be reported to the physician promptly for orders. The nurse should complete an incident report because an unusual occurrence happened during the client's care. The nurse should observe the client for symptoms of hyperglycemia but first must call the physician and complete an incident report. The nursing assistant does not need to be reassigned for this error. The nurse does not need to reprimand the nursing assistant for the error because the nursing assistant already knows an error was made.

 CN: Management of care;  
CL: Synthesize


**102. 2.** After abdominal pelvic surgery, the client is especially prone to thrombophlebitis. Measuring calf circumference can help detect edema in the affected leg. The calf should not be rubbed or palpated because a clot could be loosened and travel to the lungs as a pulmonary embolism. Homans' sign, which is calf pain on dorsiflexion of the foot when the leg is raised, is sometimes associated with thrombophlebitis. Having the client flex and extend the leg does not provide useful assessment data; the leg will not change color when raised and lowered.

 CN: Reduction of risk potential;  
CL: Analyze


**103. 1.** The client with sensorineural hearing loss has difficulty hearing high-pitched sounds. Aging and ototoxicity are two causes of sensorineural hearing loss. The client's ability to speak is not affected. The client who cannot assign meaning to sound has central hearing loss. Vertigo is commonly an indication of an inner ear problem.

 CN: Physiological adaptation;  
CL: Analyze


**104. 3.** *Grieving* best describes the client as she grieves for the changes occurring in her life since her cancer diagnosis. The other nursing diagnoses may be appropriate, but *Grieving* is the most applicable diagnosis for this client.

 CN: Psychosocial adaptation;  
CL: Analyze


**105. 3.** Nalbuphine is an analgesic that is used for clients in labor. It has a sedative effect and can slow the respiratory rate. After administering the drug, the nurse should first put the side rails up to prevent injury to the client and then assess her vital signs. Then the nurse can lower the head of the bed slightly to allow the client to sleep, cover the client with a blanket, and dim the lights.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**106. 3.** The client with emphysema is commonly underweight in appearance. It is theorized that weight loss is caused by the increased energy required to support the work of breathing. Frequent coughing, bronchospasms, and copious sputum are clinical manifestations of chronic bronchitis.

 CN: Physiological adaptation;  
CL: Analyze


**107. 4.** The traction is set up correctly. Additional weights are not needed. A well-balanced diet with fiber should be offered. A pillow under the leg would negate the effects of the traction. Because the adolescent is positioned this way for an extended period, the nurse can help by finding activities that interest the client.

 CN: Basic care and comfort;  
CL: Synthesize


**108. 1.** The client with a systolic blood pressure of 160 to 179 mm Hg should be evaluated by a health care professional within 1 month of the screening. The client with a diastolic blood pressure of 90 to 99 mm Hg should be rechecked within 2 months. Exercise and stress reduction may be desirable activities, but it is first necessary to evaluate the cause of elevated blood pressure. In the absence of other symptoms, it is not necessary to have the client evaluated immediately.

 CN: Health promotion and maintenance;  
CL: Synthesize

**109. 4.** Keeping the client's door closed is likely to contribute to feelings of isolation and sensory deprivation. Such activities as watching television, visiting with a relative, and reading a newspaper help prevent sensory deprivation and yet do not require physical effort.


 CN: Psychosocial adaptation;  
CL: Synthesize

**110. 4.** The client taking dexamethasone needs to know the early signs of Cushing's disease, which include easy bruising, moonface, buffalo hump, and osteoporosis. Loss of collagen makes the skin weaker and thinner; therefore, the client bruises more easily. The nurse should instruct the client to report any of these signs to the physician. Hypertension is a symptom of Cushing's disease, and muscle mass is decreased. Increased urinary frequency is not a symptom of Cushing's disease.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**111. 1.** Verbalizing feelings and concerns helps decrease anxiety and allows the family member to move on to understanding the current situation. Describing events or explaining equipment is


appropriate when the person is not distraught and is ready to learn. Reassuring the family member does not allow verbalization of feelings and discounts the person's feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**112. 2.** Graded exercise testing is a diagnostic and prognostic tool used to determine the physiologic responses to controlled exercise stress. Information gained from a graded exercise test can achieve diagnostic, functional, and therapeutic objectives for the client. Graded exercise tests involve the use of a treadmill, stationary bicycle, or arm ergometry. Thinking under pressure, distance walked, and duration of walking are not the purpose of a graded exercise test.

 CN: Reduction of risk potential;  
CL: Apply


**113. 2, 3, 4.** Albuterol is a beta-adrenergic agonist. Possible adverse effects include nausea, headache, and nervousness as well as insomnia and vomiting. Constipation is not associated with this drug. The client will not become lethargic; instead, he may experience restlessness.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**114. 3.** It is normal for the client who is beginning chemotherapy to be anxious and fearful about possible side effects. It is important that the nurse listen to the client's concerns, correct any misconceptions, and explain the supportive care that will be provided during the chemotherapy treatments. The client needs to understand that individuals do respond differently to the treatments, and her experience may be very different from those of other people she knows. A previously excellent health record does not necessarily ensure that the client will not experience side effects. Medications may lessen but not prevent the side effects, so client concerns should not be dismissed. Telling the client that she will die if she refuses treatment does nothing to allay her fears and concerns.

 CN: Psychosocial adaptation;  
CL: Synthesize


**115. 1.** Overprotection is a typical parental reaction to chronic illness in a child. Characteristics include sacrifice of self and family for the child, failure to recognize the child's capabilities and sense of responsibility, placement of overly stringent restrictions on play and peer friendship, and a lack of confidence in other peoples' capabilities.

 CN: Psychosocial adaptation;  
CL: Analyze


**116. 3.** Children with roseola have a high fever for 3 days, which drops suddenly. Then a nonpruritic rash appears, typically lasting for 1 to 2 days. High fever followed by a rash is a characteristic sign. Associated symptoms include cold symptoms, cough, and lymphadenopathy.

 CN: Physiological adaptation;  
CL: Evaluate


**117. 1.** Knowing that the voices are not real is a reflection that the haloperidol is effective in decreasing psychosis. Restlessness may be a side effect of haloperidol, not an indication of improvement. Awareness of need for activities of daily living is an indicator of improvement. However, recognizing that the voices are not real demonstrates a greater awareness of the client's disorder than the need for hygiene does. Wanting discharge reflects denial of illness.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**118. 1, 2, 3, 4, 6.** Diabetic ketoacidosis is a potentially life-threatening problem. The state of unconsciousness requires very astute monitoring of the neurologic condition. Frequent assessments of neurologic status (including the client's ability to respond to stimuli), blood pressure, and urinary output need to be documented. Assessment of skin condition for the presence of lesions, bruises, ulcers, or bumps is documented to assess for possible injuries, such as falls associated with head injury or internal injuries. Although it would be helpful to know how long the client has had diabetes, this information is not essential to document.

 CN: Physiological adaptation;  
CL: Analyze

**119. 2.** The elderly client commonly has multiple physicians. The client needs to inform every doctor about all the medications being prescribed by all of them.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**120. 2.** The nurse should first check with the physician for the complete order of calcium because calcium chloride has a concentration of 13.6 mEq of calcium per gram and calcium gluconate has 4.65 mEq of calcium per gram. The nurse can always offer the doctor the type of calcium available after the conversion in calcium has been made; otherwise, the error could be fatal.


 CN: Pharmacological and parenteral therapies; CL: Synthesize



**121. 3.** When administering I.V. potassium chloride, the administration should not exceed 10 mEq/hour or a concentration of 40 mEq/L via a peripheral line. These limits are extremely important to prevent the development of hyperkalemia and the possibility of cardiac dysrhythmias. In some situations, with dangerously low serum potassium levels, the client may need cardiac monitoring and more than 10 mEq of potassium per hour. Potassium-sparing diuretics may lead to hyperkalemia because they affect the kidney's ability to excrete excess potassium. Metabolic alkalosis can cause potassium to shift into the cells, thus decreasing the client's serum potassium levels. Hypokalemia can lead to digoxin toxicity.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**122. 3.** Systematic pain assessment is necessary for adequate pain management in the postoperative client. Guidelines from the Agency for Healthcare Research and Quality recommend that facilities adopt a pain assessment scale to facilitate pain management. Even though the client is receiving morphine sulfate by PCA, assessment is needed if he is experiencing pain. Encouraging the client to rest or to ignore pain without further assessment is not a sufficient intervention.

 CN: Basic care and comfort; CL: Synthesize

**123. 2.** Exposure to moisture can lead to maceration and the development of pressure ulcers. It is important for the client's skin to be kept clean and dry with prompt attention to cleanliness after incidents of incontinence. The client's age and the presence of hypertension are not factors leading to pressure ulcers. Smoking affects the oxygen status of the client but does not directly lead to the development of pressure ulcers.


 CN: Reduction of risk potential; CL: Apply

**124. 1.** The screening protocol recommended by the American Cancer Society for early detection of cancer in asymptomatic people includes: Beginning at age 50, men and women should have fecal occult blood testing every year or flexible sigmoidoscopy every 5 years or colonoscopy every 10 years. A diet low in fat and high in fruit and fiber is not a screening protocol but is good dietary advice for all clients.

 CN: Health promotion and maintenance; CL: Apply

**125. 3.** A low dose of an antipsychotic can decrease aggression. Adjustment to the structured daily routine and diminished resistance with activities of daily


living are improvements related to the nursing care given, not the medications. No medications currently given to treat Alzheimer's disease return short-term memory.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**126. 3.** A sudden gush of dark blood, a lengthening of the umbilical cord, a smaller uterus, and changing of the uterus to a round or spherical shape are impending signs of placental separation. Pushing effort from the client is not a reliable indicator for impending placental separation, nor is it necessary for placental expulsion.

 CN: Health promotion and maintenance; CL: Analyze

**127. 1.** The nurse needs to assess neurologic status throughout the therapy. Altered sensorium or neurologic changes may indicate intracranial bleeding for the client who has received tissue plasminogen activator or alteplase. The nurse should carefully check for bleeding every 15 minutes during the first hour of therapy, every 15 to 30 minutes during the next 9 hours, and at least every 4 hours during the duration of therapy. Bleeding may occur from sites of invasive procedures or from body orifices. The blood glucose level does not need to be evaluated. Arterial blood gas values relate to acid base status and oxygenation and are avoided due to the invasiveness of arterial puncture at this time.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**128. 2, 4, 5.** In the emergent phase of burn management, hyperkalemia develops as a result of the destruction of red blood cells. The hematocrit is increased in response to the plasma loss that has occurred and the resulting hemoconcentration. Initially, hyponatremia may occur as sodium shifts into the interstitial spaces. "Fever spikes" of 102 to 103 degrees are common during this stage. The client will have hyperglycemia due to decreased levels of insulin production.

 CN: Physiological adaptation; CL: Analyze

**129. 1.** The nurse should explain that the child will feel a stinging when the numbing medicine is inserted into the area around the introduction site of the catheter. There may also be a feeling of pressure when the catheter is introduced. Because the child will be sedated and will feel little during the procedure, telling the child that a momentary sharp pain is felt on entering the heart is inappropriate. A tingling sensation in the extremities is not felt.

 CN: Reduction of risk potential; CL: Synthesize

**130. 2.** In conjunction with the child's history of recent respiratory infection and report of dark urine, swelling around the eyes should lead the nurse to suspect acute glomerulonephritis. Therefore, the nurse should ask about a recent sore throat because a child with glomerulonephritis typically would have had a sore throat in the past 10 days. Drinking lots of liquids is unrelated to the periorbital edema.

 CN: Physiological adaptation;  
CL: Analyze

**131. 2.** Measuring the pH of the aspirated gastric fluid is the most accurate determination of the placement of the NG tube. A pH lower than 4 indicates that the tube is in the stomach. Whether or not the client is gagging or coughing is not an accurate way to determine if the tube is placed correctly. No fluids should be inserted into the tube until the placement has been determined. Inserting air into the tube and listening for the resulting whoosh can be used, but this is not as accurate as pH measurement.

 CN: Reduction of risk potential;  
CL: Evaluate

**132. 2.** True labor is present when cervical dilation and effacement occur. Fetal descent into the pelvic inlet is an indication that labor will begin soon. However, for a nulligravid client, this may take 1 to 2 weeks. Painful contractions every 3 to 5 minutes may be Braxton Hicks contractions. Contractions that disappear when the client lies down are a sign of false labor. Although leaking amniotic fluid should be reported, it is not a sign of true labor.

 CN: Health promotion and maintenance;  
CL: Analyze

**133. 4.** During the first 24 hours after a total laryngectomy, maintaining a patent airway is a priority goal. After a total laryngectomy, the client will have a tracheostomy with increased secretions and will require suctioning and tracheostomy care. Providing adequate nutrition, preventing skin breakdown, and maintaining proper bowel elimination will be appropriate as the client recovers, but maintaining a patent airway is the initial priority goal.


 CN: Reduction of risk potential;  
CL: Synthesize

**134. 3.** Not sleeping to avoid nightmares reflects inadequate grief resolution. The client is not letting go or resolving the vivid memories of the trauma as expected. Statements that the client gets sad at times but can function in daily activities or that the client still misses his family but acknowledges improvement indicate that the client is recovering and continued counseling is not necessary. Working for train crossing safety indicates motivation to help others


escape what he has experienced. This action also denotes a goal for the future, indicating recovery.

 CN: Psychosocial adaptation;  
CL: Evaluate

**135. 3.** Haloperidol and lorazepam together decrease hallucinations and agitation, thus decreasing the risk of self-harm. Putting the client in restraints is premature because danger is not imminent. Asking the client to talk about her anger is inappropriate because the client is beyond rational conversation. A room search is appropriate only after the crisis with the client is handled.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**136. 1.** The nurse should adjust the heparin dose to maintain the client's partial thromboplastin time between 1.5 and 2.5 times the normal control. The prothrombin time and International Normalized Ratio are used to maintain therapeutic levels of warfarin (Coumadin), oral anticoagulation therapy. The thrombin clotting time is used to confirm disseminated intravascular coagulation.

 CN: Pharmacological and parenteral therapies; CL: Apply


**137. 2.** The oral mucous membranes are easily damaged and are commonly ulcerated in the client with leukemia. It is better to provide oral hygiene without using a toothbrush, which can easily damage sensitive oral mucosa. Applying petroleum jelly to the lips, swabbing the mouth with moistened cotton swabs, and rinsing the mouth with a nonirritating mouthwash are appropriate oral care measures for a child with leukemia.

 CN: Basic care and comfort; CL: Synthesize


**138. 1.** The nurse's first response to the error is to assess the client for any untoward reactions as a result of the error. Notifying the physician and unit manager of the error as well as completing an incident report are all appropriate later actions, but the first action is to assess the client.

 CN: Management of care; CL: Synthesize


**139. 3.** The peak action of Regular insulin is approximately 2 to 3 hours after administration. The client is having typical hypoglycemic symptoms. Acidosis results from uncontrolled diabetes mellitus, with hyperpnea (Kussmaul respirations) as the outstanding symptom. The hallmark symptoms of hyperglycemia are increased thirst, fruity breath, and glycosuria. The signs and symptoms of diabetic ketoacidosis include Kussmaul respirations, fruity breath, tachycardia, abdominal pain, nausea, vomiting, headache, thirst, dry skin, and dehydration.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**140. 4.** The nurse needs to obtain more information before plans are developed. Therefore, asking to know more about the situation is most appropriate. The nurse has no way of predicting whether abuse will occur again. Therefore, it is inappropriate for the nurse to agree with the mother, stating that the abuse probably will not happen again. Filing charges and a Child Protective Services report may be needed, but more information is needed first. These actions would not be done without the mother's understanding why.

 CN: Psychosocial adaptation;  
CL: Synthesize


**141. 2.** If the client begins to experience abdominal cramping during administration of the enema fluid, the nurse's first action is to temporarily stop the infusion and have the client take a few deep breaths. After the cramping subsides, the nurse can continue with the enema solution. If the cramping does not subside, the nurse should clamp the tubing and remove it. Raising the height of the container will increase the flow of fluid and cause the cramping to increase. Rubbing the abdomen while infusing the enema fluid will not stop the cramping.

 CN: Basic care and comfort;  
CL: Synthesize

**142. 1.** When inserting an I.V. catheter needle, the nurse initially uses veins low on the hand or arm if available, unless contraindicated. Should the I.V. fluid infiltrate or the vein become irritated at this insertion site, veins higher on the arm are still available for use. After a vein higher up on the arm has been damaged, veins below it cannot be used.

 CN: Pharmacological and parenteral therapies; CL: Apply

**143. 3.** Lactulose is used to treat hepatic encephalopathy by reducing serum ammonia levels. It is not used to stimulate bowel peristalsis, even though diarrhea can be a side effect of the drug. Lactulose does not have any effect on edema, ascites, or hemorrhage.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**144. 2.** A 12-month-old whose immunizations are current has received three diphtheria, tetanus, and acellular pertussis; three hepatitis B; and two inactivated poliovirus immunizations. Oral polio vaccine is not used routinely. *Haemophilus b* is administered at 2, 4, and 6 months, and a booster is given at 12 to 15 months.

 CN: Health promotion and maintenance;  
CL: Apply

**145. 3.** Obesity is a risk factor for osteoarthritis because it places increased stress on the joints. A high-protein diet, regular exercise, and vitamin supplements do not reduce a client's risk of developing osteoarthritis.

 CN: Health promotion and maintenance;  
CL: Create

**146. 3.** Vitamin E is a powerful antioxidant that helps to prevent oxidation of the cell membrane. Vitamins C, A, and B<sub>6</sub> are helpful in the prevention of heart disease, but vitamin E plays a more important role.

 CN: Health promotion and maintenance;  
CL: Analyze

**147. 3.** The nurse should instruct the mother to report the first voiding after the circumcision because edema could cause a urinary obstruction. Although reading a pamphlet about circumcision care may be helpful, it may not be appropriate for all mothers. Some mothers could have difficulty reading or understanding the information. Petroleum jelly gauze is used with Gomco clamp circumcisions, not Plastibell. Petroleum jelly should not be used with Plastibell circumcision methods, because the bell prevents further bleeding.

 CN: Health promotion and maintenance;  
CL: Synthesize

**148. 2.** Alcoholic cirrhosis is associated with excessive alcohol intake. In the early stages, the liver develops fatty changes. If alcohol intake stops, the fatty changes can be reversed. Avoiding overexertion is important in the client with cirrhosis, but it does not reverse the disease. Stopping smoking is a positive, healthy lifestyle change, but it does not have an impact on cirrhosis. A diet high in carbohydrates and low in fat is also recommended for the client with cirrhosis, but the diet does not reverse the pathologic changes that have occurred in the liver.


 CN: Reduction of risk potential;  
CL: Synthesize

**149. 1.9 mL.** Using the ratio-proportion method, the equations are as follows:

$$4 \text{ mg}/1 \text{ mL} = 7.6 \text{ mg}/X \text{ mL}$$

$$4X = 7.6$$

$$X = 7.6/4 = 1.9 \text{ mL.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**150. 4.** Because of the client's age, the amniocentesis is most likely being done to evaluate for Down syndrome (trisomy 21). Women older than 35 years are at higher risk for having a child with Down syndrome. Cri du chat syndrome is a genetic disorder involving a short arm on chromosome 5. This disorder is not associated with mothers who are older than 35 years. The client is AB-positive, so the amniocentesis is not being done for ABO incompatibility, in which the mother is type O and the fetus is type A, B, or AB. The amniocentesis is not being done to detect erythroblastosis fetalis because the mother is Rh-positive.

 CN: Reduction of risk potential;  
CL: Analyze


**151. 3.** The symptoms of BPH are related to obstruction as a result of an enlarged prostate. Difficulty in starting the urinary stream is a common symptom, along with dribbling, hesitancy, and urinary retention. Impotence does not result from BPH. Flank pain is most commonly related to pyelonephritis. Hematuria occurs in urinary tract infections, renal calculi, and bladder cancer, to name some of the most common causes.

 CN: Physiological adaptation;  
CL: Analyze

**152. 1.** Having the client role-play assertive statements assists the client in learning how to use assertiveness and practicing appropriate behaviors in a safe environment. Watching a videotape on assertiveness or discussing situations that appear threatening is a step toward actually using assertive techniques. Describing feelings that occur after an angry outburst motivates the client to make changes in behavior.


 CN: Psychosocial adaptation;  
CL: Synthesize

**153. 4.** Symptoms of transient tachypnea include respirations as high as 150 breaths/minute, retractions, flaring, and cyanosis. Treatment is supportive and includes provision of warm, humidified oxygen in a warm environment. The nurse should continuously monitor the neonate's respirations, color, and behaviors to allow for early detection and prompt intervention should problems arise. Feedings are given by gavage rather than bottle to decrease respiratory stress. Obtaining extracorporeal membrane oxygenation equipment is not necessary but may be used for the neonate diagnosed with meconium aspiration syndrome.


 CN: Physiological adaptation;  
CL: Synthesize

**154. 2.** One of the early signs of iron deficiency anemia in a client of Vietnamese descent with dark skin is yellowish-brown skin tones. The nurse can

assess for petechiae or jaundice, which may be observed in the conjunctiva or buccal mucosa.

 CN: Physiological adaptation;  
CL: Analyze


**155. 1.** A decreased total serum protein occurs as extensive amounts of protein are excreted from the body through the urine. Clients may develop hypocalcemia. Hyperglycemia is not a finding related to nephrotic syndrome. A decreased hematocrit is not a finding related to nephrotic syndrome.

 CN: Physiological adaptation;  
CL: Analyze


**156. 2.** The number one cause of nosocomial infections in hospital units is not washing the hands. Nosocomial infections can be significantly reduced by thorough handwashing before caring for each infant. Sterile supplies are not necessary for all treatments. Cover gowns and masks, although helpful in reducing the risk of exposure to blood and body fluids, do not decrease the risk of nosocomial infection.

 CN: Safety and infection control;  
CL: Synthesize

**157. 2.** Recommended restraints for a child who has had palate surgery is elbow restraints. They minimize the limitation placed on the child but still prevent the child from injuring the repair with fingers and hands. A safety jacket or wrist or body restraints restrict the child unnecessarily.

 CN: Safety and infection control;  
CL: Synthesize


**158. 2.** Battering is a major cause of injury to women. Although battering occurs in all socioeconomic groups, it may appear to be more common in members of lower socioeconomic groups because they are more likely to use emergency department services. Pregnant women are frequent victims of battering. Death from battering is not rare.

 CN: Psychosocial adaptation;  
CL: Create

**159. 3.** After a nephrectomy, a specific aspect of immediate postoperative management includes monitoring urine output at least hourly. Monitoring blood pressure and encouraging the use of incentive spirometry are other important considerations, but because of the surgical disruption of the urinary system, urine output is a priority. Measurement of urine output should also include an estimation of the amount of urine drainage on the flank dressing.

 CN: Reduction of risk potential;  
CL: Synthesize

**160. 4.** Severe retroversion or anteversion may lead to infertility or difficulty conceiving a child because these positions can block the deposition or migration of sperm. The normal position of the uterus is tipped slightly forward. Frequent vaginal infections commonly are associated with diabetes or human immunodeficiency virus infection, not abnormal uterine positions. Pain from endometriosis (abnormal myometrial growth outside the uterus) is not associated with abnormal uterine positions. Severe menstrual cramping or dysmenorrhea (primary) is caused by increased prostaglandin production, not abnormal uterine positions. Secondary dysmenorrhea is associated with pelvic inflammatory disease or endometriosis.

 CN: Health promotion and maintenance;  
CL: Analyze


**161. 2.** A 4-year-old is old enough to be able to cooperate and stop the behavior. Therefore, the first step is to obtain the child's cooperation. When this has occurred, then the mother makes sure it is okay to remind the child when the behavior is viewed. The mother also should be encouraged to praise the child when she sees her not engaging in the behavior.

 CN: Health promotion and maintenance;  
CL: Create


**162. 4.** During an episode of acute respiratory distress, it is important that the nurse focus the assessment on the client's respiratory system and distress to quickly address the client's problem. Conducting a complete health history and a comprehensive physical examination can be deferred until the client's condition is stabilized. It is not appropriate to delay all assessments until the respiratory distress is resolved because the nurse must have data to guide treatment.

 CN: Physiological adaptation;  
CL: Analyze


**163. 4.** The most likely indication of a dislocated hip is a shortening of the affected leg. Other indications of dislocation include increasing pain, loss of function to the extremity, and deformity. Abduction of the leg after total hip replacement is a desirable position to prevent dislocation. Loosening of the prosthesis does not necessarily indicate that the hip has dislocated. External rotation of the hip can occur without the hip's being dislocated. However, a neutral position of rotation is the desired position.

 CN: Physiological adaptation;  
CL: Analyze


**164. 1.** The client who is withdrawn, is suspicious, and projects blame is exhibiting problems in trust versus mistrust. Shame and doubt would be reflected as low self-esteem and suspiciousness. Guilt would be reflected in self-blame for all problems. Isolation would be reflected in a lack of long-term relationships.

 CN: Psychosocial adaptation;  
CL: Analyze


**165. 4.** The nurse needs to explore more about the client's feelings to assess what underlies the eating disorder. The nurse also needs to evaluate the client's suicide risk. The other statements are not therapeutic because they minimize the client's feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize


**166. 1.** An ileal conduit is a urinary diversion that requires the client to wear an appliance, or pouch, at all times because urine drains continuously. Ileal conduits are not irrigated. The urinary drainage is affected by fluid intake, not meals.

 CN: Physiological adaptation;  
CL: Apply


**167. 1.** Children with varicella or suspected varicella should be treated under airborne precautions in addition to standard precautions. Varicella is transmitted by airborne nuclei. Droplet precautions are indicated for conditions, such as pertussis, meningococcal pneumonia, and rubella. Contact precautions are indicated for conditions, such as draining major abscesses, acute viral conjunctivitis, and *Clostridium difficile* gastroenteritis. Indirect contact is not a method of controlling infection. Rather it is a mode of transmission involving contamination via some intermediate object, such as an instrument, needle, or dressing, or by hands that are not washed or gloves that are not changed between clients.

 CN: Safety and infection control;  
CL: Synthesize

**168. 1.** In multiple myeloma, neoplastic plasma cells invade the bone marrow and begin to destroy the bone. As a result of this skeletal destruction, pain can be significant. There is no cure for multiple myeloma. Nausea and vomiting are not characteristics of the disease, although the client may experience anorexia. The client should be monitored for signs of hypercalcemia resulting from bone destruction, not for hyperkalemia.

 CN: Physiological adaptation;  
CL: Synthesize


**169. 1.** Stating, “You were able to shower and dress without any help this morning,” points out a visible, realistic accomplishment and strength to the client with self-deprecatory statements, thereby helping to increase the client’s self-worth. The statements, “Your wife told me that you are a good husband and father,” and, “You don’t have any reason why you should feel this way,” are not helpful because logical statements are ineffective in changing the thinking of a client who is depressed. The client may agree with what the nurse states but be just as depressed because intellectual understanding does not help the severely depressed client. The statement, “This medication will help your thinking,” although true, does not recognize the client’s accomplishment and will have no positive effect on his self-esteem.

 CN: Psychosocial adaptation;  
CL: Synthesize


**170. 3.** The nurse uses Montgomery straps primarily to avoid the removal of long-term abdominal dressing tape and ultimate skin breakdown.

 CN: Basic care and comfort; CL: Apply


**171. 1.** The nurse’s most appropriate response is to acknowledge and validate the client’s concerns. Questioning the client’s fears is not a therapeutic response and can make the client feel defensive. False reassurance that the client should not be afraid disregards the client’s fears and does not promote further communication between the client and nurse. Dismissing the client’s feelings and telling the client to relax does not encourage sharing of feelings.

 CN: Psychosocial adaptation;  
CL: Synthesize

**172. 3.** In a child with abdominal surgery, it is important to check vital signs frequently to assess for internal bleeding. Administering I.V. fluids, assessing pain, and keeping the child on nothing-by-mouth status are all important, but monitoring vital signs frequently is the priority.

 CN: Reduction of risk potential;  
CL: Synthesize


**173. 2.** Polydipsia, or increased thirst, is a classic clinical manifestation of diabetes. The excessive loss of fluids is the result of the osmotic diuresis that occurs with glycosuria. It is unlikely that shortness of breath, early awakening, or trouble urinating is related to diabetes mellitus.

 CN: Physiological adaptation;  
CL: Analyze


**174. 2.** Cardiomyopathy is a broad term that includes three major forms: dilated, hypertrophic, and restrictive cardiomyopathies. The underlying etiology of hypertrophic cardiomyopathy is unknown; it is typically observed in young men but is not limited to them. Common symptoms are fatigue, low tolerance to activity related to the low ejection fraction, and shortness of breath. Angina may be observed if coronary artery disease is present. Abdominal pain and hypertension are not common.

 CN: Physiological adaptation;  
CL: Analyze


**175. 3.** Pinworms come out of the rectum during the nighttime and early morning hours. Therefore, the best time to apply the tape to get results is while the child is asleep.

 CN: Physiological adaptation;  
CL: Apply

**176. 3.** Maternal hydramnios occurs when the fetus has a congenital obstruction of the gastrointestinal tract, such as in the presence of a tracheoesophageal fistula. The fetus normally swallows amniotic fluid and absorbs the fluid from the gastrointestinal tract. Excretion then occurs through the kidneys and placenta. Most fluid absorption occurs in the colon. Absorption cannot occur when the fetus has a gastrointestinal obstruction. Meconium in the amniotic fluid, low implantation of the placenta, and toxemia could occur but are more specifically associated with fetal hypoxia.

 CN: Health promotion and maintenance;  
CL: Analyze

**177. 1.** A common complication of steroid therapy is gastric irritation and peptic ulcers. Hyperglycemia is a potential complication. Tachycardia and renal failure are not associated with steroid therapy.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**178. 3.** When an incision eviscerates, it is a medical emergency. The nurse’s first response is to apply a sterile dressing that has been moistened with sterile normal saline solution. The client should also be placed in semi-Fowler’s position to release any tension on the abdominal area. Vital signs should be taken, and an I.V. line may be started for emergency treatment; however, the first action is to protect the wound and abdominal contents.

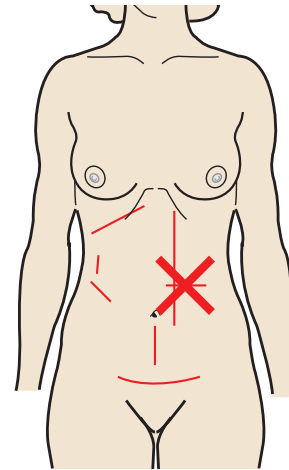
 CN: Reduction of risk potential;  
CL: Synthesize

**179. 3.** Establishing a patent airway is the priority intervention. Prophylactic intubation is initiated if heat has been inhaled or if the neck, head, or face is involved. Swelling of the upper airways can progress to obstruction. Fluid replacement can best be achieved using a large-caliber peripheral I.V. catheter, and morphine sulfate is appropriate for analgesia in a burn client. Although these are priorities, they are secondary to establishing a patent airway. Administering tetanus toxoid is a secondary priority.

 CN: Reduction of risk potential;  
CL: Synthesize

**180. 3.** The client should mark the area on the abdomen where the transverse incision will be made.

 CN: Reduction of risk potential;  
CL: Evaluate



**COMPREHENSIVE****TEST****3**

**1.** A primigravid client at 10 weeks' gestation tells the nurse that she eats fruits and vegetables but isn't fond of them. After teaching the client about possible serving sizes, the nurse determines that the teaching has been successful when the client states that one serving of fruit is equivalent to which of the following?

- 1. One-fourth of a cantaloupe.
- 2. 3 oz of vegetable juice cocktail.
- 3. Three tomatoes.
- 4. One raw apricot.

**2.** A nurse performs care on the client's Hickman catheter according to hospital policy. The client develops an infection and is considering litigation. The nurse's practice is:

- 1. Malpractice.
- 2. *Respondeat superior*.
- 3. Negligent.
- 4. Tort.

**3.** A Hispanic client is admitted to the surgical unit from the emergency department for an appendectomy. The nurse conducts the preoperative preparations and determines that the client has difficulty understanding English. The surgeon needs to obtain the client's informed consent. The best course for obtaining the client's informed consent is to:

- 1. Have the client call a family member to act as interpreter.
- 2. Have the client sign the Spanish surgical consent form.
- 3. Call the Spanish interpreter to translate the surgeon's explanation of the procedure, risks, and alternatives to obtain the client's consent and to answer the client's questions.
- 4. Notify the surgical charge nurse of the situation.

**4.** A client who has glaucoma has been prescribed timolol (Timoptic) eyedrops. Which of the following instructions should the nurse give the client about the administration of the eyedrops?

- 1. Instill the eyedrops whenever the eyes feel irritated.
- 2. The medication may cause some transient eye discomfort.
- 3. Keep the medication refrigerated between doses.
- 4. The need to use the eyedrops will be reevaluated after 1 month.

**5.** A 6-year-old child is admitted to the hospital for heart surgery to repair tetralogy of Fallot. The child asks the nurse if the cardiac catheterization will hurt. Which of the following statements offers the nurse the best guide for responding to the child's question?

- 1. The medication used to numb the insertion site will sting.
- 2. Momentary sharp pain usually occurs when the catheter enters the heart.
- 3. It is usual for a 6-year-old to feel discomfort during the procedure.
- 4. It is a painless procedure, although a tingling sensation may be felt in the extremities.

**6.** The nurse is assessing a 55-year-old client with chronic obstructive pulmonary disease. The client weighs 200 lb and is 6 feet tall. Using the diagram shown here, the nurse should record in the health history that the client's chest is:

- 1. Barrel-shaped.
- 2. Muscular.
- 3. Normal for the client's age, height, and weight.
- 4. Showing the effects of long-term use of bronchodilators.





**7.** A diabetic primigravid client at 38 weeks' gestation asks the nurse why she had a fetal acoustic stimulation during her last nonstress test. Which of the following should the nurse include as the rationale for this test?

- 1. To listen to the fetal heart rate.
- 2. To startle and awaken the fetus.
- 3. To stimulate mild contractions.
- 4. To confirm amniotic fluid amount.

**8.** The mother of an older infant reports stopping the prescribed iron supplements after 2 weeks of treatment. Which of the following responses by the nurse is most appropriate?

- 1. "Bring the child in so that we can retest him."
- 2. "You need to continue the iron for several more weeks."
- 3. "Let's start a diet that is high in iron."
- 4. "No more medication is needed at this time."

**9.** A Jewish client requests an orthodox diet while she is hospitalized. The nurse should refer this request to the:

- 1. Dietitian.
- 2. Physician.
- 3. Unit case manager.
- 4. Rabbi in pastoral care.

**10.** A mother reports to the nurse that she cannot afford the antibiotic azithromycin (Zithromax), which was ordered by the physician for her toddler's otitis media. The nurse's best response is to:

- 1. Instruct the mother on the importance of the medication.
- 2. Ask the mother if she knows anyone who could loan her the money.
- 3. Confer with the physician about whether a less expensive drug could be ordered.
- 4. Consult with the social worker.

**11.** The nurse is transferring a client who is G4 P3 at 25 weeks' gestation with preeclampsia from the obstetrical intensive care unit to the antenatal unit. To safely manage this preeclamptic client, what should be included in the transfer report about this client? Select all that apply.

- 1. Record of blood pressure trends.
- 2. Record of urine protein.
- 3. Edema observed by health care provider.
- 4. Client use of dietary sodium.
- 5. Fetal position.
- 6. Fetal heart rate pattern.
- 7. Medical and nursing interventions utilized.

**12.** The physician has prescribed nitroglycerin to a client with angina. The client also has closed-angle glaucoma. The nurse contacts the physician to discuss the potential for:

- 1. Decreased intraocular pressure.
- 2. Increased intraocular pressure.
- 3. Hypotension.
- 4. Hypertension.

**13.** A client states she thinks she is experiencing premenstrual syndrome (PMS). The nurse should next ask the client about which of the following?

- 1. Menstrual cycle irregularity with increased menstrual flow.
- 2. Mood swings immediately after menses.
- 3. Tension and fatigue before menses and through the second day of the menstrual cycle.
- 4. Midcycle spotting and abdominal pain at the time of ovulation.

**14.** For which of the following should the nurse closely assess a client who is reversing from halothane (Fluothane) general anesthesia and receiving clindamycin (Cleocin)?

- 1. Tachycardia.
- 2. Respiratory depression.
- 3. Hypotension.
- 4. Renal failure.

**15.** An adolescent with type 1 diabetes mellitus is hospitalized for appendicitis. He is weak and nauseated with poor skin turgor. The nurse notes a fruity odor to the client's breath. The client uses Lispro insulin. His last meal was lunch, 2 hours ago. Place the following nursing actions in the order in which the nurse should perform them.

1. Obtain a fingerstick test for blood glucose.

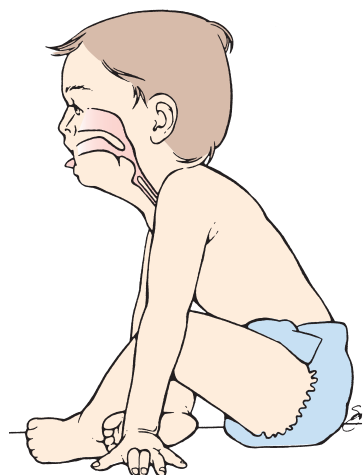
2. Start an I.V. infusion with normal saline solution.

3. Administer Lispro.

4. Notify the physician.

**16.** The nurse observes an 18-month-old who has been admitted with a respiratory tract infection (see figure). The nurse should **first**:

- 1. Position the child supine
- 2. Call the rapid response team
- 3. Offer the child a carbonated drink
- 4. Place the child in a croup tent



**17.** A nulliparous client visiting the clinic tells the nurse that she stopped taking oral contraceptives 6 months ago but doesn't think she is ovulating. Which of the following should the nurse anticipate that the physician would order if the client is anovulatory?

- 1. Dienestrol (Ortho Dienestrol).
- 2. Clomiphene citrate (Clomid).
- 3. Medroxyprogesterone (Depo-Provera).
- 4. Norgestrel (Ovrette).

**18.** A client who has been recently diagnosed with acquired immunodeficiency syndrome (AIDS) inquires about hospice services. The nurse explains that hospice care is appropriate:

- 1. For clients with an inevitable death within weeks to months.
- 2. For all clients with AIDS at any stage.
- 3. Only for clients with cancer.
- 4. When the client is ready to discuss his prognosis.

**19.** While assessing a neonate at age 24 hours, the nurse observes several irregularly shaped, red, flat patches on the back of the neonate's neck. The nurse interprets this finding as which of the following?

- 1. Stork bite.
- 2. Port wine stain.
- 3. Newborn rash.
- 4. Café au lait spot.

**20.** A mother who is Mexican brings her 2-month-old son to the emergency department with a high fever and possible sepsis. A lumbar puncture is ordered, but the mother will not sign the consent until the father arrives to give permission. The nurse should:

- 1. Report this to the social worker.
- 2. Call Child Protective Services.
- 3. Wait until the father arrives.
- 4. Inform the physician that the mother has refused to have the procedure.

**21.** A client with Alzheimer's disease is started on a low dose of lorazepam (Ativan) because of agitation and a sleep disturbance. The nurse should assess the client for which of the following?

- 1. Nighttime agitation.
- 2. Extraparal side effects.
- 3. Vomiting.
- 4. Anticholinergic side effects.

**22.** A postmenopausal client with an intact uterus asks the nurse why her hormone medicine has two drugs, estrogen and progesterone. Which of the following statements by the nurse provides the client with accurate information?

- 1. "The progesterone will help prevent cervical cancer."
- 2. "The progesterone will help prevent breast cancer."
- 3. "The progesterone will help prevent liver disease."
- 4. "The progesterone will help prevent endometrial cancer."

**23.** The nurse on the antenatal unit is planning care for four clients. The nurse should assess which of the following clients **first**?

- 1. A 29-year-old G3 P2 carrying twins, being treated for preterm labor at 29 weeks' gestation. She is receiving magnesium sulfate @ 2 g/hour. She has had no contractions for the past 2 hours and both twins appear stable, according to the nurse's shift report.
- 2. A 19-year-old 18 weeks' IUP who is now 12 hours post motor vehicle accident with bright red vaginal bleeding.
- 3. A G8 P4 Ab3 at 38 weeks' gestation hospitalized frequently during this pregnancy for placenta previa. Two days ago she was admitted with severe bright red vaginal bleeding that has tapered off now.
- 4. A 9-week IUP hospitalized for hyperemesis gravidarum who has not vomited for the last 12 hours.

**24.** The nurse should turn the client on bed rest every 2 hours to prevent the development of pressure ulcers. In addition, the nurse should:

- 1. Have the client walk at least twice a day.
- 2. Insert an indwelling urinary catheter.
- 3. Monitor serum albumin.
- 4. Monitor the white blood cell count.

**25.** A client has been hospitalized with heart failure. He is receiving digoxin (Lanoxin) and furosemide (Lasix) intravenously. He tells the nurse that he hears a continuous ringing in his ears and that he has never had this problem before. What is the appropriate action for the nurse to take at this time?

- 1. Obtain a digoxin level to check for toxicity.
- 2. Note the observation in the chart and plan to reassess in 2 hours.
- 3. Ask the client if he has been taking aspirin in addition to his other medications.
- 4. Discontinue the furosemide and notify the physician.

**26.** Which of the following discharge instructions about thermal injury should be given to a client with peripheral vascular disease? Select all that apply.

- 1. "Warm the fingers or toes by using an electric heating pad."
- 2. "Avoid sunburn during the summer."
- 3. "Wear extra socks in the winter."
- 4. "Choose loose, soft, cotton socks."
- 5. "Use an electric blanket when you are sleeping."

**27.** A client receives an I.V. dose of gentamicin sulfate (Garamycin). How long after the completion of the dose should the peak serum concentration level be measured?

- 1. 10 minutes.
- 2. 20 minutes.
- 3. 30 minutes.
- 4. 40 minutes.

**28.** A client with hydrocephalus reports having had a headache in the morning on arising for the last 3 days, but it disappears later in the day. The nurse should:

- 1. Notify the physician.
- 2. Tell the client that this is normal because intracranial pressure fluctuates throughout the day.
- 3. Instruct the client to increase fluid intake prior to going to bed to prevent headache in the morning.
- 4. Advise the client to request pain medication from the physician.

**29.** A primigravid client visits the clinic for a routine examination at 35 weeks' gestation. The client's blood pressure is near the baseline of 120/74 mm Hg with no proteinuria or evidence of facial edema. The client asks the nurse, "What should I take if I get an occasional headache after looking at my computer at work all day?" The nurse instructs the client that she can occasionally take which of the following?

- 1. Acetaminophen (Tylenol).
- 2. Aspirin.
- 3. Ibuprofen (Advil).
- 4. Naproxen (Aleve).

**30.** A 19-year-old client has undergone an examination and had evidence collected after being raped. Her father is overheard yelling at his daughter, "You're going to tell me who did this to you. What's his name?" Which of the following is the nurse's most immediate action?

- 1. "Please come with me, sir. I need some important information."
- 2. "Stop yelling. You're being inappropriate."
- 3. "Please be quiet. You're not helping your daughter this way."
- 4. "If you don't stop yelling, I'll have to call Security."

**31.** Which of the following groups is more likely to develop severe hypertension?

- 1. Asian.
- 2. African American.
- 3. European.
- 4. American Indian.

**32.** During a neonate's assessment shortly after birth, the nurse observes a large pad of fat at the back of the neck, widely set eyes, simian hand creases, and epicanthal folds. Which of the following actions is most appropriate?

- 1. Notify the physician immediately.
- 2. Ask the mother to consent to genetic studies.
- 3. Explain these deviations to the newborn's mother.
- 4. Document these findings as minor deviations.

**33.** A client with severe arthritis has been receiving maintenance therapy of prednisone (Deltasone) 10 mg/day for the past 6 weeks. The nurse should instruct the client to immediately report symptoms of:

- 1. Respiratory infection.
- 2. Joint pain.
- 3. Constipation.
- 4. Joint swelling.

**34.** A 90-year-old client discloses that he has two guns at home. The nurse asks him whether he has any grandchildren who come to visit or other school-age visitors because the most common risk factor for school-age children associated with injury or death from firearms is:

- 1. An argument with a stranger.
- 2. Firearm access.
- 3. Substance use.
- 4. Peer pressure.

**35.** A 7-year-old child is admitted to the hospital with the medical diagnosis of acute rheumatic fever. During the acute phase of the illness, it is least desirable to interest the child in which of the following diversional activities?

- 1. Reading a book to the father.
- 2. Playing with a doll with the nurse.
- 3. Watching the television with a sibling.
- 4. Playing checkers with a roommate.

**36.** A woman is taking oral contraceptives. The nurse teaches the client to report which of the following danger signs?

- 1. Breakthrough bleeding.
- 2. Severe calf pain.
- 3. Mild headache.
- 4. Weight gain of 3 lb.

**37.** Which nursing action is most essential for the hospitalized client with a new tracheostomy?

- 1. Decrease secretions.
- 2. Provide client teaching regarding tracheostomy care.
- 3. Relieve anxiety related to the tracheostomy.
- 4. Maintain a patent airway.

**38.** Immediately after the client receives an injection of bupivacaine (Marcaine), he becomes restless and nervous and reports a feeling of impending doom. Which of the following actions by the nurse is appropriate at this time?

- 1. Ask the client to talk more about what he is feeling.
- 2. Reassure the client that it is normal to feel restless before a procedure.
- 3. Assess the client's vital signs.
- 4. Administer epinephrine.

**39.** A menopausal woman is taking hormone replacement therapy. The nurse teaches the client that a warning sign for endometrial cancer that needs to be reported is:

- 1. Hot flashes.
- 2. Irregular vaginal bleeding.
- 3. Urinary urgency.
- 4. Dyspareunia.

**40.** When explaining the risk for having a child with cystic fibrosis to a husband and wife, the nurse should tell them?

- 1. The risk is greatest when both clients have the recessive gene.
- 2. The gene is carried on the X chromosome and there is little risk.
- 3. The disease will only occur if the child is a male.
- 4. The disease does not have a genetic basis.

**41.** The client complains of a severe vulvar pruritus and a yellow-green, malodorous vaginal discharge. The nurse recognizes that the symptoms suggest:

- 1. Gonorrhea.
- 2. Syphilis.
- 3. Chlamydia.
- 4. Trichomoniasis.

**42.** Following surgery, to evaluate the effectiveness of the client's use of an incentive spirometer, the nurse should determine if the client:

- 1. Has increased circulation in the extremities.
- 2. Is ready to ambulate without pain.
- 3. Has stronger abdominal muscles.
- 4. Can breathe easier.

**43.** A client was talking with her husband by telephone, and then she began swearing at him. The nurse interrupts the call and offers to talk with the client. She says, "I can't talk about that bastard right now. I just need to destroy something." At this point, which of the following should the nurse do next?

- 1. Tell her to write her feelings in her journal.
- 2. Urge her to talk with the nurse now.
- 3. Ask her to calm down or she will be restrained.
- 4. Offer her a phone book to "destroy" while staying with her.

**44.** The nurse is caring for a multigravid client in active labor when the nurse detects variable fetal heart rate decelerations on the electronic monitor. The nurse interprets this as the compression of which of the following structures?

- 1. Head.
- 2. Chest.
- 3. Umbilical cord.
- 4. Placenta.

**45.** Which of the following assessment findings should lead the nurse to suspect that a client who had a cesarean delivery 8 hours earlier is developing disseminated intravascular coagulation (DIC)? Select all that apply.

- 1. Petechiae on the arm where the blood pressure was taken.
- 2. Heart rate of 126 bpm.
- 3. Abdominal incision dressing with bright red drainage.
- 4. Platelet count of 80,000/mm<sup>3</sup>.
- 5. Urine output of 350 mL in the past 8 hours.
- 6. Temperature of 98.4° F (36.9° C).

**46.** Two days after placement of a pleural chest tube, the tube is accidentally pulled out of the chest wall. The nurse should first:

- 1. Immerse the tube in sterile water.
- 2. Apply an occlusive dressing such as petroleum jelly gauze.
- 3. Instruct the client to cough to expand the lung.
- 4. Auscultate the lung to determine whether it collapsed.

**47.** A client is admitted to the hospital with a diagnosis of a pulmonary embolism. Which of the following problems should the nurse address first?

- 1. Nonproductive cough.
- 2. Activity intolerance.
- 3. Ineffective breathing pattern.
- 4. Impaired gas exchange.

**48.** Which of the following is characteristic of cardiogenic shock?

- 1. Hypovolemia.
- 2. Increased cardiac output.
- 3. Decreased myocardial contractility.
- 4. Infarction.

**49.** The nurse is reviewing the laboratory results of a client with hypothyroidism. An expected finding is:

- 1. Decreased thyroxine ( $T_4$ ) and increased thyroid-stimulating hormone (TSH) levels.
- 2. Decreased TSH and increased  $T_4$  levels.
- 3. Decreased creatine phosphokinase levels.
- 4. Absence of antithyroid antibodies.

**50.** The mother of a 7-month-old child born 6 weeks early asks the nurse what play activities and toys is appropriate for her child. Which of the following should the nurse suggest?

- 1. Picture books.
- 2. Peek-a-boo.
- 3. Rattle.
- 4. Colored blocks.

**51.** Which of the following is the most accurate method of determining the extent of a client's fluid loss?

- 1. Measuring intake and output.
- 2. Assessing vital signs.
- 3. Weighing the client.
- 4. Assessing skin turgor.

**52.** The nurse is counseling a client regarding treatment of the client's newly diagnosed depression. The nurse emphasizes that full benefit from antidepressant therapy usually takes how long?

- 1. 1 week.
- 2. 2 to 4 weeks.
- 3. 5 to 7 weeks.
- 4. 8 weeks.

**53.** A 70-year-old, previously well client asks the nurse, "I notice I have tremors. Is this just normal for my age?" The best response for the nurse to make is which of the following?

- 1. "I wouldn't be worried because this is common with aging."
- 2. "You should report this to the physician because it may indicate a problem."
- 3. "You should drink orange juice when this occurs."
- 4. "You should have your blood pressure checked when this occurs."

**54.** A school-age child diagnosed with attention deficit hyperactivity disorder is prescribed methylphenidate (Ritalin). Which of the following should alert the school nurse to the possibility that the child is experiencing a common side effect of the drug?

- 1. Loss of appetite.
- 2. Vomiting.
- 3. Photosensitivity.
- 4. Weight gain.

**55.** A client complains of a dull headache and dizziness and has an increased pulse rate. The results of arterial blood gas analysis are as follows: pH 7.26; partial pressure of carbon dioxide, 50 mm Hg; and bicarbonate, 24 mEq/L. These findings indicate which of the following acid-base imbalances?

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

**56.** The nurse is planning a continuous quality improvement (CQI) process to decrease the infection rate on the nursing unit. The nurse should consider which of the following when planning the process? Select all that apply.

- 1. CQI processes are required by accrediting agencies.
- 2. The approach to CQI can be retrospective or concurrent.
- 3. Institutional Review Board (IRB) approval is required.
- 4. CQI is conducted by people who are not part of the process.
- 5. The CQI process has a fixed endpoint.

**57.** Which of the following is appropriate for a client with metabolic alkalosis?

- 1. Monitor serum potassium levels.
- 2. Maintain the client on bed rest.
- 3. Have the client inhale carbon dioxide using a paper bag.
- 4. Administer sodium bicarbonate as ordered.

**58.** Which of the following demonstrates that the client needs further instruction after being taught about ciprofloxacin (Cipro)?

- 1. "I must drink 1,000 to 1,500 mL of water a day."
- 2. "I shouldn't take an antacid before taking the Cipro."
- 3. "I should let the doctor know if I start vomiting from the Cipro."
- 4. "I may get light-headed from the Cipro."

**59.** When developing the plan of care for a client with Alzheimer's disease, which of the following activities is **least** beneficial to the client?

- 1. Reminiscence group.
- 2. Walking.
- 3. Pet therapy.
- 4. Stress management.

**60.** The nurse should instruct the parents of a school-age child with hemophilia to implement which of the following when the child develops bleeding into a joint? Select all that apply.

- 1. Having the child rest.
- 2. Applying heat to the joint area.
- 3. Beginning factor VIII therapy.
- 4. Starting physical therapy.
- 5. Applying a topical antifibrinolytic.

**61.** Which of the following nursing diagnoses should the nurse implement as part of the long-term care for a child with hemophilia?

- 1. *Deficient knowledge.*
- 2. *Risk for injury.*
- 3. *Situational low self-esteem.*
- 4. *Acute pain.*

**62.** When preparing a 3-year-old child to have blood specimens drawn for laboratory testing, the nurse should?

- 1. Explain the procedure in advance.
- 2. Explain why the blood needs to be drawn.
- 3. Use distraction techniques during the procedure.
- 4. Provide verbal explanations about what will occur.

**63.** The client has been prescribed lisinopril (Prinivil) to treat hypertension. The nurse should assess the client for which of the following electrolyte imbalances?

- 1. Hyponatremia.
- 2. Hypocalcemia.
- 3. Hyperkalemia.
- 4. Hypermagnesemia.

**64.** A client with a chronic mental illness who does not always take her medications is separated from her husband and receives Supplemental Security Income. She lives with her mother and older sister and manages her own medication. The client's mother is in poor health and receives Social Security benefits. The client's sister works outside the home, and the client's father is dead. Which of the following issues should the nurse need to address first?

- 1. Family.
- 2. Marital.
- 3. Financial.
- 4. Medication.

**65.** A client is receiving total parenteral nutrition (TPN). The nurse notices that the bag of TPN solution has been infusing for 24 hours but has 300 mL of solution left. The nurse should:

- 1. Continue the infusion until the remaining 300 mL is infused.
- 2. Change the filter on the tubing and continue with the infusion.
- 3. Notify the physician and obtain orders to alter the flow rate of the solution.
- 4. Discontinue the current solution, change the tubing, and hang a new bag of TPN solution.

**66.** A client with a history of cardiac problems is having severe chest pain. What should be nurse's **first** response?

- 1. Notify the physician.
- 2. Administer an analgesic to control the pain.
- 3. Assess the client's pain.
- 4. Start oxygen at 2 L/minute via nasal cannula.

**67.** Which of the following characteristics should the nurse include in the teaching plan for a multiparous client after delivering a neonate diagnosed with trisomy 13?

- 1. Webbed neck.
- 2. Small testes.
- 3. Congenital heart defects.
- 4. Polydactyly.

**68.** A client is being treated for acute low back pain. Which of these clinical manifestations must be reported to the physician immediately?

- 1. Diffuse, aching sensation in the L4 to L5 area.
- 2. New onset of footdrop.
- 3. Pain in the lower back when the leg is lifted.
- 4. Pain in the lower back that radiates to the hip.

**69.** A client with type 1 diabetes mellitus asks the nurse whether he can take ginseng at home. The nurse should tell the client:

- 1. "No, there are no therapeutic benefits of ginseng."
- 2. "Taking ginseng will increase the risk of hypoglycemia."
- 3. "You can take the ginseng to help improve your memory."
- 4. "You can take ginseng if you take it with a carbohydrate"

**70.** The nurse teaches the client with cirrhosis that he is achieving the expected effect of lactulose (Cephulac) when he has:

- 1. One regular bowel movement a day.
- 2. Two to three soft stools per day.
- 3. Four to five loose stools per day.
- 4. Five to six loose stools per day.

**71.** The nurse is evaluating the laboratory results of a client who was recently admitted to the hospital. Which one of the following results indicates the presence of inflammation?

- 1. Decreased sedimentation rate.
- 2. Thrombocytopenia.
- 3. Leukocytosis.
- 4. Erythrocytosis.

**72.** The nurse is assessing teenaged girls at a well child clinic. The nurse should describe the girl shown in the figure as having:

- 1. Normal posture.
- 2. Kyphosis.
- 3. Scoliosis.
- 4. Lordosis.



**73.** A client reports having pain in his casted left arm that is unrelieved by pain medication. The nurse assesses the arm and notes that the fingers are swollen and difficult to separate. Which action is most appropriate for the nurse to take at this time?

- 1. Administer morphine 2 mg intravenously.
- 2. Apply an ice bag to the fingers to relieve pain.
- 3. Elevate the arm on two pillows and reassess in 30 minutes.
- 4. Call the physician to report swelling and pain.

**74.** A primiparous client develops uterine atony and postpartum hemorrhage 1 hour after a vaginal delivery. The physician has ordered I.M. prostaglandin-F<sub>2a</sub>. After administration of the medication, the nurse should observe the client for which of the following?

- 1. Tachycardia.
- 2. Hypotension.
- 3. Constipation.
- 4. Abdominal distention.

**75.** While caring for a mother and her 1-day-old neonate delivered vaginally at 30 weeks' gestation, the nurse explains about the neonate's need for gavage feeding at this time instead of the mother's plan for bottle feeding. Which of the following should the nurse include as the rationale for this feeding plan?

- 1. The neonate has difficulty coordinating sucking, swallowing, and breathing.
- 2. A high-calorie formula, presently needed at this time, is more easily delivered via gavage.
- 3. Gavage feedings can minimize the neonate's increased risk of developing hypoglycemia.
- 4. This type of feeding, easily given in the isolette, decreases the neonate's risk of cold stress.

**76.** The nurse is teaching a client with rheumatoid arthritis about how to manage the fatigue associated with this disease. Which statement by the client indicates she understands how to manage the fatigue?

- 1. "I sleep for 8 to 10 hours every night so that I'll have the energy to care for my children during the day."
- 2. "I schedule afternoon rest periods for myself in addition to sleeping 10 hours every night."
- 3. "I spend one weekend day a week resting in bed while my husband cares for the children."
- 4. "I get up early in the morning and get all my household chores completed before my children wake up."

**77.** The nurse is caring for a child with hemophilia who is actively bleeding from the leg. The nurse should apply:

- 1. Direct pressure, checking every few minutes to see if the bleeding has stopped.
- 2. Ice to the injured leg area several times a day.
- 3. Direct pressure to the injured area continuously for 10 minutes.
- 4. Ice bag with elevation of the leg twice a day.

**78.** Which of the following is least likely a danger associated with pancytopenia?

- 1. Anemia.
- 2. Bleeding.
- 3. Infection.
- 4. Hypothyroidism.

**79.** A client suspected of being a victim of abuse returns to the emergency department and, sobbing, tells the nurse, “I guess you really know that my husband beats me and that’s why I have bruises all over my body. I don’t know what to do. I’m afraid he’ll kill me one of these times.” Which of the following responses best demonstrates that the nurse recognizes the client’s needs at this time?

- 1. “The fear that your husband will kill you is unfounded.”
- 2. “We can begin by discussing various options open to you.”
- 3. “You can legally leave your husband because he has no right to hurt you.”
- 4. “We can begin by listing ways to avoid making your husband angry with you.”

**80.** A client has just returned from surgery for a gastrectomy. The nurse should position the client in which position?

- 1. Prone.
- 2. Supine.
- 3. Low Fowler’s.
- 4. Right or left Sims’.

**81.** A child with heart disease starts on oral digoxin (Lanoxin). When preparing to administer the medication, which of the following should the nurse do first?

- 1. Check the last serum electrolyte results for the child.
- 2. Verify the dosage with a licensed practical nurse who is working that day.
- 3. Ask the mother if she is willing to administer the medication.
- 4. Teach the mother how to measure the child’s heart rate.

**82.** The nurse is caring for a client who has suffered deep partial-thickness and full-thickness burns. During the emergent (resuscitative) phase of burn management, the nurse would anticipate a fluid shift from the:

- 1. Intracellular to extracellular compartment.
- 2. Extracellular to intravascular compartment.
- 3. Interstitial to the intracellular compartment.
- 4. Intravascular to the interstitial compartment.

**83.** The nurse is evaluating the effectiveness of fluid resuscitation during the emergency period of burn management. Which of the following indicates that adequate fluid replacement has been achieved in the client?

- 1. An increase in body weight.
- 2. Fluid intake less than urinary output.
- 3. Urine output greater than 35 mL/hour.
- 4. Blood pressure of 90/60 mm Hg.

**84.** A client who comes to the emergency department with multiple bruises on her face and arms, a black eye, and a broken nose says that these injuries occurred when she fell down the stairs. The nurse suspects that the client may have been physically assaulted. Which of the following should the nurse do next?

- 1. Ask the client specifically about the possibility of physical abuse.
- 2. Tell the client that it is difficult to believe that such injuries resulted from a fall.
- 3. Ask the client what she did to make someone beat her so badly.
- 4. Discuss with the client what she can do to deescalate the situation next time.

**85.** What is the primary outcome for the care of a client who is in shock?

- 1. Achieve adequate tissue perfusion.
- 2. Preserve renal function.
- 3. Prevent hypostatic pneumonia.
- 4. Maintain adequate vascular tone.

**86.** The parent of a young child diagnosed with low-dose lead exposure asks about long-term effects. Which of the following should the nurse mention as possible long-term effects to this mother? Select all that apply.

- 1. Seizures.
- 2. Depression.
- 3. Hyperactivity.
- 4. Aggression.
- 5. Impulsiveness.

**87.** Which of the following is appropriate to include in an incident report?

- 1. An interpretation of the likely cause of the incident.
- 2. What the nurse saw and did.
- 3. The client’s statement about the incident that occurred.
- 4. The extenuating circumstances involved in the situation.

**88.** To reduce urethral irritation, where should the nurse tape the female client’s Foley catheter?

- 1. Inner thigh.
- 2. Groin area.
- 3. Lower abdomen.
- 4. Lower thigh.

**89.** The nurse is reconciling the medications with a client who is being discharged. Which of the following indicates there is a “discrepancy”?

- 1. There is agreement between the client’s home medication list and current medication orders.
- 2. There is justification for a difference in the medication orders.
- 3. There is lack of congruence between a client’s home medication list and current medication orders.
- 4. Sample medications have been included in the medication list.



**90.** The physician has determined that a primigravid client in active labor requires a cesarean delivery because of cephalopelvic disproportion. After the delivery of a male neonate, for which of the following should the nurse assess first?

- 1. Nasopharyngeal secretions.
- 2. High-pitched cry.
- 3. Skull fracture.
- 4. Decreased muscle tone.

**91.** A father of a toddler brings his child to the emergency room because the child has accidentally been scalded by hot water spilling from the stove. In order to differentiate the burn from potential abuse, the nurse first should assess the child:

- 1. On the back of the body.
- 2. On the front of the body.
- 3. For a circular or glove pattern.
- 4. On the buttocks.

**92.** A 17-year-old client visits the clinic at 36 weeks' gestation. The client's blood pressure is 130/90 mm Hg. On previous visits, her blood pressure ranged from 100 to 110 mm Hg systolic, 70 to 80 mm Hg diastolic. Further assessment reveals slight edema of her hands and 1 + proteinuria. The nurse anticipates that the physician will most likely order which of the following?

- 1. I.V. magnesium sulfate.
- 2. Labetalol (Normodyne).
- 3. Bed rest with bathroom privileges.
- 4. Hourly blood pressure checks.

**93.** The nurse observes that an area in the mouth of a child with leukemia is bleeding. Which of the following items should the nurse use because it is most effective for promoting homeostasis over the lesion?

- 1. Karaya gum.
- 2. A cotton ball imbedded with petroleum jelly.
- 3. A nonsticking gauze sponge.
- 4. A dry tea bag.

**94.** Which of the following is appropriate for the nurse to include in a plan for the prevention of pressure ulcers?

- 1. Daily skin cleaning with soap and hot water.
- 2. Gentle massage of bony prominences every shift.
- 3. Encouraging the client to sit up as much as possible.
- 4. Systematic skin assessment at least once per shift.

**95.** A client at 36 weeks' gestation tells the nurse, "I've been having a lot of backaches lately." After giving instructions about how to decrease the backaches, the nurse determines that the client needs further instruction when she says which of the following?

- 1. "I should walk with my pelvis tilted backward."
- 2. "I may need to put a board under my mattress."
- 3. "I should squat and not bend to pick up objects."
- 4. "I should wear flat or low-heeled shoes."

**96.** Which of the following is an initial clinical manifestation of gonorrhea in men?

- 1. Impotence.
- 2. Scrotal pain.
- 3. Penile lesion.
- 4. Urethral discharge.

**97.** A client's blood pressure is elevated at 160/90 mm Hg. The physician ordered "clonidine (Catapres) 1 mg by mouth now." The nurse sent the order to pharmacy at 7:10 a.m., but the medication still has not arrived at 8 a.m. The nurse should do all except which of the following?

- 1. Check all appropriate places on the unit to which the drug could have been delivered.
- 2. Check the client's blood pressure.
- 3. Call the pharmacy.
- 4. Go to the pharmacy to obtain the drug.

**98.** The client with major depression states, "I'm too tired to get out of bed to go to group. I just want to rest." The nurse should tell the client:

- 1. "Perhaps you'll feel better later on."
- 2. "I'll let you rest for as long as you need."
- 3. "Attending group is an important part of your treatment plan."
- 4. "You've been in bed long enough and need to get up."

**99.** After teaching the mother of a 7-month-old diagnosed with bronchiolitis, the nurse determines that the teaching has been effective when the mother states which of the following as a sign to report immediately?

- 1. Seven wet diapers a day.
- 2. Temperature of 100° F (37.8° C) for 2 days.
- 3. Clear nasal discharge for longer than 2 days.
- 4. Longer periods of sleep than usual.

**100.** Which of the following clients would benefit from the application of warm moist heat?

- 1. A client with appendicitis.
- 2. A client with a recently sprained joint.
- 3. A client with a suspected malignancy.
- 4. A client with low back pain.

**101.** A 65-year-old client is newly diagnosed with pernicious anemia. The nurse emphasizes to the client the need to increase vitamin B<sub>12</sub> intake by:

- 1. Increasing dietary intake of vitamin B<sub>12</sub>.
- 2. Taking an oral vitamin B<sub>12</sub> replacement.
- 3. Taking vitamin B<sub>12</sub> injections or nasal spray replacement.
- 4. Chelation therapy.

**102.** The nurse is caring for a client with an acute exacerbation of Crohn's disease. The nurse has received an order to add 20 mEq of potassium chloride to a 1,000-mL bottle of I.V. fluid. The nurse has a 30-mL, multiple-dose vial of potassium chloride. The label reads 2 mEq/mL. How many milliliters should the nurse add to the I.V. fluid?

\_\_\_\_\_ mL.

**103.** A client with major depression and suicidal ideation is suddenly calmer and more energetic. Which of the following conclusions should the nurse reach?

- 1. The client is improving.
- 2. The client's medication dosage is too high.
- 3. The client is overstimulated.
- 4. The client is imminently suicidal.

**104.** A multigravid client at 38 weeks' gestation is scheduled to undergo a contraction stress test. Which of the following should the nurse include in the explanation as the purpose of this test?

- 1. Evaluation of fetal lung maturity.
- 2. Determination of the fetal biophysical profile.
- 3. Assessment of fetal ability to tolerate labor.
- 4. Determination of fetal response during movements.

**105.** The nurse is caring for a client who has been diagnosed with atypical pneumonia. The nurse should assess this client carefully for:

- 1. High fever.
- 2. Tachypnea.
- 3. Dry cough.
- 4. Severe chills.

**106.** The nurse is teaching a client with emphysema how to do pursed-lip breathing. What is the primary reason to use pursed-lip breathing?

- 1. To increase oxygenation.
- 2. To prolong exhalation.
- 3. To prevent respiratory infection.
- 4. To decrease shortness of breath.

**107.** The advantage of using automated medication dispensing equipment includes which of the following?

- 1. It facilitates the change-of-shift count of narcotics.
- 2. It keeps a record of narcotic usage.
- 3. It allows nurses unmonitored access to narcotics.
- 4. It cancels the charges for narcotics.

**108.** A 21-year-old male client is transported by ambulance to the emergency department after a serious automobile accident. He has severe pain in his right chest where he struck the steering wheel. He also has a compound fracture of his right tibia and fibula and multiple lacerations and contusions. The primary goal at this point is to:

- 1. Reduce the client's anxiety.
- 2. Maintain adequate oxygenation.
- 3. Decrease chest pain.
- 4. Maintain adequate circulating volume.

**109.** While assessing a primiparous client 8 hours after delivery, the nurse inspects the episiotomy site, finding it edematous and slightly reddened. Which of the following interpretations by the nurse is most appropriate?

- 1. The client needs application of an ice pack.
- 2. The episiotomy site is probably infected.
- 3. A hematoma will likely develop.
- 4. The client has had a repair of a vaginal laceration.

**110.** When administering an I.M. injection, the nurse uses the Z-track technique when the medication:

- 1. Takes a long time to absorb.
- 2. Takes effect very quickly.
- 3. Is irritating to tissues.
- 4. Is viscous in consistency.

**111.** A client with an Axis I diagnosis of bipolar disorder, mania, is monopolizing the use of the telephone by making several calls each day, interfering with the ability of other clients to use the telephone. The nurse should:

- 1. Instruct the other clients to be patient.
- 2. Limit the amount of calls the client can make each day.
- 3. Remind the client that others need to use the telephone.
- 4. Take away the client's telephone privileges.

**112.** When preparing a 20-month-old with a foreign body in the nasal passage for removal of the foreign body by the health care provider, the nurse should:

- 1. Jacket restraint.
- 2. Elbow restraint.
- 3. Use of father to hold.
- 4. Papoose board.

**113.** The nurse auscultates the lungs of a client who has been diagnosed with lung cancer and notes wheezing over one lung. The nurse understands that the most likely cause of this clinical finding is:

- 1. The presence of exudate in the airways.
- 2. The result of the client's history of smoking.
- 3. An indication of pleural effusion.
- 4. Obstruction of the airway by a tumor.

**114.** The nurse is teaching a client who is taking insulin about the signs of diabetic ketoacidosis, which include:

- 1. Kussmaul's respirations.
- 2. Excessive hunger.
- 3. Dry, flaky skin.
- 4. High blood pressure.

**115.** A nurse at the outpatient clinic receives a lithium level report of 1.0 mEq/L for a client who has been taking lithium for 2 months. The nurse should interpret this level to indicate which of the following?

- 1. An error in reporting.
- 2. Too low to be therapeutic.
- 3. Too high, indicating toxicity.
- 4. Within the therapeutic range.

**116.** A 16-year-old Hispanic client at 10 weeks' gestation has been diagnosed with mild iron deficiency anemia. The client tells the nurse that she doesn't like to eat much meat. Which of the following foods should the nurse suggest to provide the client with the greatest amount of iron in her diet?

- 1. 1 cup of lentils.
- 2. 1 cup of sunflower seeds.
- 3. 1½ oz of hard cheese.
- 4. 2 poached eggs.

**117.** A client has been receiving radiation therapy for 3 weeks to treat his cancer. He is complaining of fatigue. Which of the following should be considered while the nurse plans interventions to help the client cope with the fatigue?

- 1. Fatigue is a temporary problem that requires no active intervention.
- 2. The client should be closely examined to determine the cause of fatigue.
- 3. Fatigue indicates that the client's cancer is not under control.
- 4. The client should be encouraged to maintain activity to combat the fatigue.

**118.** When educating unlicensed assistants on how to prevent the development of pressure ulcers, the nurse should emphasize that most tissue injuries related to shearing can be prevented by implementing which of the following activities?

- 1. Close adherence to a turning schedule.
- 2. Keeping the skin clean and dry.
- 3. Proper positioning and moving of the client.
- 4. Use of skin lubricants.

**119.** When using crutches, the client should be instructed to bear weight primarily on the:

- 1. Axillae.
- 2. Elbows.
- 3. Upper arms.
- 4. Hands.

**120.** Which of the following nursing diagnoses is a priority for the family whose child is dying of leukemia?

- 1. *Disabled family coping.*
- 2. *Impaired parenting.*
- 3. *Fear.*
- 4. *Grieving.*

**121.** Which of the following should the nurse do first for a toddler just admitted with croup?

- 1. Monitor vital signs.
- 2. Assess respiratory status.
- 3. Ensure adequate fluid intake.
- 4. Place a tracheostomy set at the bedside.

**122.** Before the nurse administers I.V. replacement of 5% dextrose in water with potassium chloride, what nursing intervention must be completed first?

- 1. Adding potassium chloride to the bag at the bedside.
- 2. Evaluating laboratory results for electrolytes.
- 3. Priming tubing using sterile technique.
- 4. Checking the rate for I.V. push administration.

**123.** Homocysteine may be cleared from the blood with the help of which of the following vitamins?

- 1. Vitamin C.
- 2. Vitamin E.
- 3. Vitamin K.
- 4. Vitamin B<sub>6</sub>.

**124.** Which of the following signs and symptoms is an early indication that a client has developed hypocalcemia?

- 1. Tingling in the fingers.
- 2. Depressed reflexes.
- 3. Ventricular dysrhythmias.
- 4. Memory changes.

**125.** The nurse is auscultating the lung sounds of a client with long-standing emphysema. The nurse should determine if the client has?

- 1. Fine crackles.
- 2. Diminished breath sounds.
- 3. Stridor.
- 4. Pleural friction rub.

**126.** A client with a paranoid personality disorder sees some clients laughing during a group activity and asks the nurse, "Why are they laughing at me? I bet they're making fun of me." Which of the following responses by the nurse is most appropriate?

- 1. "You shouldn't let yourself get so upset."
- 2. "Don't worry about them. They don't mean any harm."
- 3. "Look. They seem to be having fun."
- 4. "They're laughing at a joke John told. They aren't laughing at you."

**127.** Mebendazole (Vermox) is prescribed for an 8-year-old child with pinworms. The child has an 18-month-old brother and a 4-year-old sister. The nurse should be sure that the parents are also treating which of the following family members with this drug?

- 1. Both of the child's siblings.
- 2. The child's parents and brother.
- 3. Everyone who lives in the household.
- 4. The parents and sister.

**128.** When planning a presentation on the topic of osteoporosis to a group of middle-aged women, which of the following should the nurse plan to include in the presentation?

- 1. An early symptom of osteoporosis is the dowager's hump.
- 2. African American and Latina women are at greater risk.
- 3. Loss of height is an early symptom of the disease.
- 4. Conventional radiographs are usually used to confirm the disease.

**129.** Which of the following statements best explains why the nurse should evaluate gastric residual before administering the client's next enteral feeding?

- 1. To determine how well nutrients are being absorbed.
- 2. To determine if the client is receiving enough feeding.
- 3. To prevent overdistention of the stomach.
- 4. To prevent mixing undigested formula with partially digested formula.

**130.** Which of the following serologic tests should the nurse have on the chart before a client is started on tissue plasminogen activator or alteplase recombinant (Activase)?

- 1. Partial thromboplastin time.
- 2. Potassium level.
- 3. Lee-White clotting time.
- 4. Fibrin split product.

**131.** When planning the care for a client diagnosed with hepatitis A, which of the following nursing interventions should the nurse expect to include? Select all that apply.

- 1. Implementing an exercise program.
- 2. Providing relief from nausea and vomiting.
- 3. Administering pain medication.
- 4. Encouraging multiple small meals daily.
- 5. Planning frequent rest periods.

**132.** Following cardiac bypass surgery, the client has been referred to a cardiac rehabilitation exercise program. The client is a diabetic and has bilateral leg discomfort with walking. The nurse should advise the client to exercise using a stationary bicycle and intermittent training because of the client's:

- 1. Diabetic neuropathy.
- 2. Muscle atrophy.
- 3. Raynaud's disease.
- 4. Transient ischemic attacks.

**133.** The client with borderline personality disorder spends much time around the nurse's station, making numerous minor requests. The nurse interprets these behaviors as indicating which of the following?

- 1. Fears of abandonment and attention seeking.
- 2. Enjoyment of bothering the staff.
- 3. Boredom suggesting the need for something to do.
- 4. Lack of desire for involvement in milieu activities.

**134.** A client has soft wrist restraints to prevent her from pulling out her nasogastric tube. Which of the following nursing interventions should be implemented while the restraints are on the client?

- 1. Instruct the client not to move while the restraints are in place.
- 2. Remove the restraints every 4 hours to provide skin care.
- 3. Secure the restraints to side rails of the bed.
- 4. Check on the client every 30 minutes while the restraints are on.

**135.** A client with alcohol dependence states, "I feel so bad because of what I've done to my wife and kids. I'm just no good." Which of the following responses by the nurse is most appropriate?

- 1. "You'll need to make up for a lot of things."
- 2. "They will need to forgive your shortcomings."
- 3. "Alcohol dependence is a disease that can be treated."
- 4. "Alcoholism is painful for everyone involved."

**136.** After teaching the parents of a toddler about appropriate snack foods for their child, the nurse judges that the instructions about not giving the child raisins for snacks are effective when the father states which of the following?

- 1. "Raisins are low in nutritional value."
- 2. "Raisins can increase tooth decay."
- 3. "Raisins are easy to choke on."
- 4. "Raisins are hard to digest entirely."

**137.** A client has been diagnosed with atrial fibrillation. The physician ordered warfarin (Coumadin) to be taken on a daily basis. The nurse instructs the client to avoid using which of the following over-the-counter medications while taking warfarin?

- 1. Aspirin.
- 2. Diphenhydramine (Benadryl).
- 3. Digoxin (Lanoxin).
- 4. Pseudoephedrine (Sudafed).

**138.** The nurse should inform a client taking carbamazepine (Tegretol) that it can affect other medications in which of the following ways?

- 1. It decreases the effects of oral anticoagulants.
- 2. It decreases the serum concentration of verapamil (Calan).
- 3. It increases the serum concentration of other anticonvulsants.
- 4. It increases the effects of oral contraceptives.

**139.** A client has been diagnosed with viral hepatitis. Which of the following goals is most appropriate for the client?

- 1. Achieve control of abdominal pains.
- 2. Increase activity levels gradually.
- 3. Be able to breathe without difficulty.
- 4. Experience relief from edema.

**140.** Which of the following activities by the mother offers the most support to the child during the first few days after surgery to repair a cleft lip?

- 1. Holding and cuddling the child.
- 2. Helping the child play with some toys.
- 3. Reading some of the child's favorite stories.
- 4. Staying at the bedside and holding the child's hand.

**141.** Which of the following is the most effective strategy for a nurse to use to reduce the number of children involved in automobile accidents who were not wearing seat belts?

- 1. Contact the local state representative to discuss new legislation about child seat belts.
- 2. Attend a school board meeting to advocate for classes teaching children seat belt safety.
- 3. Call the town mayor's office with this information so that the mayor can discuss it with the media.
- 4. Start a letter-writing campaign to the school superintendent about seat belt importance.

**142.** The nurse is developing a discharge plan for a client who has had a myocardial infarction. Planning for discharge for this client should begin:

- 1. On discharge from the hospital.
- 2. On discharge from the cardiac care unit.
- 3. On admission to the hospital.
- 4. 4 weeks after the onset of illness.

**143.** A child is admitted to the emergency department with dyspnea related to bronchospasms. The nurse should place the client in which of the following positions?

- 1. High Fowler's.
- 2. Side-lying.
- 3. Prone.
- 4. Supine.

**144.** The nurse is preparing to administer I.M. morphine sulfate to a client who is in pain. On checking the physician's order, the nurse notes that the order states, "morphine sulfate 60 mg I.M. every 4 hours as needed for pain." The usual dose of morphine is 10 to 15 mg. What is the most appropriate action for the nurse to take?

- 1. Administer the medication as ordered.
- 2. Administer 15 mg of the drug.
- 3. Contact the physician to verify the order.
- 4. Ask another nurse to review the order.

**145.** Following surgery for removal of a brain tumor, a client is coughing, short of breath, and says he has a "bad" feeling. The nurse obtains the following vital signs: blood pressure of 80/60 mm Hg; pulse rate of 120 beats/minute; and respiratory rate of 30 shallow breaths per minute. What should the nurse do **first**?

- 1. Call the neurosurgeon.
- 2. Place the client in the Trendelenburg position.
- 3. Consult the neurologic Clinical Nurse Specialist (CNS).
- 4. Activate the Rapid Response Team (RRT).

**146.** The nurse is preparing a client for paracentesis. Which of the following activities should the nurse complete in preparation for this test?

- 1. Have the client void before the procedure.
- 2. Prepare the client's abdomen with Betadine solution.
- 3. Position the client supine.
- 4. Put the client on nothing-by-mouth (NPO) status 4 hours before the procedure.

**147.** A nurse suspects that a 20-month-old is being abused. Which of the following behaviors should lead the nurse to suspect this?

- 1. Absence of crying during the examination.
- 2. Clinging to the parent during the examination.
- 3. Playing with toys on the examination room floor.
- 4. Talking easily with the nurse.

**148.** Which of the following should the nurse plan to include when teaching the client and family about a substance abuse problem?

- 1. The role of the family in perpetuating the problem.
- 2. The family's responsibility for the client.
- 3. The physical, physiologic, and psychological effects of substances.
- 4. The reasons that could have led the client to use the substance.

**149.** A client who has had a laparoscopic cholecystectomy receives discharge instructions from the nurse. Which statement indicates that the client has understood the instructions?

- 1. "I need to maintain a low-fat diet for the next 6 months."
- 2. "I can remove the dressing from my incision tomorrow and take a shower."
- 3. "I can anticipate some nausea for several days after surgery."
- 4. "I can return to work in 4 to 6 weeks."

**150.** The nurse is obtaining a health history from a Mexican American adult. The nurse should interpret the findings by understanding that Mexican American culture most highly values:

- 1. Children.
- 2. Materialism.
- 3. Firstborn sons.
- 4. The elderly.

**151.** A client comes into the emergency department with extreme fatigue. He is malnourished and laboratory tests reveal that he is severely anemic. The nurse should specifically ask the client about his intake of food **high** in which of the following nutrients?

- 1. Vitamins A, E, and C.
- 2. Vitamins B6 and B12, folate, iron, and copper.
- 3. Thiamine, riboflavin, and niacin.
- 4. Vitamins A and B.

**152.** The nurse is assessing a neonate born to a diabetic mother. Which of the following findings should the nurse expect to see in the infant?

- 1. Hypertonia.
- 2. Hyperactivity.
- 3. Large size.
- 4. Scaly skin.

**153.** A client who had transurethral resection of the prostate complains of dribbling urine after his Foley catheter is removed on the second postoperative day. The nurse notes that the client had 200 mL of urine output in the last 8 hours with a 1,000 mL intake. Which of the following interventions is a priority for the nurse at this time?

- 1. Apply a condom catheter.
- 2. Assess for bladder distention.
- 3. Obtain a urine specimen for culture.
- 4. Teach the client Kegel exercises.

**154.** A client has atrial fibrillation. The nurse should monitor the client for:

- 1. Cardiac arrest.
- 2. Cerebrovascular accident.
- 3. Heart block.
- 4. Ventricular fibrillation.

**155.** A child diagnosed with tinea is being treated with griseofulvin (Grifulvin V). Which of the following instructions should the nurse give to the parents?

- 1. Give the medication before a meal.
- 2. Have the child avoid intense sunlight.
- 3. Give the medication for 10 days.
- 4. Encourage increased fluid intake.

**156.** After going through the necessary procedures for collecting physical evidence after a rape, a client is crying and talking about what happened to her. The nurse should:

- 1. Advise the client to try to forget about what happened.
- 2. Recommend that the client be thankful for the fact that she's alive.
- 3. Question the client about what she could have done to deter the attack.
- 4. Listen to the client's descriptions about what occurred.

**157.** A client undergoes cystoscopy with bladder biopsy. After the procedure, which assessment is most appropriate for the nurse to make?

- 1. Assess the patency of the Foley catheter.
- 2. Assess urine for excessive bleeding.
- 3. Percuss the bladder for distention.
- 4. Obtain a urine specimen for culture.

**158.** When a client of Mexican American descent tells the nurse that she treated her infection by drinking milk, the nurse interprets the client's remark as:

- 1. Confusion from fever.
- 2. Use of the hot disease concept.
- 3. Use of milk as a laxative.
- 4. The need for a dietitian to assist her with meal planning.

**159.** A female client with paranoid schizophrenia has been hearing negative voices and "getting special messages from various sources." Which of the following interventions is most appropriate for the client's symptoms?

- 1. Asking her to make simple decisions.
- 2. Being matter-of-fact with her.
- 3. Monitoring her reactions to television programs.
- 4. Reinforcing appropriate dress and hygiene.

**160.** The nurse is talking with a client who was diagnosed with bulimia 3 months ago. The client needs more education about the illness if she makes which of the following comments? Select all that apply.

- 1. "I know that this illness is chronic and intermittent. I'll always have to control it."
- 2. "If I start severely restricting my eating, I may be building up to a bingeing episode."
- 3. "When I'm not bingeing and purging, I can skip that Eating Disorder support group."
- 4. "I've made a real effort to be more social and involved in activities."
- 5. "My depression is gone so I don't need my antidepressant any longer."

**161.** The nurse judges that the parents of a newborn with imperforate anus know what a low defect is when they say that the rectum:

- 1. Is below the abdominal rectus muscle.
- 2. Is above the abdominal rectus muscle.
- 3. Has descended through the puborectalis muscle.
- 4. Has ascended through the puborectalis muscle.

**162.** A 75-year-old man is receiving meperidine (Demerol) after surgery. For which of the following side effects of meperidine should the nurse carefully evaluate the client?

- 1. Respiratory depression.
- 2. Dysrhythmias.
- 3. Constipation.
- 4. Seizures.

**163.** A client with iron deficiency anemia is taking iron supplements. The nurse emphasizes to the client that the drug will have increased absorption if taken with:

- 1. Milk.
- 2. Orange juice.
- 3. Food.
- 4. Beta-carotene.

**164.** When obtaining the nursing history of a client who has diabetes mellitus, the nurse should assess the client for which of the following early symptom of renal insufficiency?

- 1. Polyuria.
- 2. Dysuria.
- 3. Hematuria.
- 4. Oliguria.

**165.** A client is planning to be treated for infertility with the zygote intrafallopian transfer (ZIFT) method. Which of the following should the nurse include when teaching the client about this type of treatment method?

- 1. Fertilization takes place outside of the body.
- 2. ZIFT is helpful for clients with bilateral blocked fallopian tubes.
- 3. Ova and sperm are needed for instillation into the fallopian tube.
- 4. Fertilized ova are instilled into the vagina to enter the uterus.

**166.** When assessing for oxygenation in a client with dark skin, the nurse should examine the client's:

- 1. Skin.
- 2. Buccal mucosa.
- 3. Nape of the neck.
- 4. Forehead.

**167.** Which of the following rehabilitative measures should the nurse teach the client to perform after chest surgery to prevent shoulder ankylosis?

- 1. Turn from side to side.
- 2. Raise and lower the head.
- 3. Raise the arm on the affected side over the head.
- 4. Flex and extend the elbow on the affected side.

**168.** A client with a tracheostomy tube coughs and dislodges the tracheostomy tube. The nurse's first action should be to:

- 1. Call for emergency assistance.
- 2. Attempt reinsertion of tracheostomy tube.
- 3. Position the client in semi-Fowler's position with the neck hyperextended.
- 4. Insert the obturator into the stoma to reestablish the airway.

**169.** An infant is to return to the clinic for a regular check-up and receive immunizations. In preparation for this next visit, which of the following should the nurse suggest to the parents?

- 1. "Be prepared for the infant to be very fussy."
- 2. "Give the infant acetaminophen (Tylenol) before coming."
- 3. "Plan to keep the infant out of day care for that day."
- 4. "Bring someone else to the appointment to support you."

**170.** A first-time mother is concerned that her 6-month-old infant is not gaining enough weight. The best response for the nurse to make is which of the following?

- 1. "Birth weight doubles by 6 months of age."
- 2. "Birth weight doubles by 3 months of age."
- 3. "The baby will eat what he needs."
- 4. "You need to make sure the baby finishes each bottle."

**171.** In accurately assessing a client who reports a back injury, it is critical for the nurse to question the client concerning which of the following?

- 1. Family history of back problems.
- 2. Previous hospitalizations.
- 3. Personal history of illness.
- 4. Mechanism of injury.

**172.** A client is taking antihypertensive medication. The medication is effective if it:

- 1. Lowers the blood pressure.
- 2. Increases the heart rate.
- 3. Improves circulation in the extremities.
- 4. Decreases dyspnea.

**173.** The nurse is examining a client with possible early rheumatoid arthritis. Which of the following symptoms should the nurse observe?

- 1. Nausea.
- 2. Joint swelling.
- 3. Fatigue.
- 4. Limitation of movement.

**174.** The nurse instructs the client in mixing and administering regular and NPH insulin. Which of the following statements indicates that the client needs additional instruction?

- 1. "I draw up the regular insulin first."
- 2. "I shake the bottle of NPH insulin before drawing it up."
- 3. "I store the insulin in a cool place."
- 4. "I insert the needle at a 90-degree angle."

**175.** The mother of a child with newly diagnosed Duchenne's muscular dystrophy asks how her child developed the disease. The nurse formulates a response incorporating which of the following statements about its transmission?

- 1. It is an autosomal recessive genetic disorder.
- 2. It is a genetic disorder carried by males and transmitted to male children.
- 3. It is a disorder primarily transmitted by males in the family.
- 4. It is a disorder usually carried by females and transmitted to male children.

**176.** Which of the following should the nurse identify as a priority nursing diagnosis for an infant with intussusception?

- 1. *Deficient fluid volume.*
- 2. *Diarrhea.*
- 3. *Impaired skin integrity.*
- 4. *Acute pain.*

**177.** The physician orders I.V. cefazolin (Kefzol) 1 g for a client. In preparing to administer the Kefzol, the nurse notes that the client is allergic to penicillin. Based on this information, what is an appropriate action for the nurse to take?

- 1. Continue to prepare to administer the Kefzol as ordered.
- 2. Notify the physician of the client's allergy to penicillin.
- 3. Administer the Kefzol, staying at the client's bedside during the infusion.
- 4. Call the pharmacist to verify that the Kefzol should be administered as ordered.

**178.** A client is prescribed buspirone (BuSpar) 5 mg two times a day. Which of the following statements indicates that the client has understood the nurse's teaching about this drug? Select all that apply.

- 1. "This medicine will make me sleepy."
- 2. "BuSpar will relax my muscles."
- 3. "My anxiety will be completely gone by tomorrow."
- 4. "BuSpar will help me not to worry so much."
- 5. "I'll be able to focus better."

**179.** When a client has a tearing of tissue with irregular wound edges, the nurse should document this as:

- 1. Contusion.
- 2. Abrasion.
- 3. Laceration.
- 4. Colonization.

**180.** A client with schizophrenia is responding well to risperidone (Risperdal) and is no longer psychotic. After teaching the client about managing his illness, which of the following statements reflects a need for further education?

- 1. "I just don't know if I can afford to keep taking medicines every day."
- 2. "When my thoughts start racing, I know I need to relax more."
- 3. "I can name the side effects of Risperdal, but I'm not having any."
- 4. "I don't listen to my mom's religious beliefs about not using medicines."

## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

**1. 1.** One serving of fruit is equivalent to one-fourth of a cantaloupe. The client needs 6 oz of a vegetable juice cocktail, two tomatoes, or two raw apricots to meet one fruit serving.

🔑 CN: Basic care and comfort; CL: Evaluate

**2. 2.** *Respondeat superior* is Latin for "The master is responsible for the acts of his servants." The nurse, as an employee of the hospital, acted according to the established policy of the hospital. Because the nurse followed hospital policy, it is unlikely that this incident involved malpractice, negligence, or tort law.

🔑 CN: Management of care; CL: Evaluate


**3. 3.** The surgeon is required to give the client explanations and have questions answered. The nurse has no way of assessing the client's understanding without the interpreter. The client should sign the Spanish consent form only after receiving an explanation of the procedure, its risks, and alternatives. A family member cannot be relied on to translate the surgeon's instructions. The nurse



is commonly asked to witness the explanation and to obtain the client's signature on the informed consent form. Informed consent is the provision of information concerning the procedure and its risks, not obtaining the client's signature on the form. The surgical charge nurse does not need to be notified.

 CN: Management of care; CL: Synthesize


**4. 2.** Timolol can cause some eye discomfort when administered. It is important for the client to continue to take the drug. Glaucoma eyedrops should be administered as prescribed, not whenever the client desires. The client with glaucoma needs to take eye medication on an ongoing basis to control the disorder and prevent vision damage. There is no need to refrigerate the drug.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**5. 1.** The nurse's best response when a child asks if cardiac catheterization is painful is to explain that the child will feel a little stinging when the numbing medicine is inserted into the area around the introduction site of the catheter. There may also be a feeling of pressure when the catheter is introduced. The child's trust in the nurse will be quickly lost if the nurse is untruthful. The child is usually sedated and feels little during the procedure.

 CN: Reduction of risk potential;  
CL: Synthesize

**6. 1.** This client has a barrel chest. The anterior-posterior diameter of the chest is larger than the transverse diameter, as is characteristic of the client with chronic obstructive pulmonary disease. Although the client may be muscular, the barrel chest is not associated with the client's age, height, or weight. Use of bronchodilators will not change the shape of the client's chest.


 CN: Physiological adaptation;  
CL: Analyze

**7. 2.** Fetal acoustic stimulation involves the use of an instrument that emits sound levels of approximately 80 dB at a frequency of 80 Hz. The sharp sound startles and awakens the fetus and is used with nonstress testing as a method to evaluate fetal well-being. A fetoscope or Doppler stethoscope is used to listen to the fetal heart rate. Nipple stimulation or intravenous oxytocin is used to stimulate contractions. Ultrasound testing is used to determine amniotic fluid volume.

 CN: Reduction of risk potential;  
CL: Apply

**8. 2.** Typically, iron supplements are needed for at least 1 month. By the end of this time, there should be a significant rise in the hemoglobin and hematocrit. Therefore the mother needs to continue

the iron supplements for several more weeks. Testing the child after only 2 weeks of treatment may not be beneficial. A significant rise in hemoglobin and hematocrit usually requires approximately 1 month of therapy. An iron-rich diet should have been started when the diagnosis was made and continued for at least the duration of iron supplement therapy.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**9. 1.** The dietary department should meet with the client to ensure that the foods are available and prepared according to her religious beliefs. On admission, the client should be asked whether there are special dietary needs. The dietary department should be notified of these special needs, and a dietary representative should meet with the client and family when possible. The physician should be consulted if a requested food is contrary to a prescribed diet restriction. The unit case manager does not need to be contacted regarding a dietary request. The rabbi is not involved in dietary requests.

 CN: Management of care; CL: Apply

**10. 3.** The nurse must act as an advocate for the client when the client cannot afford treatment. It is possible to substitute a less expensive antibiotic. Correct procedure includes contacting the physician to explain the mother's economic situation and request a substitution. For example, amoxicillin (Amoxil) is more economical than azithromycin.


 CN: Management of care; CL: Synthesize

**11. 1, 2, 3, 6, 7.** The important information to be given with a preeclamptic client should include blood pressure trends while being monitored and the protein that is and has been present in the urine as these are indicators of increasing eclampsia. Edema of the face, a history of headache, blurred vision, and epigastric pain are important as these also indicate worsening pre-eclampsia. The fetal position at 25 weeks is of minor importance as the fetus is constantly changing positions at this point in the pregnancy. The medical and nursing interventions utilized to treat preeclampsia will provide the nurse on the antenatal unit with information about what has been utilized and their effect. The use of dietary sodium does not have an impact on preeclampsia. Glycosuria is an important consideration if this client has gestational diabetes, but is not significant for the client with preeclampsia.

 CN: Safety and infection control;  
CL: Synthesize

**12. 2.** Nitroglycerin causes vasodilation, which results in increased intraocular pressure. The vasodilatory effects of the medication can trigger an attack, causing pain and loss of vision. Hypotension


is a common side effect of nitroglycerin, which dilates the blood vessels but is not a concern in the client with glaucoma.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**13. 3.** The timing of symptoms is important to the diagnosis of PMS. The client should keep a 3-month log of symptoms and menses. With PMS, the symptoms begin 3 to 7 days before menses and resolve 1 to 2 days after the menstrual cycle has started. Menstrual cycle irregularity and mood swings after menses are not related to PMS, and other causes should be investigated. Midcycle spotting and pain are related to ovulation.

 CN: Health promotion and maintenance; CL: Analyze

**14. 2.** The client who has received general anesthesia with halothane or other neuromuscular blocking agents must be carefully monitored when given clindamycin. A serious interaction is enhanced neuromuscular blockage, skeletal muscle weakness, or respiratory depression if this combination is used during or immediately after surgery. Concurrent use should be avoided. The combined effect of the medications places the client at increased risk and the nurse should assess the client closely for respiratory depression or paralysis. The nurse will be monitoring the client's heart rate, blood pressure, and urinary output, but not specifically because of potential drug interactions and adverse effects of clindamycin.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**15.**


2. Start an I.V. infusion with normal saline solution.

1. Obtain a fingerstick test for blood glucose.

4. Notify the physician.

3. Administer Lispro.

The client is experiencing ketoacidosis. The first action is to initiate I.V. fluids to prevent further dehydration. Next, the nurse should obtain serum glucose values to report to the physician, who will then order the appropriate dose of insulin.


 CN: Physiological adaptation; CL: Synthesize

**16. 4.** The child is in respiratory distress and is sitting in a position to relieve the airway obstruction; the nurse should provide a humidified

environment with a croup tent with cool mist to facilitate breathing and liquefy secretions. The child should remain sitting to facilitate breathing; the nurse should allow the child to determine the most comfortable position. After the child is breathing normally, the nurse can offer fluids; the physician also may order intravenous fluids. The nurse can call the rapid response team if the respiratory distress is not relieved by using a croup tent or other vital signs changes indicate further distress.

 CN: Reduction of risk potential; CL: Synthesize

**17. 2.** When ovulation is suppressed for 6 to 8 months after oral contraceptive use, the physician may prescribe clomiphene citrate to stimulate ovulation. Clomiphene acts to give the hypothalamus the signal to increase secretion of follicle-stimulating hormone and luteinizing hormone, thereby stimulating ovulation. Dienestrol is an estrogen applied topically to treat atrophic vaginitis and kraurosis vulvae in postmenopausal women. Medroxyprogesterone is a progesterone derivative that prevents maturation of the follicle and ovulation. Norgestrel is a progesterone-only contraceptive that is believed to alter the cervical mucus, possibly suppress ovulation, and interfere with implantation in the uterus.

 CN: Pharmacological and parenteral therapies; CL: Apply

**18. 1.** Hospice programs are appropriate programs for clients with any type of terminal illness when death is imminent within weeks up to 6 months. Clients may discuss their prognosis of a terminal illness before it progresses to the terminal stage when a referral to hospice care is indicated.

 CN: Management of care; CL: Apply

**19. 1.** Several irregularly shaped red patches, common skin variations in neonates, are termed stork bites. They eventually fade away as the neonate grows older. Port wine stains are disfiguring darkish red or purplish skin discolorations on the scalp and face that may need laser therapy for removal. Newborn rash is typically generalized over the body, not localized to one body area, and is commonly raised. Café au lait spots are brown and typically found anywhere on the body. More than six spots or spots larger than 1.5 cm are associated with neurofibromatosis, a genetic condition of neural tissue.


 CN: Health promotion and maintenance; CL: Analyze

**20. 3.** In the traditional Mexican household, the man is the head of the family and makes the major decisions. Efforts should be made to reach the father as soon as possible to acquire his permission. It is not necessary to contact the social worker at this point. The client has not refused the procedure, so it


is premature to contact the physician. This is not a situation of suspected child abuse.

 CN: Management of care; CL: Synthesize

**21. 1.** In the cognitively impaired client, benzodiazepines, such as lorazepam, can increase confusion and nighttime agitation. Extrapyramidal side effects are more common with antipsychotics. Vomiting and sweating are signs of benzodiazepine withdrawal. Anticholinergic side effects are more likely with antipsychotics and tricyclic antidepressants.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**22. 4.** A woman with a uterus who takes unopposed estrogen has an increased risk of endometrial cancer. The addition of progesterone prevents the formation of endometrial hyperplasia.

 CN: Pharmacological and parenteral therapies; CL: Apply

**23. 2.** The client who is 18 weeks' IUP is not stable with bright red vaginal bleeding. Even with a non-viable fetus, the mother is in jeopardy with continued bleeding. The client who is 9 weeks' IUP and has not vomited for 12 hours appears stable at this point with a non-viable fetus. The G8 also appears stable as her bleeding has tapered off since admission. The 29-week gestation client carrying twins has no information indicating that she is in jeopardy, with no contractions in the past two hours, and is becoming more stable.


 CN: Health promotion and maintenance; CL: Synthesize

**24. 3.** The nurse should monitor the client's serum albumin. A decreased serum albumin indicates malnutrition and is considered a risk factor in the development of pressure ulcers. Other risk factors include immobility, incontinence, and decreased sensation. Having the client walk and inserting an indwelling catheter require a physician's order. The white blood cell count is monitored if an infection is present.

 CN: Physiological adaptation; CL: Synthesize

**25. 4.** The nurse should recognize the ringing in the ears, or tinnitus, as a sign of ototoxicity probably caused by the furosemide. The appropriate action is for the nurse to stop the furosemide and notify the physician. If the drug is stopped soon enough, permanent hearing loss can be avoided and the tinnitus should subside. The nurse should note the observation in the chart but should not delay action. Tinnitus is not a symptom of digoxin (Lanoxin) toxicity. Aspirin can cause tinnitus, but the nurse should


first investigate the obvious cause of tinnitus, which in this case is the furosemide.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**26. 2, 3, 4.** The client should recognize the signs of potential thermal dangers to prevent skin breakdown. He should be instructed to wear clean, loose, soft cotton socks so that the feet are comfortable, air can circulate, and moisture is absorbed. In the winter or if the client complains of cold feet, the client should be encouraged to wear an extra pair of socks and a larger shoe size. Getting a sunburn during the summer puts the client at risk for tissue injury and skin breakdown. Using a heating pad to warm the feet or using an electric blanket places the client at risk for injury and should be avoided.

 CN: Reduction of risk potential; CL: Create

**27. 3.** The peak serum dose of an antibiotic is drawn 30 minutes after the completion of the I.V. dose of the antibiotic.


 CN: Pharmacological and parenteral therapies; CL: Apply

**28. 1.** ICP is highest in the early morning, and the client with hydrocephalus may be experiencing signs of increased ICP that need to be treated. The increased ICP is not related to fluid levels, and the nurse should not advise the client to increase fluid intake. While ICP does fluctuate during the day, it is highest in the morning and the nurse should notify the physician. Pain medication will not treat the potentially increasing ICP and may mask important signs of increasing ICP.


 CN: Physiological adaptation; CL: Synthesize

**29. 1.** The nurse should instruct the client that symptoms from an occasional headache due to eye strain or continuous work at a computer can be relieved by acetaminophen. Although this drug causes prostaglandin inhibition, this effect is rapidly reversed and cleared with no apparent harmful effects in pregnancy. If the headaches become more frequent or severe, the client should be instructed to contact her health care provider immediately. Aspirin should be avoided during pregnancy because it inhibits prostaglandin synthesis. It also decreases uterine contractility and may delay the onset of labor or prolong pregnancy and labor. Aspirin decreases platelet aggregation, possibly increasing the risk of bleeding. Ibuprofen and naproxen can lead to premature closure of the fetal ductus arteriosus and decreased amniotic fluid with prolonged

use. They may also prolong pregnancy or labor because of their antiprostaglandin effects.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**30. 1.** With this level of anger in a crisis, the father needs simple but firm directions to leave the room, calm down, and then to talk. Doing so relieves the daughter of any pressure from her father. Telling the father to stop yelling or be quiet provides no concrete directions to the father and may embarrass him in front of his daughter. Telling the father that if he doesn't stop yelling, the nurse will call Security is a threat, possibly leading to an escalation of the situation.

 CN: Psychosocial adaptation; CL: Synthesize


**31. 2.** Epidemiologic and experimental research studies indicate that African Americans are more likely to develop severe hypertension.

 CN: Health promotion and maintenance; CL: Analyze


**32. 1.** A large pad of fat at the back of the neck, widely set eyes, a simian crease in the hands, and epicanthal folds are typically associated with Down syndrome. The nurse should notify the physician immediately. The physician should obtain consent for genetic studies and is responsible for explaining these deviations to the parents. However, the nurse may need to provide additional teaching to the mother and to answer any questions that may arise.

 CN: Health promotion and maintenance; CL: Synthesize

**33. 1.** Clients receiving chronic steroid therapy can become immunosuppressed and are prone to infections. Signs of infection can also be masked with prednisone. Signs and symptoms of infection should be reported immediately. Joint pain, constipation, and joint swelling are not related to the adverse effects of steroid therapy.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**34. 2.** Injury and death from firearms is a major public health problem in the United States. One reason that this is such an epidemic is that children, grandchildren, and neighbor children have easy access to firearms.


 CN: Safety and infection control; CL: Analyze

**35. 4.** School-age children enjoy board games and are commonly intense about following rules. Their play can become emotional. Adequate rest is of utmost importance during the acute stage of rheumatic fever. Therefore, playing a game with


another child probably would be too strenuous. Such diversional activities as reading a book, playing with a doll, and watching television would be more satisfactory.

 CN: Health promotion and maintenance; CL: Synthesize


**36. 2.** Women who take oral contraceptives are at increased risk for thromboembolic conditions. Severe calf pain needs to be investigated as a potential sign of deep vein thrombosis. Breakthrough bleeding, mild headache, or weight gain may be common benign side effects that accompany oral contraceptive use. Clients may be monitored for these side effects without a change in treatment.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**37. 4.** The priority for a client with a new tracheostomy is to maintain a patent airway. A new tracheostomy commonly causes bleeding and excess secretions, and the client may require frequent suctioning to maintain a patent airway.

 CN: Reduction of risk potential; CL: Synthesize

**38. 3.** The nurse should assess the client's vital signs because he is most likely having a reaction to the bupivacaine. If the client's vital signs are abnormal, immediate intervention may be necessary. Although the nurse may ask the client to continue to describe how he is feeling, this is not likely to be a psychosocial reaction. Simple reassurance is inappropriate in most clinical situations and can be dangerous if physiologic causes of restlessness are overlooked. The nurse should not administer epinephrine until vital signs have been assessed.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**39. 2.** Endometrial cancer has very few warning signals; irregular bleeding may be the only sign. Any irregular bleeding in a menopausal woman should be investigated, and an endometrial biopsy may be ordered. Hot flashes result from the decreased estrogen levels that accompany menopause. Urinary urgency should be monitored and treated as a separate problem. Dyspareunia is the occurrence of pain in the labial, vaginal, or pelvic areas during or after sexual intercourse. It may be caused by inadequate vaginal lubrication in the menopausal woman.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**40. 1.** Cystic fibrosis is an autosomal recessive genetic disorder. This means that both parents have the gene. There is a one in four chance with each

pregnancy from such parents that the child will have cystic fibrosis.

 CN: Physiological adaptation;  
CL: Synthesize


**41. 4.** Trichomoniasis is caused by a protozoan. Although the client may not have symptoms, the classic symptom of trichomoniasis is a malodorous, yellow-green discharge. Gonorrhea, syphilis, and chlamydia do not commonly manifest as a vaginal discharge.

 CN: Physiological adaptation;  
CL: Analyze

**42. 4.** Incentive spirometry promotes lung expansion and increases respiratory function. When used properly, an incentive spirometer causes sustained maximal inspiration and increased cardiac output.

 CN: Reduction of risk potential;  
CL: Evaluate


**43. 4.** At this level of aggression, the client needs an appropriate physical outlet for the anger. She is beyond writing in a journal. Urging the client to talk to the nurse now or making threats, such as telling her that she will be restrained, is inappropriate and could lead to an escalation of her anger.

 CN: Psychosocial adaptation;  
CL: Synthesize

**44. 3.** Variable decelerations are associated with compression of the umbilical cord. The nurse should alter the client's position and increase the I.V. fluid rate. Fetal head compression is associated with early decelerations. Severe compression of the fetal chest, such as during the process of vaginal delivery, may result in transient bradycardia. Compression or damage to the placenta, typically from abruptio placentae, results in severe, late decelerations.

 CN: Reduction of risk potential;  
CL: Analyze


**45. 1, 2, 3, 4.** DIC is diagnosed based on clinical symptoms and laboratory findings. Excessive and unusual bruising or bleeding over areas of tissue trauma, such as I.V. insertion or incision sites or application of a blood pressure cuff, is observed. Tachycardia and diaphoresis also may be noted. Laboratory results reveal low platelet, fibrinogen, proaccelerin, antihemophilic factor, and prothrombin levels. Bleeding time is normal and partial thromboplastin time is increased. A urine output of 350 mL in 8 hours indicates adequate renal function. Temperature is not an indication of DIC.

 CN: Physiological adaptation;  
CL: Analyze


**46. 2.** If the chest tube is accidentally pulled out (a rare occurrence), a petroleum jelly gauze and sterile 4-× 4-inch dressing should be applied over the chest wall insertion site immediately. The dressing should be covered with adhesive tape and be occlusive, and the surgeon should be notified. The lungs can be auscultated and vital signs can be taken after the dressing is in place and the surgeon has been called.

 CN: Reduction of risk potential;  
CL: Synthesize

**47. 4.** Emboli obstruct blood flow, leading to a decreased perfusion of the lung tissue. Because of the decreased perfusion, a ventilation-perfusion mismatch occurs, causing hypoxemia to develop. Arterial blood gas analysis typically will indicate hypoxemia and hypocapnia. A priority objective in the treatment of pulmonary emboli is maintaining adequate oxygenation. A nonproductive cough and activity intolerance do not indicate impaired gas exchange. The client does not demonstrate an ineffective breathing pattern; rather, the problem of impaired gas exchange is caused by the inability of blood to flow through the lung tissue.

 CN: Physiological adaptation;  
CL: Synthesize

**48. 3.** Cardiogenic shock occurs when myocardial contractility decreases and cardiac output greatly decreases. The circulating blood volume is within normal limits or increased. Infarction is not always the cause of cardiogenic shock.

 CN: Physiological adaptation;  
CL: Analyze


**49. 1.** The nurse should expect to find decreased levels of thyroxine and triiodothyronine and increased thyroid-stimulating hormone. Other indicators of hypothyroidism are the presence of antithyroid antibodies and elevation of the creatine phosphokinase (CPK-MM) level. Hypothyroidism has a metabolic effect on skeletal muscle. Muscle injury results, causing the CPK-MM to spill out of the damaged cells and into the bloodstream.

 CN: Physiological adaptation; CL: Analyze


**50. 3.** Although chronologically the infant is 7 months old, because of being born 6 weeks early, the child is only 5½ months old developmentally. Appropriate activities for a 5- to 5½-month-old infant include placing a rattle or ball in the infant's hand. Picture books are an appropriate choice for an infant older than 9 months. Playing peek-a-boo is appropriate for a 9- to 12-month-old infant. Colored blocks are appropriate for a toddler approximately age 15 to 18 months.

 CN: Health promotion and maintenance;  
CL: Synthesize

**51. 3.** Accurate daily weight measurement provides the best measure of a client's fluid status: 1 kg (2.2 lb) is equal to 1,000 mL of fluid. To be accurate, weight should be obtained at the same time every day, with the same scale, and with minimal clothing on.

 CN: Physiological adaptation;  
CL: Analyze


**52. 2.** Full benefit from an antidepressant medication usually takes about 2 to 4 weeks on an adequate dose.

 CN: Pharmacological and parenteral therapies; CL: Apply


**53. 2.** Fine tremors are the first symptom reported in 70% of clients with Parkinson's disease. A new onset of tremors needs to be investigated by the physician. Tremors are not an expected change with aging.

 CN: Reduction of risk potential;  
CL: Synthesize

**54. 1.** Loss of appetite is one of the more common adverse effects associated with methylphenidate. Although nausea is associated with this drug, vomiting is not. Photosensitivity is not associated with this drug. Because of decreased appetite, the client will not gain more weight.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**55. 2.** The pH of 7.26 indicates that the body is in a state of acidosis. The elevated partial pressure of carbon dioxide value accompanied by a normal bicarbonate value indicates that the acid-base imbalance is respiratory acidosis. The additional clinical findings of a headache, dizziness, and increased pulse rate, resulting from the elevated partial pressure of carbon dioxide, further supports this diagnosis.


 CN: Physiological adaptation;  
CL: Analyze

**56. 1, 2.** The purpose of continuous quality improvement (CQI) is to improve a local process to benefit clients and providers; it is required by the institution, regulatory, or accrediting agencies. The approach to the problem can be retrospective or concurrent; IRB approval is not required unless the results will be made available to external parties and specific clients could be identified. CQI is performed by clinicians and managers who are part of the process being studied; the timeframe is continuous or cyclical.


 CN: Management of care; CL: Synthesize

**57. 1.** With a client in metabolic alkalosis, the nurse should monitor for hypokalemia. Metabolic


alkalosis can cause potassium to shift into the cells, resulting in a decrease of serum potassium. In metabolic alkalosis, the body tries to compensate by conserving carbon dioxide, so there is no need to have the client inhale carbon dioxide, as would be the case if hyperventilation were occurring. There is already a base bicarbonate excess with this condition, so the nurse should not administer sodium bicarbonate. Unless symptoms dictate, the client does not need to be placed on bed rest.

 CN: Physiological adaptation;  
CL: Synthesize

**58. 1.** To reduce the risk of crystalluria, the client should drink 2,000 to 3,000 mL of water a day, not 1,000 to 1,500 mL. The client should not take an antacid before taking Cipro. An antacid decreases the absorption of the Cipro. The client should let the doctor know if vomiting occurs from the medication. The client may get light-headed from the Cipro. If so, the client should not drive a motor vehicle and should contact the physician.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**59. 4.** Stress management is not beneficial to the client with Alzheimer's disease because of cognitive impairment, confusion, and short-term memory loss. Reminiscence group, walking, and pet therapy is beneficial.

 CN: Psychosocial adaptation;  
CL: Synthesize

**60. 1, 3.** When a child with hemophilia develops bleeding into a joint, the parents should have the child rest and begin factor VIII therapy. If therapy is started immediately, usually other interventions such as ice are not necessary. Heat causes vasodilation and promotes bleeding. Starting factor VIII immediately helps prevent chronic joint disease. Starting physical therapy further traumatizes the joint, possibly increasing the bleeding. Applying a topical agent does not control internal bleeding.

 CN: Reduction of risk potential;  
CL: Create


**61. 2.** The priority long-term nursing diagnosis for this child is *Risk for injury*. This is always a concern for the child with hemophilia. As with all chronic illnesses, there is a potential for self-esteem problems, but no data are presented to support this diagnosis. The parents should have a good understanding of the disease process and realize the importance of obtaining regular health care for their child. *Acute pain* is an appropriate nursing diagnosis for the child who has bleeding into a joint, but this is a transient situation.

 CN: Reduction of risk potential;  
CL: Synthesize


**62. 3.** A 3-year-old child responds best to distraction during a procedure because of the typical level of cognitive development of a 3-year-old and the fear of painful events. Preparation for the procedure should be done immediately beforehand, so that the child will not become too frightened. A 3-year-old is not concerned about the why of the procedure but about whether the procedure will hurt. This child is too young for verbal explanations alone because of the limited verbal abilities at this age and the fear of a painful event.

 CN: Health promotion and maintenance;  
CL: Synthesize


**63. 3.** Lisinopril is an angiotensin-converting enzyme (ACE) inhibitor. Hyperkalemia can be a side effect of ACE inhibitors. Because of this side effect, ACE inhibitors should not be administered with potassium-sparing diuretics.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**64. 4.** Medication noncompliance is a primary cause of exacerbation in chronic mental illnesses. Of the issues listed, medications should be addressed first. Other issues, such as family, marriage, and finances can be addressed as client stabilization is maintained.

 CN: Psychosocial adaptation;  
CL: Synthesize

**65. 4.** I.V. fluids should not be infused for longer than 24 hours because of the risk of bacterial growth in the solution. The appropriate action for the nurse to take is to discontinue the current TPN solution, change the tubing, and hang a new bag of solution. Changing the filter does not decrease the risk of contamination. Notifying the physician for a change in flow rate is not an acceptable solution.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**66. 3.** The nurse's first response is to further assess the client's pain. After a thorough assessment, additional appropriate actions may be to notify the physician, administer an analgesic, and administer oxygen.

 CN: Basic care and comfort;  
CL: Synthesize

**67. 4.** Trisomy 13 (Patau's syndrome) is an autosomal disorder. Characteristics include cleft lip and palate, polydactyly, malformed ears, and mental retardation. These neonates typically die during infancy. A webbed neck is associated with Turner's syndrome (45 total chromosomes). Small testes and absence of sperm are associated with Klinefelter's syndrome (47 chromosomes). Congenital heart


defects are associated with trisomy 21 (Down syndrome) and trisomy 18 (Edwards' syndrome).

 CN: Physiological adaptation;  
CL: Synthesize


**68. 2.** Neurologic symptoms, such as footdrop, or bowel or bladder changes should be reported to the physician immediately. When musculoskeletal strain causes back pain, these symptoms may take 4 to 6 weeks to resolve. As an accompanying symptom of acute low back pain, the client may have a diffuse, aching sensation in the L4 to L5 area, pain in the lower back when the leg is lifted, or pain that radiates to the hip.

 CN: Reduction of risk potential;  
CL: Analyze


**69. 2.** Taking ginseng when on insulin is not encouraged because ginseng increases the risk of hypoglycemia. Ginseng can be therapeutic in certain situations, but is potentially harmful for clients taking insulin. Taking ginseng with a carbohydrate will not offset the effect of the ginseng.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**70. 2.** The expected effect of lactulose is for the client to have two to three soft stools a day to help reduce the pH and serum ammonia levels, which will prevent hepatic encephalopathy.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**71. 3.** Leukocytosis, an increased white blood cell count, indicates the presence of inflammation, infection, or a leukemia process. In inflammation and infection, the client's sedimentation rate is increased. Thrombocytopenia, a platelet deficiency, occurs in the client with leukemia, immunocompromise, aplastic anemia, or other conditions. Erythrocytosis, an elevation of the red blood cell count, occurs in polycythemia vera.

 CN: Physiological adaptation;  
CL: Analyze

**72. 4.** This girl has an exaggeration of the lumbar spine, swayback, or lordosis. Kyphosis is an increased convexity or roundness of the curve of the thoracic spine. Scoliosis is a lateral curvature of the spine.


 CN: Health promotion and maintenance;  
CL: Analyze

**73. 4.** The most appropriate action is to report the swelling, loss of mobility, and unrelieved pain to the physician. These symptoms are indicators of neurovascular impairment. Administering opioids will not eliminate the cause of the problem, which is unrelieved pressure on nerves and blood supply.

If prompt action (cutting the cast) is not taken to relieve the pressure, permanent muscular and neurologic injury may result. Applying the ice bag would have been appropriate earlier to decrease or prevent swelling, but applying it at this time could actually lead to further decreased circulation. The arm should be elevated, but the nurse cannot wait 30 minutes to reassess the client without risking permanent damage.

 CN: Reduction of risk potential;  
CL: Synthesize

**74. 1.** Prostaglandin  $F_{2a}$  promotes uterine contractions, thereby minimizing uterine atony and subsequent hemorrhage. Possible side effects include nausea, tachycardia, hypertension, and diarrhea. Abdominal distention is not associated with the use of prostaglandin  $F_{2a}$ .

 CN: Pharmacological and parenteral therapies; CL: Analyze

**75. 1.** Before 32 weeks' gestation, most neonates have difficulty coordinating sucking and swallowing reflexes along with breathing. Increased respiratory distress may occur with bottle feeding. Bottle feedings can be given after the neonate shows sucking and swallowing behaviors. High-calorie formulas can be given by bottle or by gavage feeding. Although frequent feeding prevents hypoglycemia, the feeding does not have to be given via a gavage tube. Although these neonates can be stressed by cold, they can be kept warm with blankets while being bottle-fed or fed while in the warm isolette environment.

 CN: Health promotion and maintenance;  
CL: Apply

**76. 2.** Regularly scheduled rest periods during the day along with 8 to 10 hours of sleep at night helps relieve the fatigue, pain, and stiffness associated with rheumatoid arthritis. Even with mild rheumatoid arthritis, the client may find it difficult to perform activities of daily living without some rest periods. Spending 1 day a week in bed to relieve fatigue does not adequately manage the disease. The client must recognize the need for rest before feeling exhausted because overexertion can cause exacerbations. In addition, prolonged periods of inactivity can increase joint stiffness and pain. Getting up early to do household chores before the children are awake does not allow for adequate rest.

 CN: Basic care and comfort; CL: Evaluate

**77. 3.** For the child with hemophilia who is actively bleeding, the nurse should apply direct pressure to the injured area for 10 minutes continuously along with elevating the leg. The continuous application of direct pressure aids in stopping the bleeding. Elevating the leg reduces blood flow to the


area, thereby minimizing the extent of blood loss. Although ice will cause local vasoconstriction and slow the bleeding, applying continuous direct pressure is essential.

 CN: Physiological adaptation; CL:  
Synthesize

**78. 4.** Hypothyroidism is not associated with pancytopenia. Various anemias are associated with pancytopenia owing to the reduction in all cellular elements of the blood. Bleeding and clotting difficulties can be associated with pancytopenia. Infection is a common danger associated with pancytopenia.

 CN: Physiological adaptation;  
CL: Analyze


**79. 2.** The client's return to the emergency department and her statement about not knowing what to do about being abused by her husband indicate that the client is asking for help. The nurse's best course of action is to explain the various options available to her. This helps the client make decisions based on appropriate knowledge. Research reveals that women are more likely to be killed by partners than by strangers. Although the client can legally leave her husband, this answer provides the client with no safety options. Listing ways to avoid making the husband angry ignores the dynamics of abuse and blames the victim.

 CN: Psychosocial adaptation;  
CL: Synthesize

**80. 3.** The nurse places a postoperative client who has had abdominal surgery in low Fowler's position. This position relaxes abdominal muscles and promotes maximum respiratory and cardiovascular function.


 CN: Reduction of risk potential;  
CL: Synthesize

**81. 1.** It is most important to know the child's serum potassium level when administering digoxin. Digoxin increases contractility of the heart and increases renal perfusion, resulting in a diuretic effect with increased loss of potassium and sodium. Hypokalemia increases the risk of digoxin toxicity. Verifying the dosage is specified by facility policy and varies among facilities. Although the child may take the medication better from the mother than from the nurse, asking the mother to give the medication is not necessary. In addition, this would be done after the nurse has checked the electrolyte levels. Teaching the parent how to measure the child's heart rate can be done at any time, not necessarily when preparing to give digoxin.


 CN: Pharmacological and parenteral therapies; CL: Synthesize




**82. 4.** During the emergent phase of burn management, there is a massive shift of fluid from the blood vessels (intravascular compartment) into the tissues (interstitial compartment). The result of this shift is hypovolemic shock and edema formation. The fluid shift, which occurs between the intravascular and interstitial extracellular compartments, is caused by increased capillary permeability that allows water, sodium, and protein to shift to the tissues. As the emergent period ends and capillary permeability returns to normal, the fluid in the interstitial compartment will return to the intravascular compartment.

 CN: Physiological adaptation;  
CL: Analyze

**83. 3.** A urine output of 30 to 50 mL/hour indicates adequate fluid replacement in the client with burns. An increase in body weight may indicate fluid retention. A urine output greater than fluid intake does not represent a fluid balance. Depending on the client, blood pressure of 90/60 mm Hg could indicate the presence of a hypovolemic state; by itself, it does not indicate adequate fluid replacement.

 CN: Physiological adaptation;  
CL: Evaluate

**84. 1.** Many clients who experience abuse are hesitant to talk about it and need help to do so. The nurse should ask the client directly about abuse when it is suspected, using a sensitive, empathetic, and compassionate approach. In this way, the client can feel comfortable revealing information about the abuse. Telling the client that it's difficult to believe her injuries resulted from a fall is not helpful because it is blameful and puts the client on the defensive. Asking the client what she did to make someone hit her or discussing what she can do the next time blames and alienates the client.

 CN: Psychosocial adaptation;  
CL: Synthesize

**85. 1.** A primary outcome for the care of the client in shock is to achieve adequate tissue perfusion, thus avoiding multiple organ dysfunction. The lungs are susceptible to injury, especially acute respiratory distress syndrome. Vasoconstriction occurs as a compensatory mechanism until the client enters the irreversible stage of shock.

 CN: Reduction of risk potential;  
CL: Evaluate

**86. 3, 4, 5.** The neurologic system can be affected and cause long-term consequences in a young child exposed to lead. Common behavioral effects include hyperactivity, impulsivity, and aggression. Seizures may occur in a child with high-dose lead exposure.

Depression is not usually associated with lead exposure.

 CN: Physiological adaptation; CL: Apply


**87. 2.** The incident report includes only what the nurse saw and did—the objective data. The nurse does not try to interpret the likely cause of the incident, include statements from the client about the incident, or comment on extenuating circumstances.

 CN: Management of care; CL: Apply

**88. 1.** To reduce urethral irritation and allow drainage, the nurse should tape the Foley catheter to a female client's inner thigh. Taping the catheter also prevents excessive traction against the bladder neck. Taping the catheter to the groin or lower abdomen would not allow for proper drainage and would cause urethral discomfort. Taping the catheter to the lower thigh would pull on the catheter and cause urethral irritation.

 CN: Reduction of risk potential;  
CL: Apply

**89. 3.** The medications ordered for, administered to, or dispensed to the client while under the care of a health care organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved. A complete list of the client's medications is communicated to the next provider of service when a client is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. The complete, accurate list of medications is also provided to the client on discharge from the organization. The next provider of service checks the Medication Reconciliation List again to make sure it is accurate and in concert with any new medications to be ordered or prescribed.

 CN: Safety and infection control;  
CL: Analyze


**90. 1.** A neonate delivered by cesarean delivery has not had the benefit of the chest-squeezing action of a vaginal delivery, which helps remove some of the nasopharyngeal secretions. The nurse should place the neonate under the radiant warmer and suction the mouth and nares with a bulb syringe to remove nasopharyngeal secretions. A high-pitched cry is associated with neurologic involvement or neonatal drug withdrawal and is unrelated to cesarean delivery. Skull fractures may occur with difficult vaginal deliveries and are not typically seen with cesarean deliveries. Decreased muscle tone is associated with oversedation, neurologic impairment, or use of general anesthesia.

 CN: Health promotion and maintenance;  
CL: Analyze

**91. 2.** Accidental scaldings are usually splash-related and occur on the front of the body. Any burns on the back of the body or in a well-defined circular or glove pattern may indicate physical abuse. Immersion burns on the buttocks are also suspicious injuries.

 CN: Health promotion and maintenance;  
CL: Analyze

**92. 3.** A client exhibiting mild preeclampsia is initially treated with activity restriction. Bed rest, or lying on the left side, decreases pressure on the vena cava and improves circulatory blood flow. Restriction of visitors and a quiet environment are also necessary. I.V. magnesium sulfate, a central nervous system depressant, is usually ordered for the client with severe preeclampsia. Labetalol is used for the client with severe preeclampsia. Frequent monitoring of the client's blood pressure is important. However, hourly blood pressure checks are more routinely ordered for the client with severe preeclampsia. Additionally, the client needs to rest, and checking her blood pressure hourly could interfere with her ability to rest.

 CN: Reduction of risk potential;  
CL: Synthesize

**93. 4.** A dry tea bag placed on the bleeding area can be effective to control bleeding from lesions on the oral mucosa. The tannic acid in the tea apparently helps control bleeding.

 CN: Reduction of risk potential;  
CL: Synthesize

**94. 4.** The best treatment for a pressure ulcer is prevention. If a client has been determined to be at risk for developing a pressure ulcer, a systematic skin assessment should be conducted at least once per shift. Other preventive measures include daily gentle cleaning of the skin and avoiding harsh soaps and hot water, which are damaging to the skin. Massage of bony prominences is not done because it can increase damage to the underlying tissue. The client should be encouraged to change position at least every 2 hours to avoid pressure on any one area for a prolonged period.


 CN: Reduction of risk potential;  
CL: Synthesize

**95. 1.** The client needs further instructions when she says, "I should walk with my pelvis tilted backward." Walking in this position puts greater strain on the back. The client should walk with her pelvis tilted forward. Pelvic tilt exercises can also help the client with backaches. Putting a board under the mattress makes the mattress firmer and provides more support. Squatting and not bending to pick up objects helps decrease back strain. Squatting


involves the use of the large thigh muscles rather than those of the back. Flat or low-heeled shoes provide better balance and greater support and can help decrease backaches.

 CN: Reduction of risk potential;  
CL: Evaluate


**96. 4.** Urethritis is usually the initial clinical manifestation of gonorrhea in men. The symptoms include a profuse, purulent discharge and dysuria. Complications are uncommon, but they include prostatitis and sterility. Impotence, scrotal pain, and penile lesions are not associated with gonorrhea.

 CN: Safety and infection control;  
CL: Analyze

**97. 4.** Although the nurse needs to obtain and administer the medication as soon as possible, it is inappropriate for the nurse to go to the pharmacy and request the drug without first calling the pharmacy and checking to see whether the medication was delivered. The drug may have been delivered to several appropriate spots on the unit, such as the client's drug bin, the transport system, or the delivery box. The nurse should assess the client's blood pressure to determine the immediacy of the condition for which the medication was ordered.

 CN: Safety and infection control;  
CL: Synthesize

**98. 3.** The client with major depression suffers from lack of energy and withdrawal. The nurse should emphasize the importance of group involvement for the client to gain support from others and to see that others have similar problems and concerns. Attendance at group sessions and activities decreases social isolation and destructive rumination. The other statements are not therapeutic and interfere with increasing the client's involvement with others.

 CN: Psychosocial adaptation;  
CL: Synthesize

**99. 4.** An infant's sleeping longer than usual can indicate that the child is expending too much energy to breathe and is tiring, suggesting that the child's condition is getting worse. This should be reported to the physician. Fewer than seven wet diapers a day indicates that the child is not drinking enough. A temperature of 100° F (37.8° C) for longer than 2 days should be reported. Clear nasal drainage is normal. However, yellow nasal drainage lasting longer than 24 hours should be reported.


 CN: Reduction of risk potential;  
CL: Evaluate

**100. 4.** Direct application of warm moist heat would benefit a client with low back pain because the heat relaxes muscle spasms. Heat should not be

applied to a client who has appendicitis because it can lead to rupture of the appendix and peritonitis. Ice is applied to recently sprained joints to help decrease edema. Applying heat to the area of a suspected malignancy can increase blood flow to the tumor and promote nourishment of the cancer cells.

 CN: Basic care and comfort; CL: Analyze


**101. 3.** The client with pernicious anemia will require lifelong supplementation of vitamin B<sub>12</sub>, available through injection or nasal spray administration. It must be given in these forms to ensure absorption. Oral vitamin B<sub>12</sub> would not be absorbed because the client lacks the intrinsic factor in the stomach necessary for absorption. Chelation therapy is used to extract metals at toxic levels such as in lead poisoning.

 CN: Pharmacological and parenteral therapies; CL: Apply


**102. 10 mL**

To administer 20 mEq of potassium chloride, the nurse needs to administer 10 mL. The following formula is used to calculate the correct dosage:

$$\begin{aligned} 20 \text{ mEq}/X \text{ mL} &= 2 \text{ mEq}/1 \text{ mL} \\ X &= 10 \text{ mL} \end{aligned}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**103. 4.** When a client with major depression and suicidal ideation displays a sudden elevation in mood, seems calmer, has more energy, and is more peaceful, the nurse should judge these behaviors as an indication that a suicide attempt is imminent. These symptoms may indicate relief from ambivalent thoughts about suicide and that the client has an immediate plan for killing himself.

 CN: Psychosocial adaptation; CL: Analyze

**104. 3.** The purpose of a contraction stress test is to determine fetal response during labor. If late decelerations are noted with the contractions, the test is considered positive or abnormal. Fetal lung maturity is evaluated through amniocentesis to obtain the lecithin-sphingomyelin ratio. The nonstress test is part of the biophysical profile. Determining fetal response during movements is evaluated as part of the nonstress test.

 CN: Reduction of risk potential; CL: Apply

**105. 3.** Atypical pneumonia is characterized by a gradual onset of symptoms, such as dry cough, headache, sore throat, fatigue, nausea, and vomiting. Typical pneumonia is characterized by tachypnea, fever, chills, and productive cough with purulent sputum.

 CN: Physiological adaptation; CL: Analyze


**106. 2.** The primary reason for instructing the client with emphysema about how to pursed-lip breathe is to prolong exhalation. Prolonging exhalation helps to prevent bronchiolar collapse and the trapping of air. It does not directly prevent respiratory infection. Because pursed-lip breathing affects the expiratory phase of the respiratory cycle, it does not affect oxygenation. It may decrease shortness of breath, but this is not the primary reason for the technique.

 CN: Reduction of risk potential; CL: Apply

**107. 2.** The primary purpose of the automated dispensing machine for nurses is to keep an up-to-date record of the narcotic usage and count. The automated dispensing machine has eliminated the need for change-of-shift counts for narcotics. It does not include unmonitored access by nurses to narcotics, which would not be considered an advantage. The pharmacy has direct information about the narcotics being used on the client at what intervals and by whom, and it automatically records the charges of narcotics used. Not recording the charges would not be an advantage.

 CN: Management of care; CL: Apply


**108. 2.** Blunt chest trauma can lead to respiratory failure. Maintenance of adequate oxygenation is the priority for the client. Decreasing the client's anxiety is related to maintaining effective respirations and oxygenation. Although pain is distressing to the client and can increase anxiety and decrease respiratory effectiveness, pain control is secondary to maintaining oxygenation, as is maintaining adequate circulatory volume.

 CN: Physiological adaptation; CL: Synthesize


**109. 1.** An episiotomy that is edematous and slightly reddened 8 hours after delivery is normal. Therefore, the nurse should offer the client an ice pack to provide some relief from the perineal pain for the first 24 hours. An infection is present if greenish, purulent drainage is observed from the site. The edema and discoloration of the episiotomy at this time after delivery are normal and do not indicate that a hematoma is likely to develop. A laceration when repaired should appear intact with edges well-approximated, clean, and dry.

 CN: Health promotion and maintenance; CL: Analyze


**110. 3.** The Z-track technique is used with medications that are irritating to tissues. It allows the medication to be trapped in the muscle and prevents it from leaking back through the tissues.

 CN: Basic care and comfort; CL: Apply

**111. 2.** The nurse should limit the amount of telephone calls the client can make. Setting limits for a client with bipolar disorder, mania, helps to control the hyperactive client who has excessive goal-directed activity, especially when it interferes with the rights of other clients. Instructing the other clients to be patient is neither fair to them nor helpful to the hyperactive client in managing behavior. Reminding the client that others need to use the telephone will probably be futile because the client with mania is experiencing cognitive impairment and needs to be active. Taking away the client's telephone privileges is not the best action because the client has a right to use the telephone. The nurse is responsible for helping the client manage behavior by setting constructive limits.

 CN: Psychosocial adaptation;  
CL: Synthesize

**112. 4.** Because a toddler is strong and moves frequently, the child needs to be restrained during the removal procedure by a total body restraint. To protect the child, the papoose board is best because the arms, legs, chest, and head can be fully restrained. A jacket restraint would immobilize only the child's upper body. Elbow restraints would immobilize only the child's arms. The father should be available to provide comfort before and after the procedure, but not to hold the child down during the procedure.

 CN: Safety and infection control;  
CL: Synthesize


**113. 4.** Wheezing over one lung in the presence of lung cancer is most likely caused by obstruction of the airway by a tumor. Exudate would be more likely to cause crackles. The client's history of smoking would not cause unilateral wheezing. Pleural effusion would produce diminished or absent breath sounds.

 CN: Physiological adaptation; CL: Apply

**114. 1.** The client with diabetic ketoacidosis exhibits Kussmaul respiration, as well as flushed skin, dry mouth, urinary frequency, glucosuria, and ketonuria. Excessive hunger and high blood pressure are not associated with diabetic ketoacidosis.

 CN: Reduction of risk potential;  
CL: Apply

**115. 4.** For the client who has been receiving lithium therapy for the past 2 months, a maintenance serum lithium level of 0.6 to 1.2 mEq/L is considered therapeutic. A lithium level greater than 1.2 mEq/L suggests toxicity.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**116. 2.** One cup of sunflower seeds contains 15 mg of iron. During pregnancy, 30 mg of iron is recommended daily. One cup of lentils provides the equivalent of 6.9 mg of iron. One and one-half ounces of hard cheese provides the equivalent of the amount of calcium in 1 cup of milk. Two poached eggs provides only 2 mg of iron.

 CN: Health promotion and maintenance;  
CL: Synthesize

**117. 4.** The plan of care to treat fatigue associated with radiation therapy should include encouraging the client to remain active and to plan scheduled rest periods as necessary before activity. Engaging in activities, such as walking, has been shown to decrease the cycle of fatigue, anxiety, and depression that can occur during treatment. Fatigue is a very common side effect of radiation therapy that typically begins during the third or fourth week of treatment and persists until after treatment ends. The presence of fatigue does not mean that the cancer is not responding to treatment or that the client has developed another health problem.

 CN: Reduction of risk potential;  
CL: Synthesize

**118. 3.** Shearing forces occur because of improper movement and positioning, which causes the underlying tissues and capillary blood supply to be pulled and disrupted. This leads to tissue trauma and the potential beginning of skin breakdown. To prevent shearing, clients should be moved with the use of lift sheets and other devices, thus preventing dragging of the skin across the mattress and linens. Clients should also be positioned and supported to prevent pulling or tension of the skin across bony prominences. Turning clients, if not done properly, can cause shearing injuries. Keeping the skin clean, dry, and lubricated is an important aspect of care, but care must be used to decrease the amount of pulling forces exerted on the tissues.

 CN: Reduction of risk potential;  
CL: Apply

**119. 4.** The proper use of crutches requires supporting the body weight primarily on the hands. Improper use of crutches can cause nerve damage from excess pressure on the axillary nerve.


 CN: Reduction of risk potential;  
CL: Apply

**120. 4.** Because this family is waiting for the child to die, the most appropriate nursing diagnosis is *Grieving*. Families grieve at the time of diagnosis as well as during the illness, as the child is dying, and after death has occurred. This is a normal process


and does not indicate *Disabled family coping*, *Impaired parenting*, or *Fear*.

 CN: Psychosocial adaptation;  
CL: Analyze

**121. 2.** For the child with croup, assessing the child's respiratory status is the priority. It is especially important to assess airway patency because laryngeal spasms can occur suddenly. After the nurse has assessed the toddler's respiratory status, having a tracheostomy set at the bedside would be the next priority. Monitoring vital signs is important, as is ensuring adequate fluid intake to keep secretions loose, but assessing respiratory status is key.

 CN: Physiological adaptation;  
CL: Synthesize


**122. 2.** I.V. solutions are ordered based upon the fluid and electrolyte status of the client, so laboratory results should be monitored first. Safety recommendations are for standard premixed solutions. If solutions are not premixed, additives are completed by the pharmacy, not at the bedside. Potassium chloride is never given by I.V. push because this could be fatal. Administration guidelines require no more than 10 mEq of potassium chloride be infused per hour on a general medical-surgical unit. An infusion device or pump is required for safe administration.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**123. 4.** Research indicates that vitamin B<sub>6</sub>, vitamin B<sub>12</sub>, and folate may help to clear homocysteine from the blood. Elevated homocysteine correlates with a high incidence of heart and artery disease.

 CN: Health promotion and maintenance;  
CL: Apply


**124. 1.** Neuromuscular irritability is usually the first indication that a client has developed a low serum calcium level. Numbness and tingling around the mouth as well as in the extremities is an early sign of neuromuscular irritability. Depressed reflexes, decreased memory, and ventricular dysrhythmias are indications of hypercalcemia.

 CN: Physiological adaptation;  
CL: Analyze


**125. 2.** In emphysema, the anteroposterior diameter of the chest wall is increased. As a result, the client's breath sounds may be diminished. Fine crackles are present when there is fluid in the lungs. Stridor occurs as a result of a partially obstructed larynx or trachea; stridor can be heard without auscultation. A pleural friction rub is present when pleural surfaces are inflamed and rub together.

 CN: Physiological adaptation;  
CL: Analyze

**126. 4.** The client with paranoid personality disorder interprets the actions of others as personal threats and feels vulnerable. He questions and is overly sensitive to others' motives. Saying, "They're laughing at a joke John told. They aren't laughing at you," is a simple explanation of others' behavior, which helps to decrease the client's suspiciousness and promote trust. The other statements do not help the client to realistically interpret situations and the behavior of others and are not helpful in reducing the client's suspicions or mistrust.

 CN: Psychosocial adaptation;  
CL: Synthesize

**127. 4.** Mebendazole is prescribed for household members older than 2 years. Although the child's 18-month-old brother would not receive the drug, his 4-year-old sister and parents would.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**128. 3.** Loss of height and back pain are early indications of the disease that are caused by collapse of the vertebrae. Later signs include the dowager's hump and loss of the waistline. The dowager's hump is a later sign of osteoporosis that occurs when the vertebrae can no longer support the upper body in an upright position. Fair-skinned, small-boned, white and Asian women are at greater risk for osteoporosis. Conventional radiographs are little help because more than 30% of the bone mass must be lost before the disease is detected. High-density bone scans can detect the disease earlier.

 CN: Reduction of risk potential;  
CL: Synthesize


**129. 3.** The primary reason for evaluating gastric residual is to determine whether gastric emptying has been delayed and the stomach is becoming overdistended from the feeding. With delayed gastric emptying, the possibility of aspiration of the feeding into the lungs is increased. It is not possible to determine how well the client's body is absorbing nutrients or whether the client is receiving enough feeding by checking the gastric residual. It is not necessary to keep partially digested formula separate from undigested formula.

 CN: Reduction of risk potential;  
CL: Apply

**130. 1.** The baseline values of the client's partial thromboplastin time, bleeding time, and prothrombin time should be obtained. Potassium levels do not indicate a client's coagulation time. The Lee-White clotting time or baseline fibrin split product does not need to be established before starting tissue plasminogen activator or alteplase.

 CN: Reduction of risk potential;  
CL: Apply


**131. 2, 4, 5.** Clients with hepatitis A commonly experience fatigue and altered nutrition due to anorexia and nausea. Because of the severe fatigue associated with hepatitis, clients are encouraged to rest and restrict activity during the active phase of the disease. It is important that frequent rest periods be planned throughout the day. Clients may experience nausea and vomiting; thus, providing relief is important. Small, frequent meals help clients manage the anorexia associated with hepatitis. An exercise program is not appropriate due to the need for rest. Clients with hepatitis do not experience pain. All medications administered to clients with hepatitis need to be evaluated for their potential for hepatotoxicity.

 CN: Physiological adaptation;  
CL: Synthesize


**132. 1.** A common complication of diabetes is diabetic neuropathy. Diabetic neuropathy results from the metabolic and vascular factors related to hyperglycemia. Damage leads to sensory deficits and peripheral pain. Muscle atrophy can result from disuse, but it is not a direct consequence of diabetes. Raynaud's disease is associated with vasospasms in the hands and feet. Transient ischemic attacks involve the cerebrum.

 CN: Reduction of risk potential;  
CL: Analyze

**133. 1.** Clients with borderline personality disorder have fears of abandonment and seek attention. Clients are dependent and fear being alone; this stems from disapproval, feelings of being abandoned, and not having needs met earlier in their life. The nurse intervenes by reducing attention-seeking behaviors and abandonment fears to help with intense feelings and emotions.


 CN: Psychosocial adaptation;  
CL: Analyze

**134. 4.** The application of restraints places the client in a vulnerable, confined position. The nurse should check on the client every 30 minutes while she is restrained to make sure that her needs are being met and she is safe. The client should be able to move while the restraints are in place. The restraints should be removed every 2 hours to provide skin care and exercise the extremities. Restraints should not be secured to the side rails; they should be secured to the movable bed frame so that when the bed is adjusted the restraints will not be pulled too tightly.

 CN: Safety and infection control;  
CL: Synthesize

**135. 3.** The most appropriate response is, "Alcohol dependence is a disease that can be treated" because


it conveys hope. It also emphasizes that the client has a treatable illness, which is helpful in reducing denial and guilt and encouraging the client to seek and comply with treatment. The other statements are judgmental and guilt-producing, possibly leading to denial and furthering the need for alcohol.

 CN: Psychosocial adaptation;  
CL: Synthesize


**136. 2.** Raisins are high in nutritional value but are sticky and have a high sugar content. The raisin can stick to the teeth and act like high-sugar foods in promoting tooth decay. Although anything can be aspirated, round, hard, smooth foods are more easily aspirated than raisins, which are soft and chewy. Raisins need to be chewed thoroughly for maximum nutritional value.

 CN: Health promotion and maintenance;  
CL: Evaluate


**137. 1.** Aspirin is an antiplatelet medication. The use of aspirin is contraindicated while taking warfarin because it will potentiate the drug's effects. Diphenhydramine and pseudoephedrine do not affect blood coagulation. Digoxin is not an over-the-counter medication; it requires a physician's order.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**138. 1.** The nurse should inform the client that carbamazepine can decrease the effects of oral anticoagulants. Tegretol can increase the serum concentration of verapamil and can decrease the serum concentration of other anticonvulsants and the effects of oral contraceptives.

 CN: Pharmacological and parenteral therapies; CL: Apply

**139. 2.** Viral hepatitis causes fatigue. It is important for the client to rest to allow the liver to recover. Activity levels are resumed gradually as the client begins to recover. Abdominal pain is not a common manifestation of hepatitis. The client typically does not have difficulty breathing or experience edema.


 CN: Physiological adaptation;  
CL: Synthesize

**140. 1.** The mother should be encouraged to hold and cuddle her child to provide needed emotional support. Such activities as helping the child play with toys, reading stories, and staying with the child would not be contraindicated but do not offer as much emotional support as holding and cuddling.


 CN: Psychosocial adaptation;  
CL: Synthesize

**141. 2.** The best strategy to affect child seat belt safety is to attend the school board meeting and advocate for educational programming. The


programming could be simple and done quickly. This action also targets the best audience.

 CN: Health promotion and maintenance;  
CL: Synthesize


**142. 3.** A basic principle of rehabilitation, including cardiac rehabilitation, is that rehabilitation begins on hospital admission. Early rehabilitation is essential to promote maximum functional ability as the client recovers from an illness. Delaying rehabilitation activities is associated with poorer client outcomes.

 CN: Basic care and comfort; CL: Apply


**143. 1.** The goal of the intervention is to decrease the child's work of breathing by decreasing pressure on the diaphragm and increase chest expansion by increasing the pull of gravity on the diaphragm. Placing the client in high Fowler's position accomplishes this. Side-lying positions make it more difficult to expand the side of the lung closest to the bed. The prone or supine position does not decrease the work of breathing unless the head of the bed is raised.

 CN: Physiological adaptation;  
CL: Synthesize

**144. 3.** The most appropriate action is to contact the physician to verify that the order is correct. Although 60 mg of morphine is a significant dose, the amount of morphine administered to a client can vary widely, especially if a client has been taking morphine for an extended period and has developed a tolerance to the medication. The safest approach is for the nurse to verify orders that do not appear to fall within the norm. Administering the medication without verification is unsafe. The nurse cannot decide to reduce the amount of a prescribed medication without an order. Asking another nurse to review the order is not inappropriate; however, checking with the physician to verify the order should be done.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**145. 4.** Rapid response teams (RRTs), or medical emergency teams, provide a team approach to evaluate and treat immediately clients with alterations in vital signs or neurological deterioration. Calling the neurosurgeon or consulting the CNS may not result in a rapid response. The Trendelenburg position is usually used in treating shock, but because the client has had brain surgery, the head should not be lower than the trunk.


 CN: Physiological adaptation;  
CL: Synthesize

**146. 1.** Before paracentesis, the client is asked to void. This is done to collapse the bladder and


decrease the risk of accidental bladder perforation. The abdomen is not prepared with Betadine. The client is placed in a Fowler's position. The client does not need to be put on NPO status before the procedure.

 CN: Reduction of risk potential;  
CL: Apply

**147. 1.** Children who are being abused may demonstrate behaviors such as withdrawal, apparent fear of parents, and lack of an appropriate reaction, such as crying, and attempting to get away when faced with a frightening event (an examination or procedure).

 CN: Psychosocial adaptation;  
CL: Analyze

**148. 3.** The nurse should include teaching the client and family about the physical, physiologic, and psychological effects of substances to educate them about the potential injury, illness, and disability that can result from substance use. Teaching about the role of the family in perpetuating the problem, the family's responsibility for the client, or the reasons that could have led the client to use the substance is inappropriate and based on an erroneous assumption. Including these topics blames the family for the problem and attempts to rationalize the use of the substance.

 CN: Psychosocial adaptation;  
CL: Synthesize


**149. 2.** Postoperative care after a laparoscopic cholecystectomy includes removal of the dressing from the incisional site the day after surgery and allowing the client to bathe or shower. The client can resume a normal diet but may wish to follow a low-fat diet for a few weeks after surgery. Nausea is not expected to last for several days after surgery. The client usually can return to work within 1 week.

 CN: Reduction of risk potential;  
CL: Evaluate

**150. 1.** Children are highly valued and are closely protected by godparents. The tradition of the family is all-encompassing, and the health care provider gains trust and improved compliance rates by including the family in teaching and health care matters.

 CN: Psychosocial adaptation; CL: Apply

**151. 2.** Many vitamin and mineral deficiencies can result in anemia. All of these vitamins and minerals need to be assessed, preferably through a nutrition assessment. Deficiencies of vitamins A, B6, and C result in a small cell, microcytic anemia. Folate and vitamin B12 deficiencies result in a large cell, macrocytic anemia. Iron, copper, and vitamin E deficiencies can also result in anemia.

 CN: Physiological adaptation;  
CL: Analyze


**152. 3.** Women with diabetes mellitus generally have neonates who are large but physically immature. Other common findings in these infants are hypoglycemia, hypocalcemia, hyperbilirubinemia, polycythemia, renal thrombosis, and congestive anomalies. The neonates do not exhibit hypertonia, hyperactivity, or scaly skin.

 CN: Health promotion and maintenance;  
CL: Analyze


**153. 2.** The imbalance between the client's intake and output indicates that the client may be retaining urine since the removal of his Foley catheter. The nurse's first action is to validate this assumption by assessing for bladder distention. Applying a condom catheter will not relieve urinary retention; condom catheters are meant to be used for incontinence. A urine specimen for a culture is obtained if a urinary infection is suspected, but this is not a priority at this point. Kegel exercises are helpful in controlling urinary dribbling but do not treat retention.

 CN: Reduction of risk potential;  
CL: Synthesize

**154. 2.** Because of the poor emptying of blood from the atrial chambers, there is an increased risk for clot formation around the valves. The clots become dislodged and travel through the circulatory system. As a result, cerebrovascular accident is a common complication of atrial fibrillation.


 CN: Physiological adaptation;  
CL: Analyze

**155. 2.** Griseofulvin is associated with photosensitivity reactions. Therefore, the nurse should instruct the parents to have the child avoid intense sunlight. Griseofulvin is best absorbed when administered after a high-fat meal. Treatment with griseofulvin typically lasts for at least 1 month. There are no indications that increased fluid intake affects absorption.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**156. 4.** The nurse should actively listen to the client's descriptions and details about being raped and allow her to talk about the trauma. This allows the client to vent, decreases feelings of isolation, and guides the nurse to potential areas that could be problematic for the client. The nurse is a safe person to confide in, thus helping to decrease the client's apprehension about disclosing intimate details and feelings. Advising the client to try to forget about what happened, recommending that she be thankful for being alive, or questioning her about what she could have done to deter the attack is contraindicated for the victim of violence. These responses blame the victim and tend to increase her guilt, as

if somehow she is to blame or would have been capable of preventing the rape.

 CN: Psychosocial adaptation;  
CL: Synthesize


**157. 2.** After cystoscopy with biopsy, the nurse would assess for excessive hematuria, which might indicate hemorrhage caused by the biopsy. Catheters are not routinely inserted after cystoscopy. The nurse would not assess for bladder distention unless the client was having difficulty voiding. Urine cultures are not routinely ordered after cystoscopy.

 CN: Reduction of risk potential;  
CL: Analyze


**158. 2.** The nurse interprets the client's statement as use of the hot disease concept in the Mexican American culture, where the belief of a hot and cold balance of the body exists. A hot disease such as an infection is treated with the opposite, a cold food such as milk. The nurse should focus on the cultural differences and be sensitive to the cultural diversity.

 CN: Health promotion and maintenance;  
CL: Analyze


**159. 3.** A client who is "getting special messages" (ideas of reference) commonly misinterprets content presented on television as containing messages for the client. Therefore, it is important for the nurse to monitor the client's reactions to television programs.

 CN: Psychosocial adaptation;  
CL: Synthesize

**160. 3, 5.** Not attending the support group consistently and not taking the antidepressant may lead to a relapse and the client needs this information. Bulimia is chronic and intermittent and involves cycles of bingeing, purging, and restrictive eating. Increased socialization and activities promote healthy relationships.

 CN: Psychosocial adaptation;  
CL: Evaluate


**161. 3.** In a low anorectal anomaly, the rectum has descended normally through the puborectalis muscle. In an intermediate anomaly, the rectum is at or below the level of the puborectalis muscle; in a high anomaly, the rectum ends above the puborectalis muscle.

 CN: Physiological adaptation;  
CL: Evaluate


**162. 1.** It is especially important for the nurse to carefully assess the elderly client for respiratory depression after administering a dose of meperidine. It may be necessary to reduce the dosage to prevent respiratory depression. Dysrhythmias, constipation, and seizures are all potential adverse effects




of meperidine, but respiratory depression is most significant in the elderly.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**163. 2.** Ascorbic acid (vitamin C) increases iron absorption. Taking iron with a food rich in ascorbic acid, such as orange juice, increases absorption. Milk delays iron absorption. It is best to give iron on an empty stomach to increase absorption. Beta-carotene does not affect iron absorption.

 CN: Pharmacological and parenteral therapies; CL: Apply

**164. 1.** In early renal insufficiency, the kidneys lose the ability to concentrate urine, resulting in polyuria. Oliguria occurs later. Dysuria and hematuria are not associated with renal insufficiency.

 CN: Physiological adaptation; CL: Analyze

**165. 1.** The ZIFT method requires that fertilization take place outside the body. After fertilization has occurred, the fertilized eggs are transferred by laparoscopy to the open end of the fallopian tube. At least one tube must be patent for this procedure to succeed, so it is not beneficial if the client has bilateral blocked fallopian tubes. Ova and sperm are instilled in the fallopian tube for fertilization when the gamete intrafallopian transfer method is used. With in vitro fertilization, a fertilized ovum is instilled into the vagina to enter the uterus for implantation.

 CN: Health promotion and maintenance; CL: Synthesize

**166. 2.** The nurse should examine the buccal mucosa, along with the conjunctiva and sclera, nailbeds, palms, soles, lips, and tongue to assess for oxygenation in a client with dark skin.

 CN: Reduction of risk potential; CL: Apply

**167. 3.** A client who has undergone chest surgery should be taught to raise the arm on the affected side over the head to help prevent shoulder ankylosis. This exercise helps restore normal shoulder movement, prevents stiffening of the shoulder joint, and improves muscle tone and power.

 CN: Reduction of risk potential; CL: Synthesize

**168. 2.** The nurse's first action should be to attempt to replace the tracheostomy tube immediately so that the client's airway is reestablished. Although the nurse may also call for assistance, there should be no delay before attempting reinsertion of the tube. The client is placed in a supine position with the neck hyperextended to facilitate


reentry of the tube. The obturator is inserted into the replacement tracheostomy tube to guide insertion and is then removed to allow passage of air through the tube.

 CN: Reduction of risk potential; CL: Synthesize


**169. 2.** Many parents are advised to administer acetaminophen before the child receives immunizations to minimize local and systemic reactions. Typically, infants should not be very fussy after receiving immunizations. There is no reason to keep the infant out of day care that day; the child is not contagious. Although it may be helpful to the parents to have someone with them at the appointment, advising them to give the infant acetaminophen is more important.

 CN: Health promotion and maintenance; CL: Synthesize


**170. 1.** A general growth parameter is that the birth weight doubles in 6 months and triples in a year. Telling the mother that the baby will eat what he needs is not appropriate. The nurse needs to investigate whether the baby's weight is within the normal parameters of infant weight gain. A bottle-fed baby should not be forced to complete the bottle because this may contribute to obesity.

 CN: Health promotion and maintenance; CL: Synthesize

**171. 4.** The mechanism of injury is always the most critical information to obtain from a client with a musculoskeletal injury. In the event of a back injury, the mechanism of injury provides the greatest clue as to the extent of injury and the proper treatment plan. The other questions are important but will not give the critical information needed related to this specific complaint and injury.


 CN: Physiological adaptation; CL: Analyze

**172. 1.** Antihypertensive medications work to lower the blood pressure by reducing peripheral resistance or decreasing cardiac output; the effectiveness of these drugs is noted by a lowering of the blood pressure. Vasodilators are used to improve peripheral circulation. Cardiac stimulants and antiarrhythmia drugs are used to increase heart rate. Although cardiac problems can cause dyspnea, the use of drugs to manage dyspnea depends on the underlying cause.


 CN: Pharmacological and parenteral therapies; CL: Evaluate

**173. 3.** Typical early signs of rheumatoid arthritis are nonspecific and not necessarily related to specific arthritic joint complaints. Common early symptoms include fatigue, anorexia, weight loss,

and generalized feelings of stiffness. Joint swelling and limitation of movement usually occur as joint involvement becomes more specific. Nausea is not typically associated with the disease process but can be related to medications prescribed to treat rheumatoid arthritis.

 CN: Physiological adaptation;  
CL: Analyze


**174. 2.** NPH insulin should be rolled between the palms to mix it before drawing it up; shaking it will introduce air bubbles into the solution, which can cause inaccurate dosing.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**175. 4.** The gene for Duchenne's muscular dystrophy is carried by women and transmitted to their male children. It involves an X-linked inheritance pattern. About one-third of new cases involve mutations.

 CN: Physiological adaptation; CL: Apply


**176. 4.** Because of colic-like abdominal pain, *Acute pain* is the priority nursing diagnosis. There are no data to indicate a skin problem or dehydration. Diarrhea or constipation may precede the appearance of currant-jelly stools.

 CN: Physiological adaptation;  
CL: Analyze


**177. 2.** The nurse should notify the physician that the client is allergic to penicillin before giving the Kefzol. Cephalosporins are contraindicated in clients who are allergic to penicillin. Clients who are allergic to penicillin may have a cross-allergy to cephalosporins.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**178. 4, 5.** Buspirone is not a benzodiazepine but acts as a serotonin agonist. Serotonin is the neurotransmitter implicated in depression. BuSpar reduces symptoms of worry, apprehension, difficulty with concentration, and irritability. It is not sedating, does not cause a high, takes 1 to 6 weeks to be effective, does not cause muscle relaxation, and does not produce dependence, withdrawal, or tolerance. Full therapeutic benefit takes 3 to 6 weeks.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**179. 3.** The nurse should document a tearing of tissue with irregular wound edges as a laceration. A contusion or a bruise is a closed wound caused by a blunt object resulting in bleeding in underlying tissue. An abrasion is a superficial wound from a rubbing or a scraping of the surface of the skin such as from a fall. Colonization is a wound containing microorganisms.

 CN: Safety and infection control;  
CL: Apply

**180. 1.** The major cause of relapse is noncompliance. If the client states that he's not sure he can afford to keep taking his medicines, it is a warning sign to the nurse that the client may be at risk for noncompliance. Therefore, the nurse needs to stress the need for compliance to prevent relapse. If money is a problem, a referral to a social worker may be necessary.

 CN: Psychosocial adaptation;  
CL: Evaluate

**COMPREHENSIVE**

**TEST  
4**

**1.** A primigravid client at 26 weeks' gestation asks the nurse what causes heartburn during pregnancy. The nurse should explain to the client that heartburn during pregnancy is usually caused by which of the following?

- 1. Increased peristaltic action during pregnancy.
- 2. Displacement of the stomach by the diaphragm.
- 3. Decreased secretion of hydrochloric acid.
- 4. Backflow of stomach contents into the esophagus.

**2.** A client at a follow-up appointment after having a miscarriage 2 weeks previously yells at the nurse, "How could God do this to me? I've never done anything wrong." Which of the following responses by the nurse would be **most** appropriate at this time?

- 1. "God can handle your anger. It's okay."
- 2. "I know you are angry. It's so hard to lose your baby."
- 3. "It isn't God's fault. It was an accident."
- 4. "You're a strong person. You will get through this."

**3.** A client with cancer has been advised by the physician that he should have chemotherapy. The client is concerned about chemotherapy and wants to take herbal treatments instead. The nurse's **best** response to the client is which of the following?

- 1. "You are making a mistake and placing your life in jeopardy."
- 2. "Herbal treatments are not approved by the Food and Drug Administration (FDA)."
- 3. "Herbal treatments have not been researched with cancer."
- 4. "Tell me about your concerns with chemotherapy."

**4.** A 4-year-old child is admitted for a cardiac catheterization. Which of the following is **most** important to include as the nurse teaches this child about the cardiac catheterization?

- 1. A plastic model of the heart.
- 2. A catheter that will be inserted into the artery.
- 3. The parents.
- 4. Other children undergoing a catheterization.

**5.** A client has a reddened area over a bony prominence. The nurse finds a nursing assistant massaging this area. The nurse should:

- 1. Reinforce the nursing assistant's use of this intervention over the bony prominence.
- 2. Explain to the nursing assistant that massage is effective because it improves blood flow to the area.
- 3. Inform the nursing assistant that massage is even more effective when combined with the use of lotion.
- 4. Instruct the nursing assistant that massage is contraindicated because it decreases blood flow to the area.

**6.** A worried mother confides in the nurse that she wants to change physicians because her infant is not getting better. The **best** response by the nurse is which of the following?

- 1. "This doctor has been on our staff for 20 years."
- 2. "I know you are worried, but the doctor has an excellent reputation."
- 3. "You always have an option to change. Tell me about your concerns."
- 4. "I take my own children to this doctor."

**7.** A mother who is breast-feeding and has known food sensitivities is asking the nurse what foods she should avoid in her diet. The nurse should advise her to avoid which foods? Select all that apply.

- 1. Fish.
- 2. Soy.
- 3. Peanuts.
- 4. Beef.
- 5. Lamb.

**8.** A widowed client who is receiving chemotherapy tells the nurse that he does not like to cook for himself. A community resource for this client is:

- 1. Hospice Association.
- 2. Visiting Nurses' Association (VNA).
- 3. Meals on Wheels.
- 4. American Association of Retired Persons (AARP).

**9.** The nurse assists the physician in inserting a temporary pacemaker into the client. After the procedure, the nurse should verify that which of the following has been documented?

- 1. The client's cardiovascular status.
- 2. The client's emotional state.
- 3. The type of sedation used.
- 4. Pacemaker rate, type, and settings.

**10.** The nurse judges that the parent of a 9-month-old infant in a hip spica cast understands how to feed the child when the parent states which of the following?

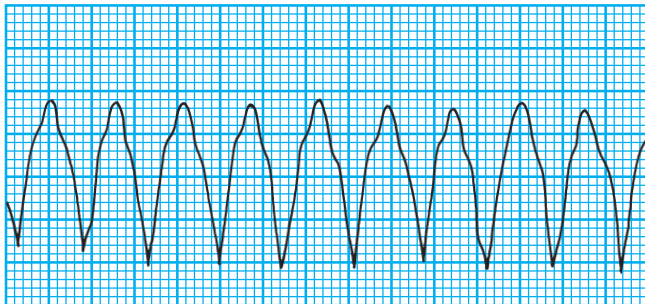
- 1. "I can lay my child flat and feed that way."
- 2. "I'll raise my child's head up and leave the hips and legs on a pillow."
- 3. "I can borrow a special feeding table to use."
- 4. "It will take two of us, one to hold and one to feed."

**11.** The nurse is assessing home care needs for a group of clients. Which clients qualify for home care services? The client who? Select all that apply.

- 1. Requires monitoring of prothrombin time due to Coumadin (warfarin) therapy.
- 2. Needs additional instruction regarding preparation of food on a low-sodium diet.
- 3. Has episodes of vertigo that result in falls.
- 4. Has multiple sclerosis with an open, draining lesion on a foot.
- 5. Needs stronger lenses for glasses.

**12.** The nurse is assessing a client who has had a myocardial infarction. The nurse notes the cardiac rhythm shown below (see figure). The nurse identifies this rhythm as:

- 1. Atrial fibrillation.
- 2. Atrial tachycardia.
- 3. Premature ventricular contractions.
- 4. Ventricular tachycardia.



**13.** The nursing staff has finished restraining a client. In addition to determining whether anyone was injured, the staff is mandated to evaluate the incident to obtain which of the following ultimate outcomes?

- 1. Coordinate documentation of the incident.
- 2. Resolve negative feelings and attitudes.
- 3. Improve the use of restraint procedures.
- 4. Calm down before returning to the other clients.

**14.** The nurse is caring for a client who has experienced severe multiple trauma. The client's arterial blood gases reveal low arterial oxygen levels that are not responsive to high concentrations of oxygen. The nurse is aware that this finding is a major indicator of the development of which of the following conditions?

- 1. Hospital-acquired pneumonia.
- 2. Hypovolemic shock.
- 3. Acute respiratory distress syndrome (ARDS).
- 4. Asthma.

**15.** A client asks the nurse why he was asked to complete an advance directive when he entered the hospital. The nurse's **best** response is which of the following?

- 1. "This will provide a substitute for informed discussion with the physician."
- 2. "It is a legal requirement for all clients entering a hospital to be offered the chance to make an advance directive."
- 3. "The physician will make the best decisions for you in an emergency."
- 4. "Are you worried that extraordinary means will be taken if you are dying?"

**16.** When witnessing an adult client's signature on a consent for a procedure, the nurse verifies that the consent was obtained in an appropriate manner. The nurse should verify which of the following? Select all that apply.

- 1. That there was adequate disclosure of information.
- 2. That the client understood the information.
- 3. That there was voluntary consent on the client's part.
- 4. That the client has full awareness of the potential complications.
- 5. The client's relative, spouse or legal guardian was present.

**17.** A pregnant woman at 22 weeks' gestation is diagnosed with gonorrhea. The physician orders doxycycline (Vibramycin). The nurse should **first** :

- 1. Instruct the client about the effects of the drug.
- 2. Make sure the record notes that the baby must receive eyedrops when born.
- 3. Have the physician add a single dose of ceftriaxone (Rocephin).
- 4. Discuss with the physician the need to change the order.

**18.** After a client undergoes a contraction stress test that is negative, which of the following should the nurse assess **next**?

- 1. Evidence of ruptured membranes.
- 2. Viability status of the fetus.
- 3. Indications that contractions have ceased.
- 4. Fetal heart rate variability.

**19.** An infant is at risk for an ileus after surgery to correct intussusception. Which observation should the nurse not include in an assessment for this complication?

- 1. Measurement of urine specific gravity.
- 2. Assessment of bowel sounds.
- 3. Characteristics of the first stool.
- 4. Measurement of gastric output.

**20.** A client with asthma asks the nurse if she should use her salmeterol (Serevent) inhaler when she exercises and experiences wheezing and shortness of breath. The nurse's **best** response is which of the following?

- 1. "Yes, use the inhaler immediately for these symptoms."
- 2. "No, this drug is a maintenance drug, not a rescue inhaler."
- 3. "Use the inhaler 5 minutes before you exercise to prevent the wheezing."
- 4. "This inhaler is for allergic rhinitis, not asthma."

**21.** The nurse should assess the child with nephrotic syndrome for which of the following? Select all that apply.

- 1. Normal blood pressure.
- 2. Generalized edema.
- 3. Normal serum lipid levels.
- 4. No red blood cells in the urine.
- 5. Elevated streptococcal antibody titers.

**22.** A client is receiving spironolactone (Aldactone) for treatment of bilateral lower extremity edema. The nurse should instruct the client to make which of the following nutritional modifications to prevent an electrolyte imbalance?

- 1. Increase intake of milk and milk products.
- 2. Restrict fluid intake to 1000 mL per day.
- 3. Decrease foods high in potassium.
- 4. Decrease foods high in sodium.

**23.** A nurse is assessing a client who is receiving clozapine (Clozaril). The nurse reviews the chart below. What should the nurse do **next**?

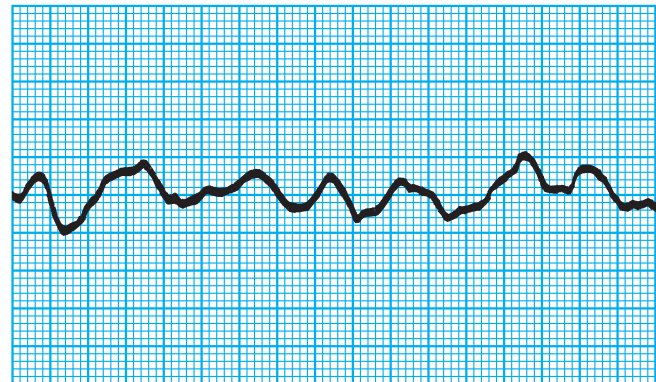
- 1. Give the clozapine, and tell the client to lie down.
- 2. Withhold the clozapine, and tell the client to go to an exercise group.
- 3. Administer the clozapine, and notify the physician.
- 4. Withhold the clozapine, and notify the physician.

#### Vital Signs

Date	06/12/07	06/12/07
Time	8 am	12 noon
Temperature	98° F	98° F
Pulse	140	148
Respirations	22	24
Blood pressure	120/80	122/84

**24.** A nurse is assessing a client with a history of myocardial infarction who is in the surgical unit following a gastric resection. The client complains of chest pains. The nurse obtains the electrocardiogram (ECG) shown (see figure). What should the nurse do **first**?

- 1. Administer oxygen.
- 2. Inspect the client's incision.
- 3. Call the rapid response team.
- 4. Reposition the ECG electrodes.



**25.** The nurse is watching two siblings, ages 7 and 9 years, verbally arguing over a toy. The nurse has counseled the parent before about how to handle this situation. The nurse should judge that the teaching has been effective when the parent does which of the following?

- 1. Tells the siblings to stop arguing and shake hands.
- 2. Ignores the arguing and continues what she is doing.
- 3. Tells the children they will be punished when they go home.
- 4. Says they will not go out to lunch now since they have argued.

**26.** A client is diagnosed with genital herpes, (herpes simplex virus type 2, or HSV-2). The nurse should instruct the client that:

- 1. Using occlusive ointments may decrease the pain from the lesions.
- 2. Reducing stressful life events may decrease the incidence of herpetic outbreaks.
- 3. There are no effective drug therapies to manage herpes symptoms.
- 4. Herpes is transmitted to partners only when lesions are weeping.

**27.** The client is having ototoxic effects of the vestibular branch of the acoustic nerve. The nurse should assess the client for which of the following? Select all that apply.

- 1. Vertigo.
- 2. Tinnitus.
- 3. Nausea.
- 4. Ataxia.
- 5. Hearing loss.

**28.** A young adult has been bitten by a human and the skin on the forearm is broken. The client's last tetanus shot was about 8 years ago. The nurse should prepare the client to receive:

- 1. An injection of tetanus toxoid.
- 2. Application of a corticosteroid cream.
- 3. Closure of the wound with sutures.
- 4. Testing for tuberculosis.

**29.** A client 6 weeks postpartum is asking the nurse about taking progesterone (Depo-Provera) for birth control. Prior to discussing options, what should the nurse determine? Select all that apply.

- 1. If the client has a sexually transmitted disease.
- 2. How willing her husband is to have her take the drug.
- 3. If the woman is experiencing postpartum depression.
- 4. That the woman is not currently pregnant.
- 5. If the woman is breast-feeding.

**30.** A mother who is visibly upset tells the nurse she wants to take her child home because the child is dying. Which of the following would be the nurse's **best** response?

- 1. "I know how you feel, but the medication will make your child feel better."
- 2. "I can't let you do this without calling your physician first."
- 3. "Can you tell me why you want to take your child home now?"
- 4. "I can imagine how hard this is for you, but it's not what's best for the child."

**31.** A client with chronic obstructive pulmonary disease is bedridden at home and gets little exercise. The nurse should assess the client for which of the following?

- 1. Increased sodium retention.
- 2. Increased calcium excretion.
- 3. Increased insulin use.
- 4. Increased red blood cell production.

**32.** Which of the following indicates that a 5-month-old weighing 15 lb and being treated for dehydration has a normal urine output? The urine output is:

- 1. 1 to 2 mL/kg/hour.
- 2. 3 to 5 mL/kg/hour.
- 3. 6 to 8 mL/kg/hour.
- 4. 10 to 12 mL/kg/hour.

**33.** The nurses in the neonatal intensive care unit are not identifying important clinical changes in the clients that need to be documented. The unit director should initiate which of the following actions? Select all that apply.

- 1. Identify the problem at a staff meeting without placing blame on any individual or group.
- 2. Ask the unit staff to develop a plan that they think will work for the unit members.
- 3. Ask an experienced nurse to spend time reorienting newer staff members.
- 4. Collaborate with the staff development educator to develop a plan.
- 5. Ask the neonatologist to give a presentation about assessing newborns.

**34.** A 24-year-old client has been diagnosed with acute osteomyelitis in the left leg. He complains of acute pain in the leg that intensifies when he moves it. The client has a temperature of 101° F (38.3° C) and a reddened, warm area in the midcalf region over the shaft of the tibia. Based on this information, which of the following nursing diagnoses would be **most** appropriate for this client?

- 1. *Grieving* related to possible left lower leg amputation.
- 2. *Activity intolerance* related to severe left leg pain.
- 3. *Disturbed body image* related to left leg swelling and inflammation.
- 4. *Deficient fluid volume* related to elevated temperature of 101° F (38.3° C).

**35.** A client has undergone a vasectomy. The nurse instructs the client that he can begin having unprotected intercourse:

- 1. When desired because sterilization is immediate.
- 2. As soon as scrotal edema and tenderness resolve.
- 3. When the sperm count reflects sterilization.
- 4. After 6 to 10 ejaculations.

**36.** Long-term administration of gentamicin sulfate (Garamycin) to a client has been discontinued. The nurse should assess which of the following?

- 1. Hemoglobin level in 2 weeks.
- 2. White blood cell count in 2 weeks.
- 3. Vestibular check in 3 to 4 weeks.
- 4. Serum potassium level in 1 week.

**37.** The nurse is assessing an infant diagnosed with bacterial meningitis. The nurse should ask the parent if the infant has which of the following? Select all that apply.

- 1. Fever.
- 2. Vomiting.
- 3. Diarrhea.
- 4. Poor feeding.
- 5. Abdominal pain.

**38.** Which of the following nursing interventions would **best** accomplish the goal of preventing atelectasis and pneumonia in a postoperative client?

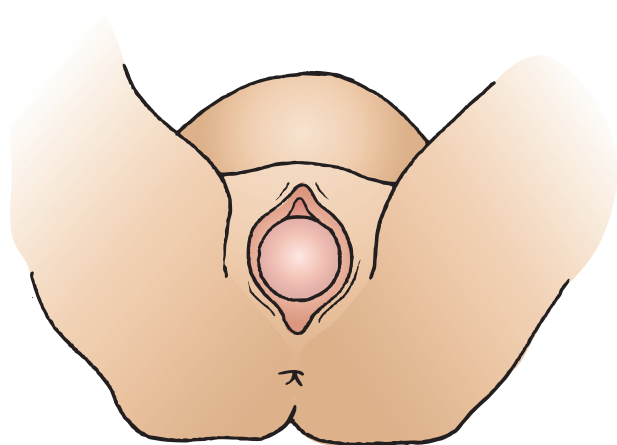
- 1. Administer oxygen therapy as needed to maintain adequate oxygenation.
- 2. Offer pain medication before having the client deep-breathe and use incentive spirometry.
- 3. Encourage the client to cough, deep-breathe, and turn in bed once every 4 hours.
- 4. Force fluids to 2,000 mL every 24 hours.

**39.** A 7-year-old child is admitted to the hospital with acute rheumatic fever. When discussing long-term care for the child with the parents, the nurse should teach them that a necessary part of this care is:

- 1. Physical therapy.
- 2. Antibiotic therapy.
- 3. Psychological therapy.
- 4. Anti-inflammatory therapy.

**40.** The nurse is assessing the perineal changes of a woman in the second stage of labor. The figure below represents which of the following perineal changes?

- 1. Anterior-posterior slit.
- 2. Oval opening.
- 3. Circular shape.
- 4. Crowning.



**41.** A client is admitted to the hospital with a diagnosis of suspected pulmonary embolism. Physician orders include the following: oxygen 2 to 4 L/minute per nasal cannula, oximetry at all times, and I.V. administration of 5% dextrose in water at 100 mL/hour. The client has increasing dyspnea and has a respiratory rate of 32 breaths/minute. The nurse should:

- 1. Increase the oxygen flow rate from 2 to 4 L/minute.
- 2. Call the physician immediately.
- 3. Provide reassurance to the client.
- 4. Obtain a sample for arterial blood gas analysis.

**42.** A 10-month-old child has cold symptoms. The mother asks how she can clear the infant's nose. Which of the following would be the nurse's **best** recommendation?

- 1. Use a cool air vaporizer with plain water.
- 2. Use saline nose drops and then a bulb syringe.
- 3. Blow into the child's mouth to clear the infant's nose.
- 4. Administer a nonprescription vasoconstrictive nose spray.

**43.** A nurse is assessing a client with metastatic lung cancer. The nurse should assess the client for:

- 1. Diarrhea.
- 2. Constipation.
- 3. Hoarseness.
- 4. Weight gain.

**44.** A physician is calling the pediatric unit and asking the nurse to go into the electronic medical record (EMR) for test results of a fellow pediatrician. How should the nurse respond to this request?

- 1. Identify if the calling physician is the physician of record or has a need to know.
- 2. Access the EMR and give the physician the test results.
- 3. Decline to give the physician the information requested.
- 4. Determine whether the nurse can access the EMR.

**45.** A client is at risk for development of metabolic alkalosis because of persistent vomiting. The nurse should assess the client specifically for:

- 1. Irritability.
- 2. Hyperventilation.
- 3. Diarrhea.
- 4. Edema.

**46.** Which of the following should **first** alert the nurse that a child is hemorrhaging after a tonsillectomy?

- 1. Mouth breathing.
- 2. Frequent swallowing.
- 3. Requests for a drink.
- 4. Increased pulse rate.

**47.** A nurse is caring for a client who is having an allergic reaction to a blood transfusion. In what order should the nurse provide care for this client?

1. Stop the transfusion.
2. Send the blood bag and blood slip to the blood bank.
3. Keep the vein open with normal saline solution.
4. Administer an antihistamine as directed.

**48.** The nurse is to administer chloramphenicol (Chloromycetin) 50 mg I.V. in 100 mL of dextrose 5% in water over 30 minutes. The infusion set administers 10 gtt/mL. At what flow rate (in drops per minute) should the nurse set the infusion?

\_\_\_\_\_ gtt/minute.

**49.** A client's believes she has a "special mission from God." The nurse incorporates this religious delusion of grandeur into the client's plan of care based on the understanding that the **primary** purpose of such a delusion is to provide which of the following?

- 1. Sexual outlet.
- 2. Comfort.
- 3. Safety.
- 4. Self-esteem.

**50.** A client who has been vomiting for 2 days has a nasogastric tube inserted. The nurse notes that over the past 10 hours the tube has drained 2 L of fluid. The nurse should further assess the client for:

- 1. Hypermagnesemia.
- 2. Hypernatremia.
- 3. Hypokalemia.
- 4. Hypocalcemia.

**51.** During the clinical breast examination, which of the following is a normal finding?

- 1. Pronounced unilateral venous pattern.
- 2. Peau d'orange breast tissue.
- 3. Long-term, bilateral nipple inversion.
- 4. Breast tissue that is darker than the areolae.

**52.** A child with sickle cell crisis is being discharged. As part of discharge teaching to prevent further crisis, the nurse advises the parent to do which of the following?

- 1. Encourage the child to drink lots of liquids.
- 2. Take the child's temperature every morning.
- 3. Weigh the child every day.
- 4. Offer the child a high-protein diet.

**53.** While assessing a neonate 30 minutes after birth, the nurse observes that the child has a short neck covered with webbing. The nurse should further assess the client for:

- 1. Genetic deviations.
- 2. Cleft palate.
- 3. Potter's syndrome.
- 4. Neural tube defects.

**54.** A client has severe diarrhea that has lasted for 2 days. The nurse should now assess the client for:

- 1. Muscle spasms.
- 2. Thirst.
- 3. Arrhythmia.
- 4. Confusion.

**55.** The nursing staff on the antepartal unit has Depo Lupron and Depo Provera in the pharmacy for their clients. The nursing staff observed that the vials are similar in size and shape and could be confused. In order to promote client safety, the nursing staff should take which of the following actions? Select all that apply.

- 1. Petition the pharmacy to relocate one drug away from the other product.
- 2. Move the drugs to a new position within the medication administration system during the night shift.
- 3. Communicate concerns, measures to remediate, and final decisions to all staff.
- 4. Leave repositioning of drugs to pharmacy staff to resolve.
- 5. Collaborate with pharmacy staff to develop a location that works well for both groups.

**56.** Which of the following is the **most** reliable indicator of the existence and intensity of acute pain?

- 1. The client's vital signs.
- 2. The client's self-report of pain.
- 3. The nurse's assessment of the client.
- 4. The severity of the condition causing the pain.

**57.** The nurse advises a mother with a 2-year-old child to avoid encouraging excessive milk consumption (more than 3.5 cups per day) by the infant because excess milk consumption can lead to:

- 1. Vitamin C deficiency.
- 2. Iron deficiency.
- 3. Biotin deficiency.
- 4. Folate deficiency.



**58.** The nurse is caring for a client with a fracture of a long bone. Which of the following assessments would be the **earliest** symptom of a fat embolism?

- 1. Respiratory distress.
- 2. Confusion.
- 3. Petechiae.
- 4. Fever.

**59.** A client tells the nurse, "Everybody smiles at me because they know that I was chosen by God for this mission." The nurse interprets this statement as which of the following?

- 1. Idea of reference.
- 2. Thought insertion.
- 3. Visual hallucination.
- 4. Neologism.

**60.** The mother of a newborn is voicing concerns about her baby's ability to hear. The nurse should tell the mother:

- 1. Newborns cannot hear well until they are at least 6 weeks old.
- 2. Her concern is unfounded because hearing problems are rare in newborns.
- 3. The majority of states now mandate that newborns undergo a screening test for hearing.
- 4. She can test the baby's hearing by clapping her hands 24 inches from the infant's head.

**61.** The physician decides to change a client's current dose of I.M. meperidine hydrochloride (Demerol) to an oral dosage. The current I.M. dosage is 75 mg every 4 hours as needed. What dosage of oral meperidine will be required to provide an equivalent analgesic dose?

- 1. 25 to 50 mg every 4 hours.
- 2. 75 to 100 mg every 4 hours.
- 3. 125 to 140 mg every 4 hours.
- 4. 150 to 300 mg every 4 hours.

**62.** The parent asks the nurse about causes of brain injury in children. Which of the following should the nurse expect to include in the response as the major causes? Select all that apply.

- 1. Falls.
- 2. Motor vehicle accidents.
- 3. Bicycle accidents.
- 4. Child abuse.
- 5. Tumors.

**63.** Which of the following nursing measures is **most** useful in preventing the development of osteoporosis in a client who is immobilized?

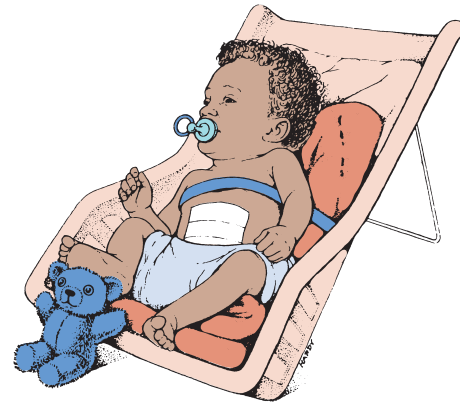
- 1. Beginning weight-bearing activities as soon as possible.
- 2. Increasing the client's calcium intake in the diet.
- 3. Performing passive range-of-motion (ROM) exercises four times a day.
- 4. Teaching the client to perform isometric exercises.

**64.** The mother of a toddler asks the nurse what she should do with her toddler when he has a temper tantrum. Which of the following suggestions would be **most** appropriate?

- 1. Move the toddler to a time-out chair.
- 2. Try to talk the toddler out of the tantrum.
- 3. Leave the toddler alone during the tantrum as long as he is safe.
- 4. Punish the toddler for having a temper tantrum.

**65.** A 6-month-old has had a pyloromyotomy to correct a pyloric stenosis. Three days after surgery, the parents have placed their infant in his own infant seat (see figure). The nurse should do which of the following?

- 1. Reposition the infant to the left side.
- 2. Ask the parents to put the infant back in his crib.
- 3. Remind the parents that the infant cannot use a pacifier now.
- 4. Tell the parents they have positioned their infant correctly



**66.** The nurse on the orthopedic unit is receiving a client from the Post Anesthesia Care Unit (PACU). Which of the following must occur to ensure a safe "hand-off"?

- 1. An email on the intranet from the nurse in the PACU from the receiving nurse on the orthopedic unit.
- 2. A page from a transporter who is bringing the client to the receiving nurse.
- 3. Interactive communication between the nurse from the PACU and the nurse from the orthopedic unit.
- 4. Delegation of RN responsibility and accountability to a non-RN on the receiving unit.

**67.** Which of the following nursing interventions is appropriate for preventing pressure ulcers in an older adult?

- 1. Clean the skin daily using mild soap and hot water.
- 2. Perform a systematic skin assessment at least once a day.
- 3. Massage bony prominences gently every shift.
- 4. Encourage the client to sit in a chair as much as possible.

**68.** The nurse is evaluating the pin insertion site of a client's skeletal traction. Which of the following indicate a complication?

- 1. Presence of crusts around the pin insertion site.
- 2. Serous drainage on the dressing.
- 3. Pin moves slightly at insertion site.
- 4. Client does not feel pain at insertion site.

**69.** On the night before a 58-year-old wife and mother is to have a lobectomy for lung cancer, she remarks to the nurse, "I am so scared of this cancer. I should have quit smoking years ago. Now I've brought all this fear and sadness on myself and now my family." The nurse should tell the client:

- 1. "It's normal to be scared. I would be, too. We'll help you through it."
- 2. "Do you feel guilty because you smoked?"
- 3. "Don't be so hard on yourself. You don't know if your smoking caused the cancer."
- 4. "It's okay to be scared. What is it about cancer that you're afraid of?"

**70.** The nurse is caring for an elderly client who has hip pain related to rheumatoid arthritis. The client is practicing appropriate self-care activities when the client chooses to sit in which of the following chairs?

- 1. Recliner chair with arms to support wrists and hands.
- 2. Couch with soft cushions to support thighs.
- 3. Straight-back chair with elevated seat.
- 4. Curved-back rocking chair.

**71.** The nurse is planning discharge care with the parents of a 16-year-old boy who recently attempted suicide. The nurse should advise the parents to tell the nurse if their son:

- 1. Expresses a desire to date.
- 2. Decides to try out for an extracurricular activity.
- 3. Gives away of valued personal items.
- 4. Desires to spend more time with his friends.

**72.** Which of the following responses would be **most** appropriate for the nurse when comforting a primiparous client whose critically ill neonate delivered at 25 weeks dies while the mother is present?

- 1. "This is probably for the best because his organs were so immature."
- 2. "You should try to get pregnant again soon to get over this loss."
- 3. "You can stay with your baby as long as you want and say anything you want."
- 4. "If you want me to, I can call the chaplain to stay with you."

**73.** A nurse is caring for a toddler who is assessed as having hypertonicity, delayed fine motor skills, and poor control of coordinated motion. This is indicative of what cerebral palsy (CP) classification? Select all that apply.

- 1. Abnormal involuntary movements.
- 2. Wormlike writhing movements.
- 3. Poor coordination.
- 4. Gross motor skills impairment.
- 5. Hypertonicity.

**74.** A 32-year-old woman recently diagnosed with Hodgkin's disease is admitted to the hospital outpatient clinic for staging by undergoing a bone marrow aspiration and biopsy. To obtain more information about the client's nutrition status the nurse should review the results of which of the following tests?

- 1. Red blood cell count.
- 2. Direct and indirect bilirubin levels.
- 3. Reticulocyte count.
- 4. Albumin level.

**75.** The nurse teaches a client taking desmopressin (DDAVP) nasal spray about how to manage treatment. The nurse determines that the client needs additional instruction when he makes which of the following comments?

- 1. "I should check for sores in my nose while taking this medication."
- 2. "I should use the same nostril each time I take the medicine."
- 3. "I should report nasal congestion."
- 4. "I should report any signs of respiratory infection."

**76.** The nurse has an order to administer ampicillin (Omnipen) 250 mg I.M. After reconstituting the ampicillin with sterile water for injection, the solution available is 500 mg/mL. How many milliliters should the nurse administer?  
\_\_\_\_\_ mL.

**77.** A client is a 43-year-old G2 P1 at 16 weeks' gestation that has completed prenatal testing for chromosomal abnormalities. The results reveal the infant is a female with Down syndrome. The parents are seeking information about this syndrome. The nurse should tell the parents which of the following? Check all that apply.

- 1. Down syndrome can occur in mothers of any age.
- 2. Down syndrome is correlated with autosomal dominant traits carried by the parents.
- 3. Down syndrome is a result of autosomal recessive traits carried by the parents.
- 4. Down syndrome depends upon maternal prenatal care since pregnancy began.
- 5. Down syndrome occurs more frequently with advanced maternal age.
- 6. Down syndrome results from a trisomy of chromosome 21.

**78.** The nurse assesses a client and notes that he has a weak, irregular pulse, as well as soft, flabby muscles. The nurse should assess the client further for:

- 1. Hypercalcemia.
- 2. Hyponatremia.
- 3. Hypokalemia.
- 4. Hypomagnesemia.

**79.** A primiparous client at 48 hours postpartum is to be given medroxyprogesterone acetate (Depo-Provera) before discharge. Which of the following should the nurse include in the teaching plan before administering this medication?

- 1. There is an increased risk of ovarian cancer with use of this drug.
- 2. Amenorrhea is common during the first 6 months.
- 3. Heavy menstrual bleeding may occur.
- 4. The client may experience periods of increased energy.

**80.** The nurse establishes the goal of preventing the development of a stress ulcer in a burn client. Which of the following interventions would **most** likely contribute to the achievement of this goal?

- 1. Implementing relaxation exercises.
- 2. Administering a sedative as needed.
- 3. Providing a soft, bland diet.
- 4. Administering famotidine (Pepcid) as ordered.

**81.** The nurse is instructing the parents of a child with acquired immunodeficiency syndrome (AIDS) how to look for signs and symptoms of infection when the child has a cut or open wound. The nurse should tell the parents to report:

- 1. Erythema around the area.
- 2. Rectal temperature higher than 100.5° F (38° C).
- 3. Tenderness around the area.
- 4. Increased warmth of the skin in the involved area.

**82.** The nurse is teaching a group of unlicensed assistive personnel (UAP) about providing care to clients with depression. Which approach by one of the UAPs indicates an understanding of the most effective approach to a depressed client?

- 1. Cheerful
- 2. Empathetic
- 3. Serious.
- 4. Humorous

**83.** When fluids by mouth are appropriate for the infant after surgery to correct intussusception, the nurse **most** likely would initiate feeding with:

- 1. Cereal-thickened formula.
- 2. Full-strength formula.
- 3. Half-strength formula.
- 4. Oral electrolyte solution.

**84.** A client is taking paroxetine (Paxil) 20 mg P.O. every morning. The nurse should monitor the client for which of the following adverse effects?

- 1. Hypertensive crisis.
- 2. Sexual problems.
- 3. Sleep disturbance.
- 4. Orthostatic hypotension.

**85.** Which of the following neurologic changes indicates that the client is in the progressive stage of shock?

- 1. Restlessness.
- 2. Confusion.
- 3. Incoherent speech.
- 4. Unconsciousness.

**86.** A child diagnosed with osteomyelitis will be discharged on I.V. nafcillin (Unipen). After teaching the parents about adverse effects that are important to report, which effects as stated by the parents indicate that they understand the teaching? Select all that apply.

- 1. Sore mouth.
- 2. Pain with urination.
- 3. Headache.
- 4. Stomach upset.
- 5. Fever.

**87.** The rapid response team arrives in the room of a client who has had a cardiac arrest. The nurse should first apply which piece of monitoring equipment?

- 1. Electrocardiogram (ECG) electrodes.
- 2. Pulse oximeter.
- 3. Blood pressure cuff.
- 4. Doppler for pulse check.

**88.** A nurse is counseling a client who is depressed. What nursing action promotes trust between the client and the nurse? Select all that apply.

- 1. Indicating an understanding for the client's feelings as well as for their cause.
- 2. Listening and encouraging the client to say more.
- 3. Acknowledging that the nurse heard what the client said.
- 4. Maintaining eye contact with the client at all times.
- 5. Standing very close to the client.

**89.** The nurse is assessing a client for heroin addiction. Which of the following indicate the client has used heroin?

- 1. Whites red and bloodshot.
- 2. Pupils small and constricted.
- 3. Pupils large and dilated.
- 4. Drooping eyelids.

**90.** When performing routine health evaluations in school-age children, which of the following would alert the school nurse to pediculosis capitis (head lice)?

- 1. Spotty baldness.
- 2. Wheals with scalp blistering.
- 3. Frequent scalp scratching.
- 4. Dry, scaly patches on the skin.

**91.** Which of the following **best** indicates that a client's peristaltic activity is returning to normal after surgery?

- 1. The client passes flatus.
- 2. The client says that she is hungry.
- 3. Bowel sounds are hypoactive on auscultation.
- 4. Peristalsis can be felt on abdominal palpation.

**92.** A client appears flushed and has shallow respirations. The arterial blood gas report shows the following: pH, 7.24; partial pressure of arterial carbon dioxide ( $Paco_2$ ), 49 mm Hg; bicarbonate ( $HCO_3^-$ ), 24 mEq/L. These findings are indicative of which of the following acid-base imbalances?

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

**93.** Which of the following measures is **most** important for pain management for a client after a lobectomy for lung cancer?

- 1. Reposition the client immediately after administering pain medication.
- 2. Reassess the client after administering pain medication.
- 3. Reassure the client after administering pain medication.
- 4. Readjust the pain medication dosage as needed.

**94.** The nurse is evaluating a female client's understanding of how to prevent sexually transmitted diseases (STDs). Which of the following statements indicates that the client understands how to protect herself?

- 1. "I will be sure my partner uses a condom."
- 2. "I need to be sure to take my birth control pills."
- 3. "I will always douche after sexual intercourse."
- 4. "I will be sure to take antibiotics to prevent an STD."

**95.** While assessing a multigravid client at 10 weeks' gestation, the nurse notes a purplish color to the vagina and cervix. The nurse documents this finding as which of the following?

- 1. Goodell's sign.
- 2. Chadwick's sign.
- 3. Hegar's sign.
- 4. Melasma.

**96.** A client with bipolar disorder, mania, has flight of ideas and grandiosity and becomes easily agitated. To prevent harmful behaviors, which of the following should the nurse do **initially**?

- 1. Encourage the client to stay in his room.
- 2. Seclude the client at the first sign of agitation.
- 3. Tell the client to seek out staff when feeling agitated.
- 4. Instruct the client to ask for medication when agitated.

**97.** The nurse is preparing written information for an older adult who is to manage intermittent self-catheterization. Which of the following will be most effective?

- 1. Use charts to help convey information.
- 2. Prepare information at an tenth-grade reading level.
- 3. Use short words.
- 4. Print the material in a condensed font.

**98.** The nurse should assess which of the following in a child newly diagnosed with hyperthyroidism? Select all that apply.

- 1. Weight gain.
- 2. Dry skin.
- 3. Constipation.
- 4. Rapid pulse.
- 5. Heat intolerance.

**99.** The nurse is planning care for four mothers and their newborns. After reviewing the clients' charts, the nurse should make rounds on which of the following clients **first**?

- 1. An 18-year-old G2 P2 with an uncomplicated SVD 12 hours ago who is complaining of abdominal cramps.
- 2. A 35-year-old G4 P4 with an uncomplicated vaginal delivery 4 hours ago. The nurse's notes indicated she soaked two peripads over the last 2 hours; fundus is firm.
- 3. A 16-year-old G1 P1 with a caesarean section 4 hours ago, diagnosed with preeclampsia and receiving magnesium sulfate at 2 grams/hour. The urinary output is 50mL/hour draining from a Foley catheter, reflexes are 2+, and the nurse's notes indicate she has a headache. Vital signs are: T 99.4, P 88, R 20, BP 128/86.
- 4. An 18-year-old G2 P2 who had a SVD two days ago and now has severe breast pain. Vital signs are T 99.8, P 96, R 22.

**100.** A nurse is evaluating the proper use of crutches by a client who has fractured the right leg. Which statement indicates the client is using the correct technique?

- 1. "I move my left leg forward first as I swing forward on my crutches."
- 2. "I need to increase my arm strength because my arms tingle after I use my crutches."
- 3. "I padded the tops of my crutches so that I can lean more comfortably on my crutches."
- 4. "I feel pressure on the palms of my hands when I am walking with my crutches."

**101.** Which of the following factors is a priority when evaluating discharge plans for a 68-year-old man after a lower left lobectomy for lung cancer?

- 1. The distance the client lives from the hospital.
- 2. Support available for assisting the client at home.
- 3. The client's ability to do home blood pressure monitoring.
- 4. The client's knowledge of the causes of lung cancer.

**102.** A primiparous client planning to breast-feed her term neonate delivered vaginally asks, "When will my 'real' milk come in?" The nurse explains to the client that after delivery breasts begin to fill with milk within which of the following periods?

- 1. 12 hours.
- 2. 24 hours.
- 3. 2 to 4 days.
- 4. 7 days.

**103.** The nurse is caring for an elderly, debilitated client who has been bedridden for an extended period. Which of the following indicates that the client has Impaired Gas Exchange?

- 1. Chills.
- 2. Productive cough.
- 3. Confusion.
- 4. Pleuritic chest pain.

**104.** A child with rheumatic fever has polyarthrititis and chorea. An echocardiogram shows swelling of the cardiac tissue. Which of the following should the nurse include in the child's plan of care?

- 1. Explaining that the chorea will disappear over time.
- 2. Performing neurologic checks every 4 hours until the chorea subsides.
- 3. Promoting ambulation by administering aspirin every 4 hours.
- 4. Keeping the child in a slightly cool environment.

**105.** A 19-year-old unmarried college student is approximately 8 weeks pregnant asks the nurse, "If I have an abortion in the next 2 or 3 weeks, how will it be done?" The nurse instructs the client that at this gestational age an abortion is usually performed by which of the following techniques?

- 1. Dilatation and curettage.
- 2. Menstrual extraction.
- 3. Dilatation and vacuum extraction.
- 4. Saline induction.

**106.** The nurse is performing a respiratory assessment on a client who has a pleural effusion. The nurse should determine if the client has:

- 1. Decreased chest movement on the affected side.
- 2. Normal bronchial breath sounds.
- 3. Hyperresonance on percussion.
- 4. Fever.

**107.** A nurse is caring for a child with intussusception. Which of the following is an expected client outcome related to the nursing diagnosis *Acute pain* related to cramping, which might be made for this child?

- 1. The child exhibits no manifestations of discomfort.
- 2. The child is very still.
- 3. The child has a normal bowel movement.
- 4. The child has not vomited in 3 hours.

**108.** Gentamicin sulfate (Garamycin) 25 mg I.M. has been ordered every 6 hours. Garamycin 40 mg/mL is available. The nurse should administer how many milliliters?

\_\_\_\_\_ mL.

**109.** Assessment of a 36-year-old woman complaining of malaise and dysuria reveals a temperature of 100° F (37.4° C) and painful blisters on the outside of her vagina. The client tells the nurse she had intercourse with a new partner 5 days ago. The nurse should:

- 1. Advise the client to ask her partner to use a condom.
- 2. Encourage the client to increase fluid to 3000 mL per day.
- 3. Tell the client to use a lubricant jelly on the blisters.
- 4. Refer the client to a health care provider.

**110.** A child with leukemia fails to respond to therapy. Which of the following statements offers the nurse the **best** guide in making plans to assist the parents in dealing with their child's imminent death?

- 1. Knowing that the prognosis is poor helps prepare relatives for the death of children.
- 2. Relatives are especially grieved when a child does well at first but then declines rapidly.
- 3. Trust in health personnel is most often destroyed by a death that is considered untimely.
- 4. It is more difficult for relatives to accept the death of a 10-year-old than the death of a younger child whose family membership has been short.

**111.** The nurse is caring for a child receiving a blood transfusion. The child becomes flushed and is wheezing. What should the nurse do **first**?

- 1. Notify the physician.
- 2. Administer oxygen.
- 3. Switch the transfusion to normal saline solution.
- 4. Take the child's vital signs.

**112.** A client who states that he is allergic to penicillin has an order to receive cefazolin (Ancef). The nurse's **initial** response is to:

- 1. Ask the client if he has taken cefazolin before.
- 2. Consult with the physician or a clinical pharmacist.
- 3. Administer cefazolin immediately.
- 4. Observe the client closely for urticaria.

**113.** A client with chronic renal failure tells the nurse that her skin feels dry and is constantly itching. Based on these data, which of the following is an appropriate nursing diagnosis?

- 1. *Ineffective health maintenance* related to poor hygiene.
- 2. *Chronic pain* related to skin irritation.
- 3. *Risk for impaired skin integrity* related to severe pruritus.
- 4. *Ineffective coping* related to manifestations of chronic illness.

**114.** When preparing the teaching plan for a client and his family about lithium therapy, the nurse should teach the client about:

- 1. Maintaining an adequate sodium intake.
- 2. Discontinuing sodium in the diet.
- 3. Buying foods labeled "low in sodium."
- 4. Increasing sodium in the diet.

**115.** A client who is undergoing radiation therapy develops mucositis. Which of the following interventions should be included in the client's plan of care?

- 1. Increase mouth care to twice per shift.
- 2. Provide the client with hot tea to drink.
- 3. Promote regular flossing of teeth.
- 4. Use half-strength hydrogen peroxide on mouth ulcers.

**116.** A parent calls the Poison Control Center because her 3-year-old has eaten 10 to 12 chewable acetaminophen tablets. What should the nurse instruct the parent to do?

- 1. Give the child a large glass of milk.
- 2. Induce vomiting.
- 3. Take the child to the emergency department.
- 4. Monitor the child's respirations for 24 hours.

**117.** The parent of a preschool-age child tells the nurse that the child is hyperactive and something needs to be done. Which of the following responses by the nurse would be **most** appropriate initially?

- 1. "What makes you think your child is hyperactive?"
- 2. "What do you think needs to be done?"
- 3. "How does your child behave normally?"
- 4. "Why not wait and see what the doctor says?"

**118.** When preparing for the discharge of a newborn after surgery to correct tracheoesophageal fistula (TEF), the nurse teaches the parents about the need for long-term health care because their child has a high probability of developing which of the following?

- 1. Recurrent mild diarrhea with dehydration.
- 2. Esophageal stricture.
- 3. Speech problems.
- 4. Ulcers.

**119.** A young man with Hodgkin's disease has been readmitted to the hospital because of his aggressive disease that is unresponsive to multiple therapies. Death appears imminent. A priority goal is for this client is to:

- 1. Reduce feelings of isolation.
- 2. Reduce fear of pain.
- 3. Reduce fear of more aggressive therapies.
- 4. Reduce feelings of social inadequacy.

**120.** A client is admitted in early active labor at 39 weeks' gestation with intact membranes. When assessing the fetal heart rate, the nurse locates the heart sounds above the client's umbilicus at midline. The nurse should further confirm that the fetus is lying in which of the following positions?

- 1. Cephalic.
- 2. Frank breech.
- 3. Face.
- 4. Transverse.

**121.** The nurse is caring for a client who has been diagnosed with pernicious anemia. Which of the following statements by the client indicates an understanding of the treatment of pernicious anemia?

- 1. "I will need to increase my dietary intake of foods that are high in vitamin B<sub>12</sub>."
- 2. "I will receive my first injection of vitamin B<sub>12</sub> tomorrow, and I will return for a follow-up injection in 1 month."
- 3. "I understand that the oral form of vitamin B<sub>12</sub> is preferred because it is safer and less expensive than the injection form."
- 4. "I will need to take vitamin B<sub>12</sub> replacements for the rest of my life."

**122.** A client's 12:00 noon blood glucose concentration was inaccurately documented as 310 instead of 130. This error was not noticed until 1:00 p.m. The nurse administered the sliding scale insulin for a blood glucose of 310 instead of 130. What should the nurse do **first**?

- 1. Notify the physician.
- 2. Assess for hypoglycemia.
- 3. Consult with the clinical pharmacist.
- 4. Call the charge nurse.

**123.** An older infant who has been injured in an automobile accident is to wear a splint on the injured leg. The mother reports that the infant has become mobile even while wearing the splint. The nurse should advise the mother to do which of the following?

- 1. Notify the physician immediately to adjust the treatment plan.
- 2. Confine the infant to one room in the apartment.
- 3. Keep the infant in the splint at night, removing it during the day.
- 4. Remove any unsafe items from the area in which the infant is mobile.

**124.** While preparing a client for surgery, the nurse assesses for psychosocial problems that may cause preoperative anxiety. Which of the following is believed to be the **most** distressing fear a preoperative client is likely to experience?

- 1. Fear of the unknown.
- 2. Fear of changes in body image.
- 3. Fear of the effects of anesthesia.
- 4. Fear of being in pain.

**125.** A 56-year-old woman is admitted for a modified radical mastectomy. The client appears anxious and asks many questions. The nurse's **best** course of action is to:

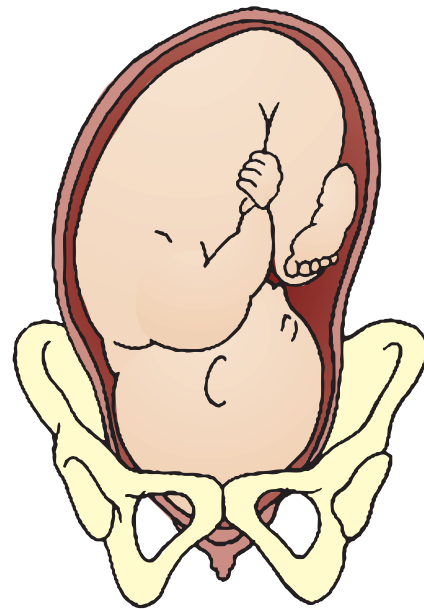
- 1. Tell the client as much as she wants to know and is able to understand.
- 2. Delay discussing the client's questions with her until the convalescent phase of her care.
- 3. Delay discussing the client's questions with her until her apprehension subsides.
- 4. Explain to the client that she should discuss her questions with her physician.

**126.** The nurse asks the client to sign a consent form before undergoing surgery. The client indicates that he was not told about the risks of the surgical procedure. Which of the following statements by the nurse is **most** appropriate?

- 1. "What are your concerns? I can answer any questions that you have."
- 2. "You can go ahead and sign the form. I will be sure to tell the surgeon you have questions."
- 3. "It is important that your questions are answered before you consent to the procedure. I will contact the surgeon."
- 4. "Actually, the risks associated with this procedure are minimal. The surgeon has performed this surgery many times."

**127.** The nurse is assessing fetal position in a 32-year-old woman in her eighth month of pregnancy. From the figure below, the fetal position can be described as:

- 1. Left occipital transverse.
- 2. Left occipital anterior.
- 3. Right occipital transverse.
- 4. Right occipital anterior.



**128.** A child has a urinary tract infection and is being treated with antibiotics. The nurse should instruct the parents to report which of the following?

- 1. Increased urine output.
- 2. Loss of appetite.
- 3. Jaundice.
- 4. Fever.

**129.** After teaching a mother about the neonate's positive Babinski's reflex, the nurse determines that the mother understands the instructions when she says that a positive Babinski's reflex indicates:

- 1. Possible partial paralysis.
- 2. Possible lower limb defect.
- 3. Immature central nervous system.
- 4. Possible injury to nerves that innervate the legs.

**130.** The nurse should instruct a client who is taking dexamethasone (Decadron) and furosemide (Lasix) to report:

- 1. Excitability.
- 2. Muscle weakness.
- 3. Diarrhea.
- 4. Increased thirst.

**131.** A client with a suspected diagnosis of lung cancer has a bronchoscopy with biopsy. Following the procedure the nurse should:

- 1. Encourage the client to gargle with oral lidocaine to decrease throat irritation.
- 2. Monitor the client for signs of pneumothorax.
- 3. Administer pain medication as needed to relieve mediastinal discomfort.
- 4. Advise the client not to talk until the gag reflex returns.

**132.** A nurse is preparing to administer 500 mL of an I.V. solution to a child over 12 hours via tubing that delivers microdrips at 60 gtt/mL. At what rate should the nurse infuse the solution?

\_\_\_\_\_ gtt/minute.

**133.** Which of the following techniques is correct when administering a subcutaneous injection?

- 1. Use a 1-inch needle for injection.
- 2. Insert the needle at a 45-degree angle to the skin.
- 3. Spread the skin tightly at the injection site.
- 4. Draw 0.2 mL of air into the syringe before administration.

**134.** Which of the following is a priority nursing diagnosis for the client presenting with pelvic inflammatory disease?

- 1. *Imbalanced nutrition: Less than body requirements.*
- 2. *Bathing/hygiene self-care deficit.*
- 3. *Acute pain.*
- 4. *Impaired skin integrity.*

**135.** The mother of a 3-year-old child tells the nurse her child is "fussy" and not as "easy going" as her other children. She is having difficulty feeding the child because he fusses and cries when she serves a meal. The nurse should instruct the mother to:

- 1. Allow the child to determine when feeding should occur.
- 2. Not to feed the child if he cries.
- 3. Provide structured feeding times and routines.
- 4. Give the child finger foods and let him eat when he wants.

**136.** When giving a client a tube feeding the nurse should:

- 1. Warm the feeding solution before administration.
- 2. Place the client in a left side-lying position.
- 3. Aspirate residual gastric contents before the feeding and discard.
- 4. Verify position of the tube before beginning feeding.

**137.** A multiparous client 48 hours postpartum who is breast-feeding tells the nurse, "I'm having a lot of cramping. This didn't happen when I nursed my first baby." Which of the following would be the nurse's **best** response?

- 1. "I will notify your doctor. It's possible there are some placental fragments remaining."
- 2. "I need to check your lochial flow. You may have a clot that is being dislodged."
- 3. "You must have gotten a heavy dose of oxytocin (Pitocin). It should wear off soon."
- 4. "The cramping is normal and is caused by your baby's sucking, which stimulates the release of oxytocin."

**138.** The mother of a child with moderate diarrhea asks how to manage her child's illness. Which of the following should the nurse suggest?

- 1. Begin clear liquids for 24 hours.
- 2. Feed the child bananas, rice, applesauce, and toast.
- 3. Offer foods that are low in fat.
- 4. Continue the child's regular diet.

**139.** The nurse is performing routine tracheostomy care. Which of the following steps would be appropriate for the nurse to include in the performance of the procedure?

- 1. Remove the inner cannula every 2 hours for cleaning.
- 2. Secure the tracheostomy ties with a square knot.
- 3. Use cut gauze under the neck plate to protect the skin.
- 4. Suction the inner cannula on completion of the procedure.



**140.** The nurse finds a sealed container of I.V. 50% dextrose in a waste bin on the nursing unit. The nurse should:

- 1. Leave it where found and notify risk management.
- 2. Send it to the pharmacy.
- 3. File an incident report.
- 4. Discard it in a sharps container.

**141.** To reduce the risk of pressure ulcer formation, which of the following activities should the nurse teach the client who is wheelchair-bound as a result of a spinal cord injury?

- 1. Bathe daily.
- 2. Eat a high-carbohydrate diet.
- 3. Shift your weight every 15 minutes.
- 4. Move from the bed to the wheelchair every 2 hours.

**142.** A client in the second stage of labor has had no anesthesia or analgesia. The nurse should assist the client into which of the following positions so the client can begin pushing?

- 1. Squatting with the body curved in a C shape.
- 2. Side-lying while keeping the head elevated.
- 3. In the knee-chest position while keeping the head down.
- 4. Squatting with the back arched.

**143.** A client with antisocial personality disorder tells the nurse, "I punched the guy out because he deserved it and then the cops arrested me." Which of the following responses would be **most** helpful to the client?

- 1. "It's wrong to punch others."
- 2. "If you punch people out, you'll get into trouble."
- 3. "I wouldn't do that again if I were you."
- 4. "Don't ever do that again; you're an adult."

**144.** The nurse is teaching an unlicensed assistive personnel about the care of clients with self-mutilation. Which of the following, if stated by the unlicensed personnel about self-mutilation, demonstrates that the teaching has been effective?

- 1. "It is a means of getting what the person wants."
- 2. "It is a nonserious event that can be ignored."
- 3. "It is a way to express anger and rage."
- 4. "It is a form of manipulation."

**145.** The nurse is obtaining a nursing history of a client suspected of having hepatitis C. The nurse should ask the client if he has:

- 1. Drunk contaminated water.
- 2. Traveled to India.
- 3. Had a tattoo.
- 4. Eaten shellfish.

**146.** A client is experiencing symptoms of early alcohol withdrawal. The client's blood pressure is 150/85 mm Hg and the pulse is 98 bpm. The nurse should:

- 1. Administer lorazepam (Ativan).
- 2. Apply arm and leg restraints.
- 3. Assign an unlicensed assistive personnel to sit with the client.
- 4. Notify the physician.

**147.** Which of the following diet instructions are appropriate when teaching a client in the early stages of cirrhosis about nutritional needs? Select all that apply.

- 1. "Limit your caloric intake so that you don't become overweight."
- 2. "An adequate intake of protein is important to your health."
- 3. "I encourage you to eat small, frequent meals."
- 4. "Restrict your fluid intake to 1,000 mL/day."
- 5. "Limit your alcohol intake to one glass of wine daily."

**148.** After a child returns from the postanesthesia care unit after surgery, which of the following should the nurse assess **first**?

- 1. The I.V. fluid access site.
- 2. The child's level of pain.
- 3. The surgical site dressing.
- 4. The functioning of the nasogastric tube.

**149.** To protect a client who has received tissue plasminogen activator (t-PA) or alteplase recombinant (Activase) therapy, the nurse should:

- 1. Use the radial artery to obtain blood gas samples.
- 2. Maintain arterial pressure for 10 seconds.
- 3. Administer I.M. injections.
- 4. Encourage physical activity.

**150.** A client is admitted with acute pancreatitis. The nurse should monitor which of the following laboratory values?

- 1. Decreased urine amylase level.
- 2. Increased calcium level.
- 3. Decreased glucose level.
- 4. Increased serum amylase and lipase levels.

**151.** For the client with a substance abuse problem, which of the following would be **most** helpful to aid the client in dealing with feelings and concerns related to alcohol and drugs?

- 1. Individual therapy.
- 2. Group sessions.
- 3. Solitary activities.
- 4. Recreation.

**152.** A client has cystitis. The nurse should further assess the client for:

- 1. Flank pain.
- 2. Oliguria.
- 3. Nausea and vomiting.
- 4. Foul-smelling urine.

**153.** A client with acute stress disorder is telling the nurse about the tornado that leveled his house and killed his wife and baby while he was out of town on business. He states, "If only I'd been at home, I could have saved them." Which of the following responses would be **most** appropriate?

- 1. "Don't blame yourself; you'll only feel worse."
- 2. "It's not your fault; so stop feeling so guilty."
- 3. "You might not have been at home."
- 4. "You couldn't have prevented the tornado; it just happened."

**154.** On the first postpartum day, the nurse is caring for a primiparous client who has recently emigrated from Japan to the United States and speaks only a little English. The nurse observes that the client has been bottle-feeding her neonate on occasion, but most of the neonatal care is being performed by the client's mother-in-law. Which of the following actions would be **most** appropriate?

- 1. Notify the social worker because bonding may be affected.
- 2. Document the unusual maternal behavior in the client's chart.
- 3. Determine whether this is a cultural practice for the client and her family.
- 4. Obtain an order to make a home visit after the client's discharge.

**155.** A client is scheduled for a creatinine clearance test. Which one of the following preparations is appropriate for the nurse to make?

- 1. Instruct the client about the need to collect urine for 24 hours.
- 2. Prepare to insert an indwelling urethral catheter.
- 3. Provide the client with a sterile urine collection container.
- 4. Instruct the client to force fluids to 3,000 mL/day.

**156.** When the nurse is assessing a client's cultural adaptation, which of the following statements is **least** sensitive to the client's needs?

- 1. "What are some of your favorite foods?"
- 2. "Describe any health problems in your past."
- 3. "Please tell me how you would like to be addressed."
- 4. "Your eyes look dark; is this normal for you?"

**157.** After several months of taking olanzapine (Zyprexa), the client reports that he is no longer hearing voices of any kind. Which of the following would confirm that the client is developing insight into his illness?

- 1. "That Zyprexa is the best medicine I have ever had."
- 2. "I didn't realize how sick I could get from a chemical brain imbalance."
- 3. "My mom is proud of me for staying on my medicines."
- 4. "I think I may be able to get a little part-time job soon."

**158.** A client who is a computer operator has developed carpal tunnel syndrome. The nurse can instruct the client to relieve the pain by managing:

- 1. Decreased circulation to the brachial nerve.
- 2. Muscle atrophy resulting from disuse.
- 3. Median nerve compression.
- 4. Progressive flexion contracture of the wrist.

**159.** A client with type I diabetes mellitus is scheduled to have surgery. The client has been NPO since midnight. In the morning, the nurse notices the client's daily insulin has not been ordered. Which action should the nurse do **first**?

- 1. Obtain the client's blood glucose at the bedside.
- 2. Contact the physician for further orders regarding insulin dosage.
- 3. Give the client's usual morning dose of insulin.
- 4. Inform the Post Anesthesia Care Unit (PACU) staff to obtain the insulin order.

**160.** A client who is recovering from transurethral resection of the prostate (TURP) experiences urinary incontinence. He tells the nurse that he has decreased his fluid intake because of the incontinence. What would be the nurse's **best** response to the client?

- 1. "Yes, limiting your fluids can decrease your incontinence."
- 2. "Limiting your fluids will cause kidney stones."
- 3. "Drink eight glasses of water a day and urinate every 2 hours."
- 4. "If your incontinence continues, we will reinsert your catheter."

**161.** Which of the following is a risk factor for toxic shock syndrome (TSS)?

- 1. Changing tampons every 3 hours.
- 2. Avoiding use of deodorized tampons.
- 3. Alternating tampons with sanitary pads.
- 4. Using only tampons at night.

**162.** A client with a history of cystitis is admitted to the hospital with a diagnosis of pyelonephritis. The nurse should assess the client for which of the following?

- 1. Suprapubic pain.
- 2. Dysuria.
- 3. Urine retention.
- 4. Costovertebral tenderness.

**163.** A woman is taking oral contraceptives. The nurse teaches the client that medications that may interfere with oral contraceptive efficacy include:

- 1. Antihypertensives.
- 2. Antibiotics.
- 3. Diuretics.
- 4. Antihistamines.

**164.** A 28-year-old female client is prescribed danazol (Danocrine) for endometriosis. The nurse should instruct the client to report:

- 1. Headaches.
- 2. Weight loss.
- 3. Increased libido.
- 4. Hair loss.

**165.** To which of the following unlicensed assistive personnel should the nurse assign an Hispanic male client who needs complete morning care?

- 1. Mary, who has two other clients requiring complete morning care.
- 2. Joe, who has one client requiring complete morning care.
- 3. Jill, who has four clients requiring partial morning care.
- 4. Jim, who has five clients requiring partial morning care.

**166.** A client with chronic renal failure is experiencing central nervous system changes caused by uremic toxins. Which nursing intervention would be **most** appropriate for addressing the changes?

- 1. Allow the client to grieve for body image changes.
- 2. Restrict foods that are high in potassium.
- 3. Restrict fluid intake to 1,000 mL/day.
- 4. Assess the client's mental status regularly.

**167.** The nurse is preparing to give a subcutaneous injection to an elderly, emaciated client. Which needle length and angle should the nurse plan to use to administer the injection safely?

- 1. A  $\frac{3}{8}$ -inch needle at a 90-degree angle.
- 2. A  $\frac{5}{8}$ -inch needle at a 45-degree angle.
- 3. A  $\frac{1}{2}$ -inch needle at a 15-degree angle.
- 4. A  $\frac{5}{8}$ -inch needle at a 90-degree angle.

**168.** A female client is treated for trichomoniasis with metronidazole (Flagyl). The nurse instructs the client that:

- 1. The medication should not alter the color of the urine.
- 2. She should discontinue oral contraceptive use during this treatment.
- 3. She should avoid alcohol during treatment and for 24 hours after completion of the drug.
- 4. Her partner does not need treatment.

**169.** A client is in the advanced stages of osteoarthritis. Which of the following **best** describes the pain that occurs in the advanced stage of the disease?

- 1. Pain occurs with minimal activity.
- 2. Crepitation develops and intensifies pain.
- 3. Joints are symmetrically affected by pain.
- 4. Fatigue accompanies pain.

**170.** A family may request to have a client of Vietnamese descent transferred to die at home because it is traditionally believed that:

- 1. It is disloyal to leave their loved one in the hospital.
- 2. The hospital cannot be trusted.
- 3. The family can provide more comfort at home.
- 4. Reincarnation will not occur in the hospital.

**171.** A client has just been admitted with acute delirium of unknown etiology. The client's daughter states that she is worried about her mom because she has never been this sick before. Which of the following should be the **most** helpful statement to make to the daughter?

- 1. "Please don't worry. We will take good care of your mother."
- 2. "The doctor will order tests to find out what is causing her condition."
- 3. "We can help you learn how to take care of her after she is discharged."
- 4. "It helps if you avoid arguing when she talks about seeing people who aren't there."

**172.** A client with Alzheimer's disease is going to live with his daughter who does not work outside of the home. The nurse determines that the daughter needs further education when she makes which of the following statements?

- 1. "I've put special locks on all the doors that Dad won't be able to unlock."
- 2. "Dad said that what he missed most while he was here was using his aftershave."
- 3. "Dad will be in a bedroom that has nothing for him to trip over getting to the bathroom."
- 4. "I've taken the knobs off of the stove so he won't be able to turn it on."

**173.** Allopurinol (Zyloprim) is prescribed for a client who has chronic gout. Which of the following comments indicates that the client understands how to take the allopurinol?

- 1. "I will take the medication whenever my joints hurt."
- 2. "I must take this drug on an empty stomach."
- 3. "I should drink plenty of fluids when taking allopurinol."
- 4. "I should not take aspirin when taking allopurinol."

**174.** The mother calls the nurse to report that her toddler just been burned on the arm. The nurse should advise the mother to **first**:

- 1. Pack the arm in ice, then take the child to the closest emergency department.
- 2. Rub the burned area with an antibacterial ointment, then call the doctor.
- 3. Run cool water over the burned area, then wrap it in a clean cloth.
- 4. Call the child's health care provider immediately, then wrap the arm in a clean cloth.

**175.** The nursing assessment of a client with osteomyelitis of the left great toe reveals pain with partial weight-bearing, unsteady gait, and complaints of general weakness. Based on these data, the priority nursing diagnosis for the client is:

- 1. *Impaired physical mobility.*
- 2. *Impaired skin integrity.*
- 3. *Ineffective coping.*
- 4. *Risk for injury.*

**176.** A client receiving a blood transfusion begins to have chills and headache within the first 15 minutes of the transfusion. The nurse should **first**:

- 1. Administer acetaminophen.
- 2. Take the client's blood pressure.
- 3. Discontinue the transfusion.
- 4. Check the infusion rate of the blood.

**177.** A 72-year-old client is referred for counseling. During the initial nursing assessment, the client denies the need for counseling. The nurse would agree with the client if she made which of the following comments?

- 1. "My doctor just put me on an antidepressant, and I'll be fine in a week or so."
- 2. "My daughter sent me here. She's mad because I don't have the energy to take care of my grandkids."
- 3. "Since I've gotten over the death of my husband, I've had more energy and been more active than before he died."
- 4. "My son got worried because I made this silly comment about wanting to be with my husband in heaven."

**178.** A client takes isosorbide dinitrate (Isordil) as an antianginal medication. Which of the following statements indicates that the client understands the adverse effects of the drug?

- 1. "I should take my pulse before taking the medication."
- 2. "I should take Isordil with food."
- 3. "I will need to change positions slowly so I won't get dizzy."
- 4. "It is important that I report any swelling in my ankles."

**179.** The nurse is working on discharge plans with a client who is diagnosed with intermittent explosive disorder, characterized by sudden angry outbursts. The nurse determines that the client is ready for discharge when he makes which of the following comments?

- 1. "I'm just not going to let myself get angry anymore."
- 2. "Drinking doesn't help, but I like being with my buddies at the bar."
- 3. "I'll be taking valproic acid (Depakote) and propranolol (Inderal) to help stay in control."
- 4. "It would help if my mom would stop getting on my case all the time."

**180.** The nurse walks into a client's room to administer the 9:00 a.m. medications and notices that the client is in an awkward position in bed. What is the nurse's **first** action?

- 1. Ask the client his name.
- 2. Check the client's name band.
- 3. Straighten the client's pillow behind his back.
- 4. Give the client his medications.

## Answers, Rationales, and Test Taking Strategies


The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

**1. 4.** Heartburn is caused when stomach contents enter the distal end of the esophagus, producing a burning sensation. To avoid heartburn during pregnancy, the client should avoid spicy foods; eat smaller, more frequent meals; and avoid lying down after eating. Peristalsis usually decreases during the latter half of pregnancy. Displacement of the stomach by the uterus, not the diaphragm, may contribute to heartburn. Increased, not decreased, secretion

of hydrochloric acid also contributes to heartburn during pregnancy.

 CN: Basic care and comfort; CL: Apply

**2. 2.** Acknowledging the anger and its source encourages communication about the client's feelings. Although anger at God is common after a loss, the client is displacing the anger that she needs to deal with more directly. Telling the client that the miscarriage was an accident or that she is a strong person and will get through this ignores the client's feelings of anger and loss, thereby cutting off communication.

 CN: Psychosocial adaptation;  
CL: Synthesize

**3. 4.** Asking the client to speak about his concerns encourages open discussion. Telling the client that he is making a mistake is judgmental of the client's wishes and eliminates opportunities for the client to explore the situation and discuss various treatment options. Saying that herbal treatments have not been approved by the FDA or that they have not been researched is irrelevant, places a value judgment on the client's wishes, and provides no opportunity for discussion.

 CN: Management of care; CL: Synthesize

**4. 3.** The most important aspect of teaching a preschooler is to have the family members there for support. Preschoolers are able to understand information that is individualized to their level. Including a plastic model of the heart and a catheter as part of the preoperative preparation may be helpful. The other family members will understand the heart model and catheter better than the preschooler will.

 CN: Reduction of risk potential;  
CL: Synthesize

**5. 4.** Massaging an area that is reddened due to pressure is contraindicated because it further reduces blood flow to the area. In the past, massaging reddened areas was thought to improve blood flow to the area, and some nursing personnel may still believe that massaging the area is effective in preventing pressure ulcer formation.

 CN: Management of care; CL: Synthesize

**6. 3.** Asking the mother to talk about her concerns acknowledges the mother's rights and encourages open discussion. The other responses negate the parent's concerns.

 CN: Management of care; CL: Synthesize

**7. 1, 3.** The breast-feeding mother is encouraged to avoid potentially allergic foods, such as fish and peanuts, during the first several months.

 CN: Health promotion and maintenance;  
CL: Apply

**8. 3.** The Meals on Wheels program delivers meals to clients once a day in their homes. In addition to the improved nutrition, it is commonly valued as a means to check on elderly persons who live alone. Hospice care involves daily needs for the terminally ill at home. VNA provides skilled nursing care to clients at home. AARP is a national organization for retired people, not a health care organization.

 CN: Management of care; CL: Apply

**9. 1.** The cardiovascular status of the client is the first information documented, and will validate the effectiveness of the temporary pacemaker. The client's emotional state and the type of sedation are important but not a high priority. The nurse will need to document the pacemaker information (settings of the pacemaker); this will be considered part of the cardiovascular information.

 CN: Physiological adaptation; CL: Apply


**10. 3.** Using a special feeding table or modified high chair is the best method for an infant who is used to sitting up for feedings. The child should not be flat because of the danger of aspiration. Raising the child's head will not work as well as using a feeding table because the child is not used to lying down to eat. Two people are not necessary.

 CN: Health promotion and maintenance;  
CL: Evaluate


**11. 3, 4.** The National Association for Home Care (NAHC) defines "home care" as services for people who are recovering, disabled, or chronically ill and who are in need of treatment or support to function effectively in the home environment. The client with multiple sclerosis and an open lesion is at risk for infection and will require assistance with managing the lesion. Prothrombin monitoring is usually done at the clinic or health care provider office. Diet instruction can be accomplished at a health care facility or dietitian office. The client with vertigo should be monitored for safety in the home. Clients receiving home care services are usually under the care of a physician with the focus of care being treatment or rehabilitation. Lenses for glasses can be evaluated at an eye clinic or an ophthalmologist's office; a prescription for stronger lenses could be written.

 CN: Management of care; CL: Evaluate


**12. 4.** Ventricular tachycardia is recognized by a wide QRS complex; the rhythm may be regular or irregular. The P waves, if observed, are not related to the QRS complex. Ventricular tachycardia is a major arrhythmia and must be treated immediately.

 CN: Physiological adaptation;  
CL: Analyze

**13. 3.** Although coordinating documentation, resolving negative feelings, and calming down are goals of debriefing after a restraint, the ultimate outcome is to improve restraint procedures.

 CN: Psychosocial adaptation;  
CL: Synthesize

**14. 3.** ARDS frequently develops after a major insult to the body. The major diagnostic indicator is low arterial oxygen levels that are not responsive to the administration of high concentrations of oxygen. Early recognition of ARDS is important to increase the client's chances of recovery. The oxygen levels of clients with hospital-acquired pneumonia, hypovolemic shock, or asthma would be expected to improve with oxygen administration.

 CN: Physiological adaptation;  
CL: Analyze


**15. 2.** By federal law, all clients entering a hospital or hospice program are offered the chance to make an advance directive, so that their wishes will be known and followed in an emergency. The directive is not a substitute for informed discussion with the physician. Worry about extraordinary means being taken can be discussed with the client later, but the client needs to be informed that the directive is a federal requirement to protect the client's autonomy.

 CN: Management of care; CL: Synthesize

**16. 1, 2, 3, 4.** The role of the nurse in witnessing the signing of the consent is to witness that the client is informed of the procedure, understands the information, is aware of potential complications, and is signing of his or her own free will. It is not necessary for a spouse, relative, or guardian to be present.

 CN: Management of care; CL: Apply

**17. 4.** Doxycycline is contraindicated in pregnancy because it can stain the teeth of the developing fetus when given during the last half of pregnancy. The nurse should withhold the drug and notify the physician to change the order. All neonates are given prophylactic ophthalmic ointment for the prevention of ophthalmic neonatorum, conjunctivitis caused by gonorrhea. Naprosyn and aspirin may be used to treat headaches. Imuran is used to prevent rejection of transplanted organs.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**18. 3.** The contraction stress test simulates labor and determines the fetal response to the labor process and the mother's contractions. Therefore, determining that contractions have ceased after the test is important. Although spontaneous rupture of


membranes is a possibility after a contraction stress test, it is not a typical occurrence. The test should not affect the viability of the fetus. Fetal viability is related to gestational age. A fetus of at least 23 weeks' gestation is considered viable, or capable of extrauterine life. A negative contraction stress test should not affect or alter fetal heart rate variability.

 CN: Reduction of risk potential;  
CL: Synthesize


**19. 1.** A postoperative ileus is a functional obstruction of the bowel. Assessment of bowel sounds, the first stool, and the amount of gastric output provide information about the return of gastric function. Measurement of urine specific gravity provides information about fluid and electrolyte status.

 CN: Reduction of risk potential;  
CL: Analyze


**20. 2.** Salmeterol (Serevent) is a beta<sub>2</sub>-agonist, a maintenance drug that the asthmatic client uses twice daily, every 12 hours. Albuterol (Proventil) is used as the "rescue inhaler" for bronchospasms. Serevent can be used to prevent exercise-induced bronchospasms, but it should be taken 30 to 60 minutes before exercise. If the client is taking Serevent twice daily, it should not be used in additional doses before exercise; twice daily is the maximum dosage. Indications for Serevent include only asthma and bronchospasm induced by chronic obstructive pulmonary disease.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**21. 1, 2, 4.** Nephrotic syndrome is characterized by massive proteinuria, hypoalbuminemia, edema, and hyperlipidemia and normal or lower than normal blood pressure. Elevated streptococcal antibody titers are associated with poststreptococcal glomerulonephritis, an immune complex disease.


 CN: Physiological adaptation;  
CL: Analyze

**22. 3.** Aldactone is a potassium-sparing diuretic often used to counteract potassium loss caused by other diuretics. If foods or fluids are ingested that are high in potassium, hyperkalemia may result and lead to cardiac arrhythmias. Increasing the intake of milk or milk products does not affect the potassium level. Restricting fluid may elevate all electrolytes due to extracellular fluid volume depletion. By increasing foods high in sodium, water would tend to be retained and so would dilute all electrolytes in the extracellular fluid compartment.

 CN: Health promotion and maintenance;  
CL: Synthesize

**23. 4.** Because clozapine can cause tachycardia, the nurse should withhold the medication if the

pulse rate is greater than 140 bpm and notify the physician. Giving the drug or telling the client to exercise could be detrimental to the client.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**24. 3.** The client has ventricular fibrillation, an arrhythmia that can lead to cardiac arrest. Given the client's history, the nurse should call the rapid response team to initiate interventions to avoid cardiac arrest. After calling the team, the nurse can administer oxygen. Taking time to inspect the incision delays the necessary intervention. This ECG strip does not show loose electrodes.

 CN: Management of care; CL: Synthesize


**25. 2.** The best approach by the mother is not to interfere. The children need to learn how to solve disagreements on their own. If the parent always intervenes, then the children do not learn how to do this. Siblings will disagree and argue as part of normal development. Punishment, including telling the children that they will not go out to lunch, is not warranted.

 CN: Health promotion and maintenance; CL: Evaluate

**26. 2.** Managing stressful life events can decrease the incidence of outbreaks of HSV-2. Occlusive ointments should not be applied. Antiviral therapies will not cure herpes, but they can manage symptoms and decrease the incidence of outbreaks. Clients with HSV-2 should use condoms to prevent HSV transmission. Cells can be shed at other times, not only when the vesicles are weeping.

 CN: Physiological adaptation; CL: Synthesize


**27. 1, 3, 4.** The nurse should assess the client for adverse effects affecting the vestibular branch of the acoustic nerve, such as vertigo, nausea and vomiting with motion, and ataxia. Tinnitus, or a ringing in the ears, is a clinical manifestation of altered function of the auditory branch of the eighth cranial nerve, not the vestibular branch. The client will not have hearing loss.

 CN: Physiological adaptation; CL: Analyze

**28. 1.** Tetanus toxoid is indicated, since there has been no booster in the last 5 years. With a human bite there is a risk of severe infection; application of a steroid cream does not prevent infection. The closure of the wound should be delayed until it is determined that there is no infection, in approximately 24 to 48 hours. Tuberculosis is not transmitted through human bites.

 CN: Reduction of risk potential; CL: Apply


**29. 3, 4, 5.** Before discussing the use of Depo-Provera as a birth control option, the nurse should determine if the woman is or has been depressed because Depo-Provera can increase depression in a client with depression. The drug can be transmitted in breast milk, and the long-term effects on the baby are not known. Women who are pregnant should not take Depo-Provera. Depo-Provera does not treat or prevent sexually transmitted diseases, so this information is not essential when considering its use. Although the husband should be a part of birth control decisions, the final decision is made by the client.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**30. 3.** With a parent who is visibly upset, it is best to try to determine the cause. Therefore, asking the mother about why she wants to take the child home can provide insight into the problem. The nurse cannot stop the mother from taking her child home. However, the physician should be notified about the mother's decision and efforts are needed to explain the ramifications of taking the child home. It is inappropriate for the nurse to say "I know how you feel" or "I can imagine how hard this is" unless the nurse has had the same experience.

 CN: Psychosocial adaptation; CL: Synthesize

**31. 2.** Prolonged inactivity causes the body to excrete excessive calcium. This leads to breakdown of bone tissue; as a result, the bones become brittle and fracture easily, a condition known as osteoporosis. The excessive calcium excretion that occurs during bed rest also predisposes the client to formation of renal calculi. Prolonged bed rest does not increase sodium retention, insulin use, or red blood cell production.


 CN: Physiological adaptation; CL: Analyze

**32. 1.** Normal urine output for an infant is 1 to 2 mL/kg/hour.


 CN: Physiological adaptation; CL: Evaluate

**33. 1, 2, 4.** All areas concerned with the safety and quality of care need to participate in the decision-making process and arrive at a plan that will meet the needs of the clients on the neonatal care unit. Identifying the problem at a staff meeting is an ideal forum to bring up the need for improvement and education. The staff is an integral part of the development team. The staff educator is an important member of the team and is responsible for orienting new nurses to the unit. Asking an experienced staff member to spend time in reorienting

staff members is difficult to do as the nurses have their own clients to care for. Although the unit director can obtain additional information from the physicians about the problem, the nursing staff has responsibility for assuring that they are providing safe and high quality care.

 CN: Safety and infection control;  
CL: Synthesize


**34. 2.** Based on the data given, the most appropriate nursing diagnosis is *Activity intolerance* related to severe left leg pain. The other diagnoses are not supported by the data presented. There is no clinical indication that the leg will need to be amputated or that the client is experiencing a disturbance in body image. A temperature of 101° F (38.3° C) would be unlikely to produce a fluid volume deficit in this client.

 CN: Physiological adaptation;  
CL: Analyze


**35. 3.** After vasectomy, a sperm analysis will be performed every 4 to 6 weeks. A sperm-free analysis is necessary before the man can be considered sterile. Sperm gradually disappear from the ejaculate. Clients must be informed that conception is possible in the immediate postvasectomy period.

 CN: Physiological adaptation; CL: Apply

**36. 3.** Gentamicin (Garamycin) is ototoxic; therefore, the client should have a vestibular and auditory check 3 to 4 weeks after discontinuing the drug. This is the most likely time for deafness to occur. It is not necessary to check the client's hemoglobin level, white blood cell count, or serum potassium level solely on the basis of having taken gentamicin. The blood urea nitrogen level and the creatinine level will be checked to assess renal function, if necessary.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**37. 1, 2, 4.** Classic signs of meningitis in an infant include fever, poor feeding, vomiting, and irritability. Abdominal pain and diarrhea are not usual signs of meningitis; they are more commonly associated with gastroenteritis.


 CN: Physiological adaptation;  
CL: Analyze

**38. 2.** Deep-breathing exercises and use of incentive spirometry are more effective when pain is minimal. A client in severe pain tends to limit movement and to breathe shallowly to decrease the pain. Enough pain medication should be given to decrease pain without depressing respirations. Administration of oxygen or forcing fluids will not prevent atelectasis or pneumonia. Deep-breathing exercises and use of incentive spirometry should be

done 10 times every hour while awake. The client's position should be changed every 1 to 2 hours to allow for full chest expansion. Ambulation, not just sitting in the chair, should be implemented as soon as physician approval is obtained.

 CN: Reduction of risk potential;  
CL: Synthesize

**39. 2.** A child who has had rheumatic fever is likely to develop the illness again after a future streptococcal infection. Therefore, it is advised that the child receive antibiotic prophylaxis for at least 5 years and sometimes even longer after the acute attack to prevent recurrence.

 CN: Physiological adaptation;  
CL: Synthesize

**40. 4.** Crowning occurs when the fetal head is visible. Anterior-posterior slit occurs as the perineum flattens and is followed by an oval opening. As labor progresses, the perineum takes on a circular shape, followed by crowning.

 CN: Physiological adaptation; CL: Apply

**41. 1.** The first action is to increase the oxygen flow rate from 2 to 4 L/minute to help ensure adequate oxygenation for the client. Although it is important to notify the physician for additional orders and to obtain further assessment data, such as arterial blood gas measurements, it is a priority to support the client's cardiopulmonary system. It would be appropriate to reassure the client while these other interventions are occurring.

 CN: Reduction of risk potential;  
CL: Synthesize

**42. 2.** Although a cool air vaporizer may be recommended to humidify the environment, using saline nose drops and then a bulb syringe before meals and at nap and bed times will allow the child to breathe more easily. Saline helps to loosen secretions and keep the mucous membranes moist. The bulb syringe then gently aids in removing the loosened secretions. Blowing into the child's mouth to clear the nose introduces more organisms to the child. A nonprescription vasoconstrictive nasal spray is not recommended for infants because if the spray is used for longer than 3 days a rebound effect with increased inflammation occurs.

 CN: Reduction of risk potential;  
CL: Synthesize

**43. 3.** Hoarseness may indicate metastatic disease to the recurrent laryngeal nerve and is commonly noted with left upper lobe lung tumors. Diarrhea and constipation are not associated with lung cancer. Weight loss, not weight gain, can be a symptom of extensive disease.

 CN: Physiological adaptation; CL: Analyze



**44. 1.** The nurse should determine if the physician is the physician of record and should have access to the information in the record. The electronic medical record is not for public access. The nurse would not give client information to any physician or refuse to give information without first determining the physician of record and/or a legitimate need to know. As an employee, the nurse should have access to electronic medical records, but it is not acceptable to enter a medical record without justification.

 CN: Management of care; CL: Synthesize

**45. 1.** A client with metabolic alkalosis may exhibit irritability or nervousness. Hyperventilation is a clinical manifestation of respiratory alkalosis. Diarrhea is a possible clinical finding in metabolic acidosis. Edema is not specifically associated with an acid-base imbalance.

 CN: Physiological adaptation; CL: Analyze

**46. 2.** An initial sign of hemorrhaging after a tonsillectomy is swallowing frequently as mucus and blood combine to increase secretions. Mouth breathing is expected after surgery because the child's mouth is very dry and the throat is sore. Because the child has been without fluids for some time, the child usually is thirsty and asks for a drink. Increased pulse rate is a later sign of hemorrhage.

 CN: Reduction of risk potential;  
CL: Analyze

**47.**


1. Stop the transfusion.

3. Keep the vein open with normal saline solution.

4. Administer an antihistamine as directed.

2. Send the blood bag and blood slip to the blood bank.

The nurse should first stop the transfusion. The nurse should next keep the I.V. open at the original blood transfusion site with normal saline at a keep-vein-open rate. Then, the nurse should administer an antihistamine. Last, the nurse should return the blood bag and blood slip to the blood bank for testing.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**48. 33 gtt/minute**


The flow rate is determined by the rate of infusion and the number of drops per milliliter of the fluid being administered:  $\text{gtt/mL} \times \text{mL/minute} = \text{I.V. flow rate (gtt/minute)}$ .

Therefore:


$$10 \text{ gtt/mL} \times 100 \text{ mL/30 minutes} = 33 \text{ gtt/minute.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**49. 4.** Delusions of grandeur provide the client with an exaggerated sense of self-esteem that is unrelated to the client's actual achievements. Other, less grandiose, religious delusions may provide comfort or meaning for the client. Delusions of persecution are frequently related to safety issues. Delusions may also be related to sexual issues.

 CN: Psychosocial adaptation;  
CL: Analyze

**50. 3.** Loss of electrolytes from the gastrointestinal tract through vomiting, diarrhea, or nasogastric suction is a common cause of potassium loss, resulting in hypokalemia. Hypermagnesemia does not result from excessive loss of gastrointestinal fluids. Common causes of hyponatremia are water loss (as in diabetes insipidus or osmotic diuresis) and excessive sodium intake. Common causes of hypocalcemia include chronic renal failure, elevated phosphorus concentration, and primary hypoparathyroidism.

 CN: Physiological adaptation;  
CL: Analyze

**51. 3.** It is a normal variation for women to have long-term, bilateral nipple inversion. A woman who has a unilateral nipple inversion that is a new change is at risk for a tumor; the weight of the tumor causes pulling on the nipple. A pronounced unilateral venous pattern, peau d'orange breast tissue, and breast tissue darker than the areolae are definite warning signals for breast cancer that must be reported to the physician immediately.


 CN: Health promotion and maintenance;  
CL: Analyze

**52. 1.** It is important for children with sickle cell disease to drink lots of fluids to help prevent a crisis. Dehydration precipitates sickling and a crisis. Although taking the child's temperature may provide information about the child's status, it will do nothing to prevent a crisis, nor will weighing the child daily. Offering the child a high-protein diet will not prevent a crisis, nor is it recommended.


 CN: Reduction of risk potential;  
CL: Synthesize

**53. 1.** The nurse notifies the pediatrician because a short, webbed neck is associated with genetic deviations or chromosomal disorders such as Turner's syndrome. Cleft palate is associated with embryonic developmental failures and an abnormal opening in the palate. Potter's syndrome (renal agenesis) is characterized by an atypical facial appearance

consisting of a flat nose, recessed chin, epicanthal folds, low-set abnormal ears, limb abnormalities, and pulmonary hypoplasia. Neural tube defects are associated with spina bifida or myelomeningocele.

 CN: Physiological adaptation;  
CL: Analyze


**54. 3.** Clinical manifestations of hypokalemia include an irregular pulse, fatigue, muscle weakness, flabby muscles, decreased reflexes, nausea, vomiting, and ileus. Muscle spasms are not seen in hypokalemia. Thirst is a symptom of hypernatremia. Confusion can be seen in hyponatremia and hypocalcemia.

 CN: Physiological adaptation;  
CL: Analyze

**55. 1, 3, 5.** Notifying the pharmacy of the nursing concerns is an appropriate first action. The nursing staff should work cooperatively with the pharmacy to develop a system that works well for both nursing and pharmacy. Constant communication with all nursing staff during the quality improvement process is integral to the final approval process of both groups. Moving the drugs to a new position within the medication system during an off shift may create errors, as medications are inserted into the system in a certain position. Leaving the decisions to the pharmacy staff eliminates the input provided by nursing, a vital link between medication and the client.

 CN: Management of care; CL: Synthesize


**56. 2.** The client's self-report of pain is the most reliable indicator of the existence and intensity of the pain. Client response to pain is highly individualized and subjective. The nurse must respect the client's self-report.

 CN: Physiological adaptation;  
CL: Evaluate

**57. 2.** Excessive milk consumption can lead to the displacement of iron-rich foods in the diet. This can result in iron deficiency anemia. Drinking excess milk will not cause vitamin C, biotin, or folate deficiencies.


 CN: Health promotion and maintenance;  
CL: Apply

**58. 2.** Although all the symptoms listed can occur in cases of fat embolism syndrome, confusion is the earliest symptom noted. The confusion is caused by a low arterial oxygen level.

 CN: Physiological adaptation;  
CL: Analyze

**59. 1.** An idea of reference is a person's view that other people recognize that she has an important characteristic or power. Thought insertion refers to a person's belief that others, or a specific other, can


put thoughts into her mind. Visual hallucinations involve seeing objects or persons not based in reality. A neologism is a word or phrase that has meaning only to the person using it.

 CN: Psychosocial adaptation;  
CL: Analyze

**60. 3.** The American Academy of Pediatrics and the American College of Obstetrics and Gynecology recommend hearing screening for all newborns. Currently more than 30 states mandate screening, which is done by otoacoustic emissions or auditory brainstem response. Newborns can hear as soon as the amniotic fluid drains from the ear canal. Even though hearing problems are not common in newborns, the mother's concerns should be addressed. Clapping to elicit a response is crude and unreliable. If done for minimal screening, the distance should be no more than 12 inches.

 CN: Health promotion and maintenance;  
CL: Apply


**61. 4.** The equianalgesic dose of oral meperidine hydrochloride is up to four times the I.M. dose. Meperidine hydrochloride (Demerol) can be given orally, but it is much more effective when given I.M.

 CN: Pharmacological and parenteral therapies; CL: Apply

**62. 1, 2, 3.** Children tend to be impulsive, which contributes to head injuries. Also, the larger size of the heads of infants and toddlers causes them to fall more easily than older children. Falls account for one-third of all head injuries. Motor vehicle accidents account for about 80% of all severe head injuries in children. Children age 5 to 15 are most likely to be involved in bicycle accidents as a result of only about 50% wearing helmets. Child abuse and tumors involve a much smaller number of children.

 CN: Health promotion and maintenance;  
CL: Apply

**63. 1.** In order to prevent disuse osteoporosis, it is important to implement weight-bearing activities as soon as medically allowed. Increasing the client's calcium intake will not prevent the development of osteoporosis without the inclusion of weight-bearing activity. Passive ROM exercises and isometric exercises do not provide the bone stress necessary to reduce the risk of osteoporosis.

 CN: Reduction of risk potential;  
CL: Synthesize

**64. 3.** Toddlers have temper tantrums in their attempt to develop autonomy. Toddlers should be left alone as long as they are safe during a tantrum. Moving the child to a time-out chair or punishing the child reinforces the behavior and is to be avoided. Attempting to talk to the toddler

also reinforces the behavior. Additionally, at this cognitive level, toddlers do not understand as well as older children do.

 CN: Health promotion and maintenance;  
CL: Synthesize

**65. 4.** Following pyloromyotomy the infant should be positioned with the head elevated and slightly on the right side to promote gastric emptying; the parents have positioned their infant correctly. The infant should be positioned on the right side, not the left side. When the child is in a crib, the head can be elevated and the infant can be propped on the right side. The infant can use a pacifier if needed.

 CN: Physiological adaptation;  
CL: Synthesize


**66. 3.** Interactive communication allowing the opportunity for questioning between the giver and receiver of client information, including up-to-date information regarding the client's care, treatment, and services, current condition, and any recent or anticipated changes is hand-off communication as mandated by The Joint Commission. Registered nurses (RNs) bear primary responsibility and accountability for utilization of all nursing care provided to clients. The RN retains the right and has the responsibility to refrain from delegating specific activities based on individual client care needs, caregiver expertise, and/or client care program requirements.

 CN: Management of care; CL: Apply

**67. 2.** Daily skin inspection is essential in preventing pressure ulcers. Hot water is irritating to skin and should be avoided. Massaging bony prominences is contraindicated and may actually promote skin breakdown. Prolonged, uninterrupted chair sitting should be avoided; the client's position should be adjusted at least every hour.


 CN: Reduction of risk potential;  
CL: Synthesize

**68. 3.** Skeletal pins should not be loose and able to move. Any pin loosening should be reported immediately. Slight serous drainage is normal and may crust around the insertion site or be present on the dressing. The pin insertion site should be cleaned with aseptic technique according to facility policy. Pin insertion sites are typically not painful; pain may be indicative of an infection and should be reported.

 CN: Physiological adaptation;  
CL: Analyze

**69. 4.** Acknowledging the basic feeling that the client expressed and asking an open-ended question allows the client to explain her fears. Saying,


"It's normal to be scared. We'll help you through it," does not focus on the client's feelings; rather, it gives reassurance. Asking if the client feels guilty for having smoked assumes guilt, which might be present, but additional information is needed to confirm. Telling the client not to be so hard on herself does not acknowledge the client's feelings at all.

 CN: Psychosocial adaptation;  
CL: Synthesize

**70. 3.** It is important that clients with rheumatoid arthritis maintain proper posture and body alignment to support joints and decrease pain and stiffness. Clients with hip pain will be most comfortable when sitting in a straight-back chair with an elevated seat. Elevated seats avoid excessive hip flexion and place less stress on the hip joints.

 CN: Basic care and comfort; CL: Evaluate


**71. 3.** Giving away personal items has consistently been shown to be an indicator of suicidal plans in the depressed and suicidal individual. The other behaviors indicate a return of interest in normal adolescent activities.

 CN: Psychosocial adaptation;  
CL: Synthesize

**72. 3.** When a neonate dies, the mother should be allowed to stay with the baby as long as she wants and say anything she wants. She is grieving and needs time with the neonate. A photograph should be taken in case the mother wants a photograph at a later time. Telling the mother that this is for the best is inappropriate because such a statement discounts the mother's feelings. Advising the mother to get pregnant again to get over the loss is not helpful because the mother needs time to grieve and be with the neonate. The nurse should remain near the mother and not delegate this responsibility to the hospital's chaplain. A chaplain or other religious member can be contacted if the mother desires.


 CN: Psychosocial adaptation;  
CL: Synthesize

**73. 3, 4, 5.** Spastic CP is the most common type, characterized by poor coordination and balance, gross motor skills impairment, and hypertonicity. CP is nonprogressive and is caused by a variety of prenatal, perinatal, and postnatal factors. Dyskinetic or athetoid CP is the next most common type and is characterized by abnormal involuntary movements and wormlike writhing movements.


 CN: Physiological adaptation;  
CL: Analyze

**74. 4.** Serum albumin levels help determine whether protein intake is sufficient. Proteins are broken down into amino acids during digestion. Amino acids are absorbed in the small intestine, and

albumin is built from amino acids. The red blood cell count, bilirubin levels, and reticulocyte count do not indicate protein intake.

 CN: Physiological adaptation;  
CL: Analyze


**75. 2.** The client who is taking desmopressin (DDAVP) nasal spray should not use the same nares for administration each time. The client should alternate nares every dose. The client should observe for and report promptly signs and symptoms of nasal ulceration, congestion, or respiratory infection.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**76. 0.5 mL**

$$500 \text{ mg/mL} = 250 \text{ mg}/X \text{ mL}$$


$$X = 0.5 \text{ mL.}$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**77. 1, 5, 6.** Down syndrome is the most common trisomal abnormality. It can occur at any maternal age with the average being 27 years. The risk of bearing a Down syndrome infant increases with advanced maternal age. The syndrome is caused by nondisjunction during the first meiotic cell division, rather than autosomal dominant or recessive traits. There is no association with timing or quality of prenatal care.

 CN: Health promotion and maintenance;  
CL: Apply

**78. 3.** Common clinical manifestations of hypokalemia include ventricular arrhythmias; weak and irregular pulse; soft and flabby muscles; and decreased deep tendon reflexes. Hypercalcemia causes confusion and decreased memory, bone pain, polyuria, and nausea, vomiting, and constipation. Hypernatremia causes signs of fluid volume deficit. Hypomagnesemia is manifested by tremors, confusion, hyperactive deep tendon reflexes, and seizures.

 CN: Physiological adaptation;  
CL: Analyze

**79. 3.** As with other contraceptives that are adverse progestin-based, heavy menstrual bleeding may occur. Other adverse effects include rash, acne, alopecia, fluid retention, edema, and sudden loss of vision. Depression and weight gain have been reported. For clients taking this drug, the risk of endometrial or ovarian cancer is decreased. Amenorrhea has been reported in clients after receiving four injections 3 months apart for 1 year. Depression and loss of energy have been reported.

 CN: Pharmacological and parenteral therapies; CL: Create


**80. 4.** Clients with burns are susceptible to the development of Curling's ulcer, a gastroduodenal ulcer that is caused by a generalized stress response. The stress response results in increased gastric acid secretion and a decreased production of mucus. Prevention is the best treatment, and clients are frequently treated prophylactically with antacids and H<sub>2</sub> histamine blockers such as famotidine (Pepcid).

 CN: Reduction of risk potential;  
CL: Synthesize


**81. 2.** Fever is a cardinal manifestation of infection in people with AIDS. Because the major physiologic alteration in AIDS is generalized immune system dysfunction, typical indicators of the body's response to infection (e.g., erythema, warmth, tenderness) may be absent.

 CN: Physiological adaptation;  
CL: Synthesize

**82. 2.** To care effectively for clients with depression, the nurse should teach the importance of demonstrating empathetic concern. Caregivers must accept clients as they are even though many will be angry and negative, acknowledge their emotional pain, and offer to help them work through their pain. For the client who is depressed, using a cheerful demeanor or a humorous, light-hearted approach may be overwhelming because the client will be unable to meet the caregiver's expectations, subsequently leading to decreased self-worth. A serious, business-like affect may threaten the client and inhibit the development of trust.


 CN: Psychosocial adaptation;  
CL: Evaluate

**83. 4.** When a child is ready to take fluids by mouth postoperatively, clear liquids are given initially. If clear liquids are tolerated, the concentration and amount of oral feedings are gradually increased. This means advancing to half-strength and then to full-strength formula while increasing the amount given with each feeding.


 CN: Basic care and comfort;  
CL: Synthesize

**84. 2.** The nurse should monitor the client taking paroxetine, a selective serotonin reuptake inhibitor, for sexual problems, such as decreased libido, impotence, and ejaculatory disturbances, because these adverse effects can occur frequently and lead to medication noncompliance. Sleep disturbances can occur with an SSRI such as paroxetine. However, this client is taking the drug every morning, which would not affect nighttime sleep. Hypertensive crisis is associated with the ingestion of foods rich in tyramine when a client is taking a monoamine


oxidase inhibitor. Orthostatic hypotension is a potential adverse effect of tricyclic antidepressants.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**85. 2.** In the progressive stage of shock, the client can display listlessness or agitation, confusion, and slowed speech. Restlessness occurs in the compensatory stage. Incoherent speech and unconsciousness are clinical manifestations of the irreversible stage.

 CN: Physiological adaptation; CL: Analyze


**86. 1, 4, 5.** Common adverse effects of nafcillin include vomiting, diarrhea, sore mouth, fever, and gastritis. Pain with urination and headache are not associated with this drug.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**87. 1.** The nurse should first apply the ECG electrodes to the client's chest. If the client is found to be in ventricular fibrillation, the immediate priority is to defibrillate the client. Pulse oximetry is not an immediate priority. The client's oxygenation is evaluated in a code situation using arterial blood gas analysis. The client's blood pressure is evaluated after the ECG rhythm has been established. A portable Doppler ultrasound unit may be needed to check for the presence of a pulse or to check the blood pressure in a code situation.

 CN: Physiological adaptation; CL: Synthesize

**88. 1, 2, 3.** Active listening facilitates trust. It means that the nurse acknowledges that she has heard the client and indicates in her own words an understanding of what the client says and the emotions underlying what is said. It also involves encouraging the client to say more. Constant eye contact and standing very close to a client can be unnerving and can hamper trust building.


 CN: Psychosocial adaptation; CL: Synthesize

**89. 2.** Heroin causes pinpoint pupils. Marijuana causes the eyes to appear red and bloodshot. Cocaine use causes pupils to dilate. Drooping of the eyelids is not typically associated with the use of any substance.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**90. 3.** A typical sign of pediculosis capitis (head lice) is frequent scratching of the scalp because the condition causes severe itching. Scratch marks are usually easily visible. Because head lice are easily transmitted to others, the child's family members


and peers also should be examined for infestation. Spotty baldness, wheals, and scaly lesions are often allergic in nature.

 CN: Physiological adaptation; CL: Analyze


**91. 1.** Passing flatus indicates the return of peristalsis, as does active bowel sounds. Hunger is not the best indicator of peristaltic return. Hypoactive bowel sounds indicate that there is some peristaltic activity but it is limited and not yet normal. Palpation is not an appropriate method of assessing bowel activity.

 CN: Physiological adaptation; CL: Evaluate

**92. 3.** The pH of 7.24 indicates that the client is acidotic. The  $\text{Paco}_2$  value of 49 mm Hg is elevated. The  $\text{HCO}_3^-$  value of 24 mEq/L is normal. The client is in uncompensated respiratory acidosis. Hypoventilation and a flushed appearance are additional clinical manifestations of respiratory acidosis.

 CN: Physiological adaptation; CL: Analyze

**93. 2.** It is essential for the nurse to evaluate the effects of pain medication after it has had time to act. Although other interventions may be appropriate, continual reassessment is most important to determine the effectiveness and need for additional intervention, if any. Repositioning could provide some comfort, but assessment of the client's pain level is essential. Reassuring the client is important, but it will be of no value unless the nurse evaluates the client's pain level. To readjust the pain dosage is appropriate only if titration is prescribed by the physician.

 CN: Physiological adaptation; CL: Synthesize

**94. 1.** Barrier contraceptives must be used to protect against STDs. Birth control pills and douching are not effective for prevention of STDs. Prophylactic antibiotics are not used to prevent the acquisition of STDs.


 CN: Safety and infection control; CL: Evaluate

**95. 2.** A purplish blue discoloration of the vagina and cervix is termed Chadwick's sign; it is caused by increased vascularity of the vagina during pregnancy and is considered a probable sign of pregnancy. Goodell's sign, also considered a probable sign of pregnancy, refers to a softening of the cervix during pregnancy. Hegar's sign, also a probable sign of pregnancy, refers to a softening of the lower uterine segment. Melasma, the mask of pregnancy, refers to the pigmentation of the skin on the face during


pregnancy. Melasma is considered a presumptive sign of pregnancy.

 CN: Health promotion and maintenance;  
CL: Apply


**96. 3.** Initially, the nurse would tell the client to seek out staff when feeling agitated or upset to prevent violent episodes. Doing so helps the client to redirect negative feelings in an appropriate manner (e.g., talking). Encouraging the client to stay in his room is inappropriate because it does not help the client to deal with his feelings. Secluding the client at the first sign of agitation is not indicated and may be perceived by the client as punishment. Instructing the client to ask for medication when agitated would not be the initial course of action. The nurse would interact with the client and direct the client to an activity to decrease his anxiety before intervening with any required medication.

 CN: Psychosocial adaptation;  
CL: Synthesize

**97. 3.** The nurse should use short words, sentences, and paragraphs and avoid medical jargon. Correct terminology should be used when appropriate (e.g., type 1 diabetes, not “sugar diabetes”). The format should be as simple as possible; charts are not necessary and may be confusing to some clients. Information should be prepared at a fifth-grade reading level. The information should be presented in large-sized type.

 CN: Psychosocial adaptation;  
CL: Synthesize

**98. 4, 5.** Rapid pulse, heat intolerance, diarrhea, exophthalmos, and accelerated linear growth are more characteristic of hyperthyroidism, which is caused by an autoimmune response to thyroid-stimulating hormone receptors. Weight gain, dry skin, and constipation are characteristic of hypothyroidism, which results from a deficiency in secretion of thyroid hormone.


 CN: Physiological adaptation;  
CL: Analyze

**99. 2.** The criteria for hemorrhage is saturating one pad per hour. The 35-year-old who delivered 4 hours ago had saturated a peripad per hour. Even though her fundus is firm, she may have experienced a cervical laceration which would be the source of the bleeding. She needs to be evaluated first, based on the bleeding. The 18-year-old who has abdominal cramps is within normal limits for a G2 P2 and is experiencing afterbirth pains normally seen in a multiparous client; she will need pain medication. The 16-year-old status post cesarean section on magnesium sulfate is stable with adequate urinary output and normal reflexes. Her vital signs are within normal limits for a postpartum

client. The headache is the one area of concern for this client. The 18-year-old who is 2 days postpartum with breast pain may be experiencing her milk coming in, although it does not indicate whether she is breast- or bottle-feeding; either situation may find a mother with milk developing within her system. The vital signs for this client are slightly elevated, but this may be from the milk coming in and would require nursing evaluation but not is not emergent.

 CN: Management of care; CL: Synthesize

**100. 4.** It is normal for the client to feel pressure on the palms of the hands when walking with crutches. The client should move her affected (right) leg forward first as she swings forward with the crutches. Leaning on the crutches can apply pressure to the axillae, leading to neurovascular impairment. If the client’s arms are tingling after she uses her crutches, she is probably applying pressure on her axillae when walking.

 CN: Reduction of risk potential;  
CL: Evaluate


**101. 2.** Because clients are discharged as soon as possible from the hospital, it is essential to evaluate the support for assistance and self-care at home. If the client has support at home, the distance from the hospital may be irrelevant. The client or support team will monitor vital signs as needed, but blood pressure monitoring is not specifically indicated. It is more important at this point for the client to understand how to manage his care at home, rather than knowing the causes of lung cancer.

 CN: Management of care; CL: Analyze

**102. 3.** If the client begins breast-feeding early and often after delivery, the breasts begin to fill with milk within 48 to 96 hours, or 2 to 4 days. The breasts secrete colostrum for the first 24 to 48 hours, which is beneficial to the neonate because of the immunoglobulins contained in colostrum.


 CN: Health promotion and maintenance;  
CL: Apply

**103. 3.** The predominant clinical finding in elderly or debilitated clients indicating that they have developed Ineffective Gas Exchange is confusion, which results from hypoxia. Fever and chills, productive cough, and pleuritic chest pain could be present, but confusion is the predominant development.


 CN: Physiological adaptation;  
CL: Analyze

**104. 1.** It is important for the child and family to understand that chorea associated with rheumatic fever is not permanent. Therefore, the nurse should explain that the chorea will disappear over time. It is not necessary to assess the child’s


neurologic status because the chorea is self-limited and nonprogressive. Because the child has cardiac involvement, ambulation is contraindicated. Aspirin is used primarily as an anti-inflammatory drug and secondarily for pain relief. A slightly cool environment is unnecessary. Environmental temperature does not affect the child's polyarthritis and chorea.

 CN: Physiological adaptation;  
CL: Synthesize


**105. 1.** When the gestation is less than 13 weeks, an elective abortion is usually performed by the dilatation and curettage method. Menstrual extraction, or suction evacuation, is the easiest method, but it is used only when the client is between 5 and 7 weeks' gestation. Dilatation and vacuum extraction is used when clients are between 12 and 16 weeks' gestation. Saline induction, used for clients between 16 and 24 weeks' gestation, involves instillation of a hypertonic saline solution into the amniotic sac to initiate expulsion. Oxytocin infusion may also be used with saline induction.

 CN: Health promotion and maintenance;  
CL: Apply

**106. 1.** A pleural effusion is a collection of fluid between the pleural layers of the lung. The effusion decreases chest wall movement on the affected side. The nurse should expect the breath sounds to be decreased or diminished over the affected area. Because of the presence of fluid, percussion would elicit dullness, not hyperresonance. Fever may be present if empyema (purulent pleural fluid with bacterial infection) has developed, but not in the case of a nonpurulent pleural effusion.

 CN: Physiological adaptation;  
CL: Analyze


**107. 1.** An expected client outcome relative to the nursing diagnosis of *Acute pain* related to cramping is that the client exhibits no manifestations of discomfort, such as crying or drawing the legs to the abdomen. Being very still may indicate either a pain state or a state of relaxation.

 CN: Physiological adaptation;  
CL: Synthesize

**108. 0.6 mL**


$$40 \text{ mg/mL} = 25 \text{ mg}/X \text{ mL}$$

$$X = 0.6 \text{ mL}$$


 CN: Pharmacological and parenteral therapies; CL: Apply

**109. 4.** The client is likely exhibiting symptoms of herpes genitalis, which include painful blisters or vesicles that appear 2 to 20 days after transmission of the disease. The client was most likely exposed from her new partner. The client should be referred to a health care provider for treatment. Having her


partner wear a condom, increasing fluids, or using lubricant jelly will not treat the infection.

 CN: Physiological adaptation;  
CL: Synthesize


**110. 2.** It has been found that parents are more grieved when optimism is followed by defeat. The nurse should recognize this when planning various ways to help the parents of a dying child. It is not necessarily true that knowing about a poor prognosis for years helps prepare parents for a child's death, that trust in health personnel is destroyed when a death is untimely, or that it is more difficult for parents to accept the death of an older child than that of a younger child.

 CN: Psychosocial adaptation;  
CL: Synthesize


**111. 3.** The child is having a reaction to the blood transfusion. The priority is to stop the blood transfusion but maintain an open venous access for medication or high fluid volume delivery. Thus, switching the transfusion to normal saline solution would be done first. Since the child is having difficulty breathing, applying oxygen would be the next action. Additionally, vital signs are taken to determine the extent of circulatory involvement. Then the physician would be notified and, if necessary, the crash cart would be obtained.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**112. 1.** A client who has an allergy to penicillin may have a cross-sensitivity to cefazolin (Ancef), a first-generation cephalosporin, and the drug should be given with caution. The nurse should ask the client whether he has taken cefazolin before. The nurse should inform the pharmacy of the client's allergy after asking the client about prior use of cefazolin. The medication should not be administered until the nurse first inquires about the client's exposure to cefazolin and then consults the pharmacist or physician. Observing the client for urticaria is appropriate but is not an initial response.

 CN: Safety and infection control;  
CL: Synthesize

**113. 3.** Clients with chronic renal failure are susceptible to uremia, an accumulation of nitrogenous waste products in the blood. Clinical manifestations include dry, itchy skin that can be severe in nature. Because of the irritation of the skin and the inclination to scratch, clients are prone to impaired skin integrity. The pruritus is not a result of poor hygiene. Chronic pain is not a likely result of the pruritus and is not a priority nursing diagnosis. The data do not support the nursing diagnosis of *Ineffective coping*.

 CN: Physiological adaptation;  
CL: Analyze


**114. 1.** The nurse would teach the client taking lithium and his family about the importance of maintaining adequate sodium intake to prevent lithium toxicity. Because lithium is a salt, reduced sodium intake could result in lithium retention with subsequent toxicity. Increasing sodium in the diet is not recommended and may be harmful. Increased sodium levels result in lower lithium levels. Therefore, the drug may not reach therapeutic effectiveness.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**115. 3.** Mucositis is an inflammation of the oral mucosa caused by radiation therapy. It is important that the client with mucositis receive meticulous mouth care, including flossing, to prevent the development of an infection. Mouth care should be provided before and after each meal, at bedtime, and more frequently as needed. Extremes of temperature should be avoided in food and drink. Half-strength hydrogen peroxide is too harsh to use on irritated tissues.

 CN: Reduction of risk potential; CL: Synthesize

**116. 3.** Acetaminophen ingestion can cause severe liver disease. The child should be evaluated in the emergency department. The child should not be offered any fluids, and the parents should not attempt to induce vomiting. Assessing the child's respirations for 24 hours will delay needed emergency treatment.

 CN: Physiological adaptation; CL: Synthesize

**117. 1.** The best approach by the nurse is to determine why the parent thinks the child is hyperactive. Some children are very active but do not have the necessary defining characteristics of hyperactivity. Asking what the parent thinks needs to be done or how the child behaves normally would be an appropriate follow-up question once more information is gathered from the parent to determine whether the child indeed is hyperactive. Telling the parent to wait for the physician ignores the parent's concern and does not deal with the parent's issue.


 CN: Physiological adaptation; CL: Synthesize

**118. 2.** Dilatation at the anastomosis site is needed during the first years of childhood in about 50% of children who have had corrective surgery for TEF. Recurrent mild diarrhea with dehydration is not likely to develop with this surgery. Speech problems can occur if other abnormalities are present to produce them; the larynx and structures of speech are not affected by TEF. Dysphagia and strictures may decrease food intake, and poor weight gain may

be noted, but gastric ulcers should not develop from surgery to repair TEF.

 CN: Reduction of risk potential; CL: Analyze

**119. 1.** Terminally ill clients most often describe feelings of isolation because they feel ignored. The terminally ill client may sense any discomfort that family and friends feel in the client's presence. Nursing interventions include spending time with the client, encouraging discussion about feelings, and answering questions openly and honestly. Reducing fear of pain or fear of more aggressive therapies is secondary to lessening the client's feelings of isolation. Reducing feelings of social inadequacy is not relevant to the terminally ill client.

 CN: Psychosocial adaptation; CL: Synthesize

**120. 2.** When the fetus is in a breech position, the fetal heart rate most often is located above the umbilicus because the fetal heart is near the top of the mother's uterus. The heart of a fetus in the cephalic position is typically located on either the left or the right side of the client's uterus. Also, because the fetal heart typically is located in the lower portion of the mother's uterus, the sounds would be heard below the umbilicus. With a face presentation, fetal heart sounds are typically located on either the left or the right side of the client's uterus; in addition, because the fetal heart typically is located in the lower portion of the mother's uterus, the sounds would be heard below the umbilicus. When the fetus is in a transverse position, the fetal heart sounds typically would be located below the umbilicus and in the midline.

 CN: Health promotion and maintenance; CL: Analyze

**121. 4.** Clients who have been diagnosed with pernicious anemia are lacking adequate amounts of the intrinsic factor (IF) that is secreted by the gastric mucosa. IF is necessary for the absorption of cobalamin (vitamin B<sub>12</sub>) in the distal ileum. Without the presence of IF, dietary intake of vitamin B<sub>12</sub> is useless because it cannot be absorbed. Treatment of pernicious anemia includes I.M. injections of cobalamin, at first daily for 2 weeks, then weekly until the anemia is corrected. A maintenance schedule of monthly injections is then implemented. The injections will need to be continued for the rest of the client's life.

 CN: Physiological adaptation; CL: Evaluate


**122. 2.** The nurse should first assess the client because a hypoglycemic reaction is likely to occur. The nurse should provide a fast-acting simple carbohydrate. The nurse (charge nurse or otherwise)




should notify the physician for orders to prevent or treat severe hypoglycemia. The nurse could consult the clinical pharmacist until able to contact the physician. The nurse should ask for assistance so that the client can be monitored by a nurse while someone prepares a longer-acting carbohydrate or protein.

 CN: Reduction of risk potential;  
CL: Synthesize


**123. 4.** Safety is the priority in caring for this infant. Infants adapt easily, increasing mobility even with a splint in place. Therefore, the mother needs to ensure that the area in which the infant is mobile is safe. There is no need to contact the physician to alter the treatment plan. Confining the infant to one room may not allow the child to achieve normal development. The child needs different environments for maximum development. The infant needs to wear the splint as ordered by the physician to ensure optimal healing.

 CN: Safety and infection control;  
CL: Synthesize

**124. 1.** Anxiety in a preoperative client may be caused by many different fears, such as fear of the effects of anesthesia, the effects of surgery on body image, separation from family and friends, job loss, disability, pain, or death. However, fear of the unknown is most likely to be the greatest fear because the client feels helpless. Therefore, an important part of preoperative nursing care is to assess the client for anxieties and explore possible causes. Emotional support can then be offered, so that the client is in the best possible psychological condition for surgery.

 CN: Psychosocial adaptation;  
CL: Analyze

**125. 1.** An important nursing responsibility is preoperative teaching. The recommended guide for teaching is to tell the client as much as she wants to know and is able to understand. Delaying discussion of issues or concerns will most likely increase the client's anxiety. Telling the client to discuss questions with the physician avoids acknowledging the client's concerns.


 CN: Psychosocial adaptation;  
CL: Synthesize

**126. 3.** The client must have adequate disclosure of the risks associated with the surgery before signing the consent form. It is the physician's responsibility to explain the risks of any procedures and to obtain the client's informed consent. If the nurse suspects that the client has not been truly informed, it is the responsibility of the nurse to act as a client advocate and contact the surgeon to provide additional information to the client. It is not appropriate


to have the client sign the consent form if the client has questions. The nurse should not minimize the procedure or dismiss the client's concerns.

 CN: Management of care; CL: Synthesize

**127. 4.** In right occipital anterior lie, the occiput faces the right anterior segment of the woman's pelvis. In left occipital transverse lie, the occiput faces the woman's left hip. In left occipital anterior lie, the occiput faces the left anterior segment of the woman's pelvis. In right occipital transverse lie, the occiput faces the woman's right hip.

 CN: Physiological adaptation;  
CL: Analyze


**128. 4.** The nurse should advise the parents to report an increasing fever which would indicate the infection is not resolving. Increased urine output may occur, but it would be very difficult for the parent to actually determine this and it is not a cardinal sign of increasing infection. The child may have a loss of appetite related to the infection or the medication, but is not indicative of an infection that is becoming worse. The child should not have jaundice from a urinary tract infection that is being treated.

 CN: Physiological adaptation;  
CL: Synthesize

**129. 3.** A positive Babinski's reflex in a neonate is a normal finding demonstrating the immaturity of the central nervous system in corticospinal pathways. A neonate's muscle coordination is immature, but the Babinski's reflex does not help determine this immaturity. A positive Babinski's reflex does not indicate a defect in the spinal cord or an injury to nerves that innervate the legs. There is no evidence to suggest partial paralysis. A positive Babinski's reflex in an adult indicates disease.

 CN: Health promotion and maintenance;  
CL: Evaluate

**130. 2.** The nurse should instruct the client who is taking dexamethasone (Decadron) and furosemide (Lasix) to observe for signs and symptoms of hypokalemia, such as malaise, muscle weakness, vomiting, and a paralytic ileus, because both dexamethasone and furosemide deplete serum potassium. This combination of drugs does not cause the client to become excitable or have diarrhea or thirst.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**131. 2.** After a bronchoscopy with a biopsy, the nurse should monitor the client for signs of pneumothorax as well as hemorrhage. The client should not gargle with oral lidocaine; this will not allow the gag reflex to return. The client should not have any mediastinal discomfort after a bronchoscopy; if pain

does occur it should be reported promptly to the physician. It is not necessary to tell the client not to talk until the gag reflex returns.

 CN: Reduction of risk potential;  
CL: Synthesize


**132. 42 gtt/minute**

The number of drops the client should receive each minute is determined as follows:


$500 \text{ mL}/12 \text{ hours} = \text{between } 41 \text{ and } 42 \text{ mL to be infused each hour}$

$42 \text{ mL} \times 60 \text{ (drop factor)} = 2,520 \text{ drops to be infused each hour}$


$2,520 \text{ drops}/60 \text{ minutes} = 42 \text{ drops to be infused every minute.}$

 CN: Pharmacological and parenteral therapies; CL: Apply

**133. 2.** Subcutaneous injections are administered at an angle of 45 to 90 degrees, depending on the size of the client. Subcutaneous needles are typically  $\frac{3}{8}$  to  $\frac{5}{8}$  inches in length. The skin should be pinched up at the injection site to elevate the subcutaneous tissue. Air is not drawn into the syringe for a subcutaneous injection.

 CN: Pharmacological and parenteral therapies; CL: Apply

**134. 3.** *Acute pain* is a priority nursing diagnosis for the client with pelvic inflammatory disease because the disease is associated with severe pain. *Imbalanced nutrition: Less than body requirements*, *Self-care deficit*, and *Impaired skin integrity* are not priority nursing diagnoses associated with pelvic inflammatory disease.

 CN: Physiological adaptation;  
CL: Analyze

**135. 3.** Each child has unique temperaments and energy levels, and parents must adapt parenting strategies for each child. Children who are easily upset do better in structured environments where they can learn what to expect. Easy-going children can manage flexible feeding times. Not feeding the child when he cries will not promote nutrition and does not provide the structure that will help the child learn appropriate eating behaviors. Children who are very active and always “on the go” respond well to eating food that can be carried in their hand, and eating more frequently.

 CN: Health promotion and maintenance;  
CL: Synthesize

**136. 4.** The position of the tube should be verified before the feeding is implemented. Warming the solution is not necessary or desirable because it can encourage bacterial growth. The client should be lying down with the head elevated or sitting


upright during administration of the feeding. Gastric residual should be aspirated and then reinstilled to prevent electrolyte losses.

 CN: Reduction of risk potential;  
CL: Apply

**137. 4.** The cramping is caused by the baby’s sucking and subsequent stimulation for the release of oxytocin. This cramping is normal. With each subsequent pregnancy, the uterus becomes “stretched” and the release of oxytocin causes the uterus to contract, resulting in the feeling of cramping. Continued moderate to large amounts of lochia rubra is indicative of retained placental fragments. Cramping indicates that the uterus is contracting and most likely firm. A boggy uterus, continued moderate to heavy lochia, mild vasoconstriction, and restlessness and anxiety suggest delayed postpartum hemorrhage due to subinvolution of the placental site, retained placental tissue, or infection. Most clients receive a standard dose of oxytocin (Pitocin) after delivery. Oxytocin has a duration of action of 60 minutes. Therefore, the effects of the drug would have worn off by 24 hours postpartum.

 CN: Health promotion and maintenance;  
CL: Synthesize

**138. 4.** The current recommendations for children experiencing mild to moderate diarrhea are to continue the child’s regular diet. With this diet plan, children seem to get well faster. Clear liquids, such as juices, colas, and gelatin, are high in carbohydrates but low in electrolytes, as are foods such as bananas, rice, applesauce, and toast. Foods low in fat also typically lack the electrolytes that the child needs.

 CN: Physiological adaptation;  
CL: Synthesize

**139. 2.** When performing tracheostomy care, it is important that the tracheostomy ties be securely tied to prevent dislodgment of the tube. It is not necessary to remove the inner cannula every 2 hours for cleaning. Routine cleaning is usually performed every 8 hours. The nurse should use precut tracheostomy dressings under the neck plate to protect the skin surrounding the stoma. Cutting and using a gauze dressing can cause loose gauze fibers to enter the airway. The inner cannula should be suctioned before cleaning, not afterward.

 CN: Reduction of risk potential;  
CL: Apply

**140. 2.** The nurse should send the sealed container of I.V. 50% dextrose found in the catch-all bin to the pharmacy. A concentrated medication such as 50% dextrose could be lethal if inadvertently administered and should not be stored outside the pharmacy. An incident report is not necessary in this


situation. The sharps container is not the appropriate method for disposal of this medication.

 CN: Management of care; CL: Synthesize

**141. 3.** The client who is wheelchair-bound with a spinal cord injury should be taught to make small weight shifts, lifting off the sacral area every 15 minutes. This decreases the risk of pressure ulcer formation. Bathing daily promotes skin cleanliness, but by itself will not prevent pressure ulcer formation. Eating a well-balanced diet that includes proteins and carbohydrates promotes good skin integrity. Moving from the bed to the wheelchair every 2 hours is not desirable because the client should not spend excessive amounts of time in bed. Pressure sores can develop in less than 2 hours.

 CN: Reduction of risk potential;  
CL: Synthesize

**142. 1.** Anatomically, the squatting position enlarges the pelvic outlet and uses the force of gravity during pushing. The mother should curve her body into a C shape for the greatest effectiveness.

 CN: Health promotion and maintenance;  
CL: Synthesize


**143. 2.** Saying, “If you punch people out, you’ll get into trouble,” helps the client by pointing out the negative consequences of his behavior. Clients with antisocial personality disorder are aggressive, impulsive, and reckless; engage in illegal activities; and lack guilt or remorse. The nurse teaches the client that there are consequences to his irresponsible behavior and that the way to stay out of trouble is to change his behavior. Saying, “It’s wrong to punch others,” is not helpful since the client does not feel guilt or remorse. Saying, “I wouldn’t do that again if I were you” or “Don’t ever do that again,” is authoritative and scolds the client without helping him.

 CN: Psychosocial adaptation;  
CL: Synthesize


**144. 3.** Self-mutilation is a way to express anger and rage, commonly seen in clients with borderline personality disorder. It typically is a cry for help, an expression of intense anger, helplessness, or guilt. When a client is experiencing numbness or feelings of unreality, self-mutilation induces physical pain which validates the person’s being alive because of the ability to feel the physical pain. Self-mutilation is not a means of getting what the person wants. It is not used as a form of manipulation, although it is often misinterpreted as such. Self-mutilation is a serious behavior that is harmful to the self and cannot be ignored.

 CN: Psychosocial adaptation;  
CL: Evaluate


**145. 3.** Hepatitis C is transferred by percutaneous exposure, such as tattooing. Hepatitis A is acquired through contaminated water, exposure in underdeveloped countries, or shellfish in contaminated waters.

 CN: Physiological adaptation;  
CL: Analyze


**146. 1.** Lorazepam (Ativan), a benzodiazepine, is commonly used to decrease the symptoms of central nervous system irritability in the client who is experiencing early symptoms of alcohol withdrawal. There is no indication that restraints are needed at this time. If the lorazepam is effective, it will not be necessary to have someone sit with the client. At this point, it is not necessary to notify the physician.

 CN: Management of care; CL: Synthesize

**147. 2, 3.** Appropriate diet instructions for the client in the early stages of cirrhosis include ensuring an adequate intake of protein and eating small, frequent meals. There is no need to limit protein intake unless the client has evidence of hepatic encephalopathy. Additionally, fluid intake is not restricted unless the client has significant ascites or edema (these typically occur later in the disease). Because of gastrointestinal dysfunction, small, frequent meals are frequently better tolerated than three regular meals. Clients with cirrhosis should be encouraged to increase their caloric intake instead of restricting it. Alcohol intake in any amount is discouraged.

 CN: Physiological adaptation;  
CL: Synthesize


**148. 3.** After surgery, the nurse’s initial assessment is the surgical site dressing to determine whether there is any bleeding or drainage. Once this assessment is completed, then the nurse would assess the other areas such as the I.V. access site, pain, and nasogastric tube function.

 CN: Physiological adaptation;  
CL: Analyze

**149. 1.** The nurse should use the radial artery to obtain blood gas samples because it is easier to maintain firm pressure there than on the femoral artery. Nursing interventions to protect the client who has received t-PA or alteplase recombinant (Activase) therapy include maintaining arterial pressure for 30 seconds because it takes longer for coagulation to occur with the thrombolytic agent on board. I.M. injections are contraindicated during thrombolytic therapy. The nurse should prevent physical manipulation of the client, which can cause bruising.

 CN: Reduction of risk potential;  
CL: Synthesize


**150. 4.** Serum amylase and lipase are increased in pancreatitis, as is urine amylase. Other abnormal laboratory values include decreased calcium level and increased glucose and lipid levels.

 CN: Physiological adaptation;  
CL: Analyze

**151. 2.** For the client with an alcohol or drug problem, group sessions are helpful in dealing with emotions and concerns about alcohol and drugs. Clients with substance abuse problems identify with each other's similar experiences and can best help each other deal with these feelings and emotions. Additionally, the members of the group are able to support and confront each other. Individual therapy is not as helpful as group sessions because group members offer peer support and confrontation when needed. Solitary activities and recreation lead to increased avoidance of the issues that must be faced and dealt with by the client. These are often areas that the client must learn to develop and manage while in recovery.

 CN: Psychosocial adaptation;  
CL: Synthesize

**152. 4.** Foul-smelling urine is indicative of cystitis. Other symptoms include dysuria and urinary frequency and urgency. Flank pain, nausea, and vomiting indicate pyelonephritis.

 CN: Physiological adaptation;  
CL: Analyze

**153. 4.** By saying, "You couldn't have prevented the tornado; it just happened," the nurse helps the client to develop an objective perspective and promotes a better understanding of the event. The other statements tell the client how to feel, possibly causing resistance and thus delay therapeutic healing. Guilt and self-blame will not be decreased.

 CN: Psychosocial adaptation;  
CL: Synthesize

**154. 3.** In many Asian cultures, the 30 days after the birth of the neonate is a time for the mother to heal from the delivery. The appropriate action by the nurse is to determine whether this is a cultural practice for this client and her family. If so, the client is behaving within her cultural practices. Teaching should be provided to both the mother and her mother-in-law. There is no indication that bonding is not taking place. Lack of bonding might be indicated if the client did not show any interest in the neonate. Documenting the client's maternal behavior in her chart is a routine task. However, the nurse should not assume that this behavior is unusual because it may be reflective of the client's cultural framework. A home visit is not warranted


unless there is evidence of infant neglect or the family needs additional follow-up or teaching.

 CN: Health promotion and maintenance;  
CL: Synthesize


**155. 1.** A creatinine clearance test is a 24-hour urine test that measures the degree of protein breakdown in the body. The collection is not maintained in a sterile container. There is no need to insert an indwelling urinary catheter as long as the client is able to control urination. It is not necessary to force fluids.

 CN: Reduction of risk potential;  
CL: Synthesize


**156. 4.** The statement, "Your eyes look dark," is the least sensitive statement because it points out an obvious difference for no real purpose. The nurse has a reason to ask the client about favorite foods and needs to know about past health problems. Also, it is appropriate for the nurse to ask the client how she wishes to be addressed.

 CN: Psychosocial adaptation;  
CL: Analyze

**157. 2.** Insight into the illness is demonstrated when the client recognizes the relationship between the chemical imbalance and his illness and symptoms. Stating that the olanzapine is the best medicine or that the client's mother is proud of him for staying on his medicines reflects awareness about the effect of medications and the need for compliance. Stating that he may be able to get a part-time job indicates an awareness of his increased capacity for work.

 CN: Psychosocial adaptation;  
CL: Evaluate

**158. 3.** Carpal tunnel syndrome is a condition in which the median nerve becomes compressed in the wrist. The brachial nerve is not affected. Carpal tunnel syndrome may be the result of a systemic disease, such as rheumatoid arthritis or diabetes mellitus, or it may be an occupational hazard for people whose jobs require repetitive hand movements. It is not a condition resulting from disuse. The wrists do not develop flexion contractures with carpal tunnel syndrome.

 CN: Physiological adaptation;  
CL: Synthesize

**159. 1.** The nurse should contact the physician and clarify whether the client's usual insulin dose should be given before surgery; having the blood glucose level is objective information that the physician may need to know before making a final decision as to the insulin dosage. The nurse should not assume that the usual insulin dose is to be given. It

is not appropriate for the nurse to defer decision-making on this issue until after surgery.

 CN: Reduction of risk potential;  
CL: Synthesize


**160. 3.** Clients who have undergone TURP need to be instructed to maintain an adequate fluid intake despite urinary dribbling or incontinence. The client should be advised to drink at least eight glasses of water a day to dilute the urine and help prevent urinary tract infections. Maintaining a voiding schedule of every 2 hours can help decrease incidents of incontinence. Teaching the client Kegel exercises is also beneficial for strengthening sphincter tone. The nurse should not encourage the client to decrease fluids. It is not necessarily true that a decreased intake will cause renal calculi. Threatening the client with a catheter is not beneficial, and it is not the treatment of choice for a client who is experiencing incontinence from TURP.

 CN: Reduction of risk potential;  
CL: Synthesize


**161. 4.** Risk factors for TSS include the use of tampons at night, when the tampon would be in place for 7 to 9 hours. TSS can occur in other situations, but it is commonly associated with women during menses, particularly women who use tampons. The longer the tampon is left in place, the greater the risk for TSS. Changing tampons every 3 hours or more frequently, avoiding use of deodorized tampons, and alternating tampons with sanitary pads are actions that decrease the risk of TSS.

 CN: Reduction of risk potential; CL:  
Analyze


**162. 4.** Costovertebral tenderness occurs on the side of the affected kidney in pyelonephritis. Dysuria, suprapubic pain, and urine retention may occur in pyelonephritis but do not specifically support a diagnosis of pyelonephritis. Dysuria, suprapubic pain, and urine retention are symptoms of cystitis, which can lead to pyelonephritis if not treated.

 CN: Physiological adaptation;  
CL: Analyze

**163. 2.** Broad-spectrum antibiotics can cause decreased efficacy of oral contraceptives, placing the client at risk for an unplanned pregnancy. When a client is prescribed a course of antibiotics, a back-up method of contraception should be used. Antihypertensives, diuretics, and antihistamines do not interfere with oral contraceptive efficacy.

 CN: Pharmacological and parenteral  
therapies; CL: Apply

**164. 1.** Adverse effects of danazol (Danocrine) include headaches, dizziness, irritability, and decreased libido. Masculinization effects, such as deepened voice, facial hair, and weight gain, also may occur.

 CN: Pharmacological and parenteral  
therapies; CL: Synthesize


**165. 2.** The nurse should assign the Hispanic male client who needs complete morning care to Joe. Modesty is a high priority for this client. The nurse must also consider work load, and Joe has the lightest assignment.

 CN: Management of care; CL: Synthesize


**166. 4.** Central nervous system changes include such symptoms as apathy, lethargy, and decreased concentration. Seizures and coma can also occur. The nurse should assess the client's level of consciousness at regular intervals and maintain client safety. Allowing the client to express feelings related to body image changes and restricting foods high in potassium and fluid intake are all appropriate activities, but they are not related to the central nervous system changes.

 CN: Physiological adaptation;  
CL: Synthesize


**167. 3.** Elderly individuals have less subcutaneous tissue. An elderly, emaciated client will require a short needle and a shallow angle to avoid hitting an underlying bone. The nurse should choose the shortest subcutaneous needle available, and use the least angle.

 CN: Pharmacological and parenteral  
therapies; CL: Apply

**168. 3.** Metronidazole (Flagyl) can cause a disulfiram (Antabuse)-like reaction if it is taken with alcohol. Tachycardia, nausea, vomiting, and other serious interaction effects can occur. Flagyl will make the urine a darker color. Oral contraceptives should never be discontinued with trichomoniasis. The partner also requires treatment to prevent retransmission of infection.

 CN: Pharmacological and parenteral  
therapies; CL: Synthesize

**169. 1.** In the advanced stages of osteoarthritis, pain can occur with minimal activity or even when the client is at rest. Crepitation can be present at any stage of the disease and does not exacerbate pain. Joints are not symmetrically affected by the disease. Symmetric joint involvement and fatigue are characteristics of rheumatoid arthritis.

 CN: Physiological adaptation;  
CL: Analyze


**170. 3.** The traditional belief of Vietnamese Americans is that the family can provide more comfort for their loved one at home. It is not seen as being disloyal if their loved one dies in the hospital. The request is not based on a feeling that the hospital cannot be trusted. Vietnamese Americans accept death as a part of life and do not think that reincarnation is prevented in the hospital.

 CN: Psychosocial adaptation; CL: Apply


**171. 2.** It is important for the daughter to know that there is an underlying cause for what her mother is experiencing and that it is treatable. Telling her not to worry is a useless cliché and does nothing to inform the daughter. Talking about care after discharge implies that the delirium is irreversible. Delirium is a reversible condition. Although not arguing with hallucinations is valid, this response ignores the daughter's concern.

 CN: Psychosocial adaptation;  
CL: Synthesize

**172. 2.** The client with Alzheimer's dementia should not have access to toiletries that could be swallowed (such as aftershave) unless closely supervised. Putting special locks on all the doors is appropriate to prevent wandering, thus maintaining the client's safety. Placing the client in a room that has nothing to trip over is appropriate to reduce the client's risk of falling. Taking the knobs off of the stove is appropriate to prevent possible burns.

 CN: Psychosocial adaptation;  
CL: Evaluate

**173. 3.** It is important that the client force fluids to 3,000 mL/day to avoid the development of renal calculi when taking allopurinol. Allopurinol must be taken consistently to be effective in the treatment of gout. The drug should be taken after meals to avoid gastrointestinal distress. Although the client can take aspirin when taking allopurinol, both drugs can cause gastrointestinal irritation and the practice is not recommended if the client is sensitive to the medications.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**174. 3.** The best advice for the nurse to give the child's mother is to run cool water over the burned area to stop the burning process. Then the area should be wrapped in a clean cloth. Once these initial actions are completed, the mother can call the child's physician. Packing the arm in ice may cause more damage to the burned area because cold can cause burns just as heat can. For most burns, it


is not advised to apply ointment until the area has been evaluated.

 CN: Reduction of risk potential;  
CL: Synthesize


**175. 4.** The priority nursing diagnosis for this client is *Risk for injury*. The goal in this situation is to prevent falling. *Impaired physical mobility* contributes to the risk of injury and is an applicable diagnosis but does not address the client's safety needs, which are the priority. *Impaired skin integrity* and *Ineffective coping* are not applicable diagnoses at this time.

 CN: Reduction of risk potential; CL: Analyze


**176. 3.** Chills and headache are signs of a febrile, nonhemolytic blood transfusion reaction and the nurse's first action should be to discontinue the transfusion as soon as possible and then notify the physician. Antipyretics and antihistamines may be ordered. The nurse would not administer acetaminophen without an order from the physician. The client's blood pressure should be taken after the transfusion is stopped. Checking the infusion rate of the blood is not a pertinent action; the infusion needs to be stopped regardless of the rate.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**177. 3.** Resolving grief and having increased energy and activity convey good mental health, indicating that counseling is not necessary at this time. Taking an antidepressant or having less energy and involvement with grandchildren reflects possible depression and the need for counseling. Wanting to be with her dead husband suggests possible suicidal ideation that warrants serious further assessment and counseling.


 CN: Psychosocial adaptation;  
CL: Evaluate

**178. 3.** Common adverse effects of isosorbide are light-headedness, dizziness, and orthostatic hypotension. Clients should be instructed to change positions slowly to prevent these adverse effects and to avoid fainting. Ankle swelling is not related to isosorbide administration. The client does not need to take his pulse before taking the medication. The client does not need to take the medication with food.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**179. 3.** Valproic acid (Depakote) and propranolol (Inderal) are often prescribed to help manage explosive anger. Recognizing the need for medications indicates readiness for discharge. Not ever getting

angry is difficult, impractical, and unrealistic without specific anger management strategies. Drinking does not address anger control and suggests a risk of continued drinking. Blaming others, such as the client's mother, does not address anger control and indicates a lack of responsibility for the client's own behavior.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**180. 3.** The nurse should first help the client into a position of comfort even though the primary

purpose for entering the room was to administer medication. After attending to the client's basic care needs, the nurse can proceed with the proper identification of the client, such as asking the client his name and checking his armband, so that the medication can be administered.

 CN: Basic care and comfort;  
CL: Synthesize

**COMPREHENSIVE**

**TEST  
5**

**1.** A nurse has been working with a battered woman who is being discharged and returning home with her husband. The nurse says, "All this work with her has been useless. She's just going back to him as usual." Which of the following statements by a nursing colleague would be **most** helpful to this nurse?

- 1. "Her reasons for staying are complex. She can leave only when she is ready and can be safe."
- 2. "I know it is frustrating to work with clients who don't follow our advice."
- 3. "You did your best. You will see her again and have another chance."
- 4. "These women almost never leave for good because of their emotional and financial dependency."

**2.** Ergonovine maleate (Ergotrate) 200 mcg I.M. has been ordered. The ampule label reads 0.2 mg/mL. The nurse should administer how many milliliters?

\_\_\_\_\_ mL.

**3.** At a 6-month-old infant is being admitted from the emergency department with dehydration secondary to viral gastroenteritis. Which of the following room assignments is the **most** appropriate for this infant?

- 1. A semiprivate room with an 8-year-old child who has had an appendectomy.
- 2. A semiprivate room with a 10-year-old child with a closed head injury.
- 3. A private room.
- 4. A semiprivate room with a 4-year-old child with leukemia.

**4.** For which of the following should the nurse be especially alert when caring for a term neonate, who weighed 10 lb at birth, 1 hour after a vaginal delivery?

- 1. Hypoglycemia.
- 2. Hypercalcemia.
- 3. Hypermagnesemia.
- 4. Hyperbilirubinemia.

**5.** A female client with infertility related to anovulatory cycles is prescribed menotropins (Pergonal). Which of the following, if stated by the client as a possible adverse effect of this medication, indicates successful teaching?

- 1. Pulmonary edema.
- 2. Ovarian enlargement.
- 3. Visual disturbances.
- 4. Breast tenderness.

**6.** A family has been notified that their son is brain dead, and the physician has discussed the possibility of donating organs. The nurse should collaborate with the physician to contact which referral source that is responsible for organ recovery in the United States are the:

- 1. Organ and Tissue Procurement Organizations.
- 2. American Transplant Association.
- 3. American Hospice Foundation.
- 4. American Association of Critical-Care Nurses.

**7.** The nurse is involved in preoperative teaching with a client who will be undergoing a lung resection. The client is told that two chest tubes will be placed during surgery. The nurse explains that the purpose of the lower chest tube is to:

- 1. Prevent clots.
- 2. Remove air.
- 3. Remove fluid.
- 4. Facilitate "milking" of the tubes.

**8.** A nurse is assessing an 82-year-old for depression. Because of the client's age, the nurses' assessment should be guided by the fact that:

- 1. Sadness of mood is usually present but it is masked by other symptoms.
- 2. Impairment of cognition usually is not present.
- 3. Psychosomatic tendencies do not tend to dominate.
- 4. Antidepressant therapies are less effective in older adults

**9.** A **primary** concern of the hospitalized adolescent is:

- 1. Respect for the need for privacy.
- 2. Allowing parents to visit after hours.
- 3. Wearing a hospital gown.
- 4. The fear of loss of control when in pain.



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

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

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

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

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

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

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

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

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

\_\_\_\_\_ gtt/minute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**24.** The nurse is discharging a client who has been hospitalized for preterm labor. The client needs further instruction when she says:

- 1. "If I think I have a bladder infection, I need to see my obstetrician."
- 2. "If I have contractions, I should contact my health care provider."
- 3. "Drinking water may help prevent early labor for me."
- 4. "If I travel on long trips, I need to get out of the car every 4 hours."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

\_\_\_\_\_ mL.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1. Excretion of bicarbonate ( $\text{HCO}_3^-$ ) by the kidneys.
- 2. Retention of  $\text{HCO}_3^-$  by the kidneys.
- 3. Increase in respiratory rate by the lungs.
- 4. Decrease in respiratory rate by the lungs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Control hemorrhaging.

2. Replace fluids.

3. Relieve the client’s anxiety.

4. Maintain a patent airway.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1. Vitamin B<sub>6</sub>.
- 2. Vitamin K.
- 3. Vitamin B<sub>12</sub>.
- 4. Iron.
- 5. Vitamin C.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Laboratory Results	
Test	Result
pH	7.24
Paco <sub>2</sub>	35 mm Hg
HCO <sub>3</sub> <sup>-</sup>	15 mEq/L

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1. Vitamin K.
- 2. Vitamin B<sub>6</sub>.
- 3. Folate.
- 4. Vitamin B<sub>12</sub>.
- 5. Vitamin D.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

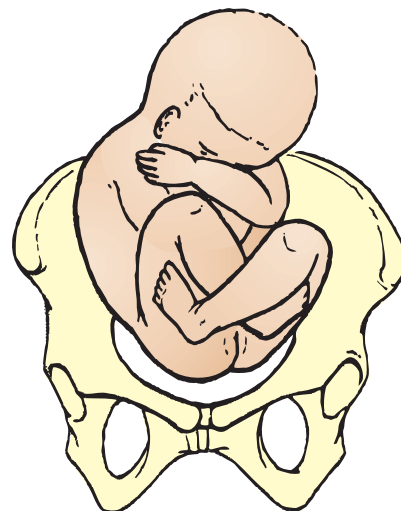
- 1. Is older than 65 years.
- 2. Has had symptoms of the stroke less than 3 hours.
- 3. Has a blood pressure within normal limits.
- 4. Does not have active internal bleeding.
- 5. Has not had an alcoholic beverage within the last 8 hours.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Notify the surgeon

2. Start an intravenous infusion.

3. Assess the effectiveness of the abdominal thrusts.

4. Perform the abdominal thrust maneuver.

5. Listen for breath sounds.

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

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

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

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

**170.** When assessing a 17-year-old client with depression for suicide risk, which of the following questions would be **best**?

- 1. "What movies about death have you watched lately?"
- 2. "Can you tell me what you think about suicide?"
- 3. "Has anyone in your family ever committed suicide?"
- 4. "Are you thinking about killing yourself?"

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

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

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

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

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

- 1. Report the development of tinnitus.
- 2. Increase vitamin B<sub>12</sub> intake.
- 3. Take with food or antacids.
- 4. Have the complete blood count (CBC) monitored monthly.

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

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

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

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

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

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

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

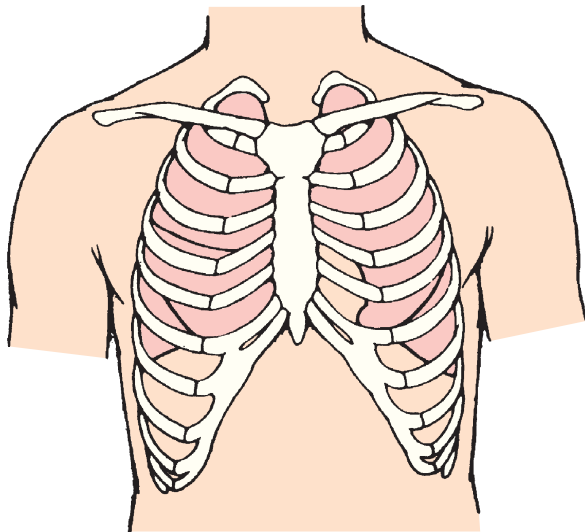
- 1. Ambulating less than twice a day.
- 2. An indwelling urinary catheter.
- 3. Decreased serum albumin level.
- 4. Elevated white blood cell count.



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

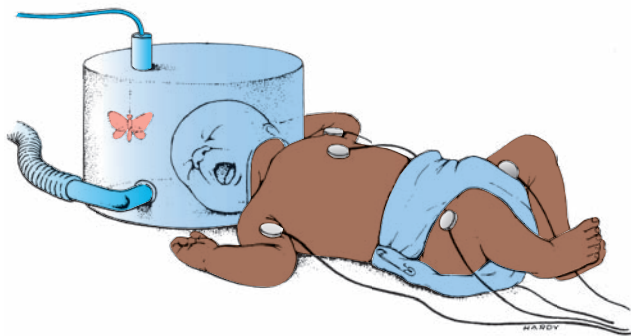
- 1. Plan frequent rest periods throughout the day.
- 2. Assist the client in ambulating to the bathroom.
- 3. Check the temperature of the water before the client showers.
- 4. Refer the client to occupational therapy for energy conservation interventions.

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



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

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



## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys (🔑) to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

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

🔑 CN: Psychosocial adaptation;  
CL: Synthesize

**2. 1 mL**

First, convert micrograms to milligrams:

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

Then:

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

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


🔑 CN: Pharmacological and parenteral therapies; CL: Apply

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


🔑 CN: Safety and infection control;  
CL: Synthesize

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

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

 CN: Physiological adaptation;  
CL: Analyze

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

 CN: Pharmacological and parenteral therapies; CL: Evaluate


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

 CN: Management of care; CL: Apply

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

 CN: Physiological adaptation; CL: Apply


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

 CN: Psychosocial adaptation;  
CL: Analyze

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

 CN: Health promotion and maintenance;  
CL: Apply

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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Management of care;  
CL: Synthesize

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

 CN: Health promotion and maintenance;  
CL: Apply

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

 CN: Pharmacological and parenteral therapies; CL: Analyze


**14. 21 gtt/minute**

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

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

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

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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Physiological adaptation;  
CL: Synthesize


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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Pharmacological and parenteral therapies; CL: Evaluate

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


 CN: Management of care; CL: Synthesize

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


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

 CN: Management of care; CL: Synthesize


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

 CN: Physiological adaptation;  
CL: Synthesize

**24. 4.** Traveling is usually discouraged if preterm labor has been a problem as it restricts normal movement. A client should be able to walk around frequently to prevent blood clots and to empty her bladder at least every 1 to 2 hours. Bladder infections often stimulate preterm labor and to prevent them is of great importance to this client. Contractions that recur indicate the return of preterm labor and the health care provider needs to be notified. Dehydration is known to stimulate preterm labor and encouraging the client to drink adequate amounts of water helps to prevent this problem.

 CN: Reduction of risk potential;  
CL: Evaluate


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

 CN: Pharmacological and parenteral therapies; CL: Synthesize


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

 CN: Health promotion and maintenance;  
CL: Apply


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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Safety and infection control;  
CL: Evaluate

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

 CN: Pharmacological and parenteral therapies; CL: Analyze


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

 CN: Pharmacological and parenteral therapies; CL: Evaluate

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

 CN: Health promotion and maintenance;  
CL: Synthesize

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


 CN: Health promotion and maintenance;  
CL: Apply

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


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

 CN: Health promotion and maintenance;  
CL: Create


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

 CN: Pharmacological and parenteral therapies; CL: Synthesize


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

 CN: Physiological adaptation;  
CL: Analyze

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

 CN: Health promotion and maintenance;  
CL: Analyze


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

 CN: Safety and infection control;  
CL: Synthesize


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

 CN: Management of care;  
CL: Synthesize

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

 CN: Physiological adaptation;  
CL: Evaluate


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

 CN: Health promotion and maintenance;  
CL: Analyze

**41. 7.5 mL**

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


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

 CN: Pharmacological and parenteral therapies; CL: Apply

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

 CN: Reduction of risk potential;  
CL: Apply

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

 CN: Psychosocial adaptation;  
CL: Analyze


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

 CN: Management of care; CL: Apply

**45. 2.** About 25% of the teenager's diet can come from snacks. This is a way for teenagers to obtain protein, thiamine, riboflavin, vitamin B<sub>6</sub>, magnesium, and zinc. Although not all snacks are low in fat or contain these nutrients, the nurse should encourage the mother to provide snacks with these nutrients.

 CN: Health promotion and maintenance;  
CL: Apply

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


 CN: Basic care and comfort;  
CL: Synthesize

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


 CN: Health promotion and maintenance;  
CL: Synthesize

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


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

 CN: Physiological adaptation;  
CL: Synthesize


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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Pharmacological and parenteral therapies; CL: Synthesize

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


 CN: Reduction of risk potential;  
CL: Synthesize

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


 CN: Basic care and comfort;  
CL: Synthesize

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


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

 CN: Safety and infection control;  
CL: Analyze


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

 CN: Safety and infection control;  
CL: Apply


**56. 2.** The compensatory mechanism for respiratory acidosis is the renal system. In respiratory acidosis, the kidneys will conserve  $\text{HCO}_3^-$  in an attempt to correct the acidosis. Excretion of  $\text{HCO}_3^-$  would exacerbate the body's acidosis. The lungs cannot compensate for a problem that arises in the respiratory system.

 CN: Physiological adaptation;  
CL: Analyze

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

 CN: Pharmacological and parenteral therapies; CL: Apply

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

 CN: Physiological adaptation;  
CL: Synthesize


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

 CN: Reduction of risk potential;  
CL: Apply


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

 CN: Reduction of risk potential;  
CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Apply

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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Health promotion and maintenance;  
CL: Apply

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


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

 CN: Reduction of risk potential;  
CL: Synthesize

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

 CN: Reduction of risk potential;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Reduction of risk potential;  
CL: Analyze

**68.**


4. Maintain a patent airway.

1. Control hemorrhaging.


2. Replace fluids.

3. Relieve the client's anxiety.

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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize


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

 CN: Reduction of risk potential;  
CL: Analyze


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



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

 CN: Physiological adaptation;  
CL: Analyze

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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Health promotion and maintenance;  
CL: Synthesize

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

 CN: Reduction of risk potential;  
CL: Analyze


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

 CN: Pharmacological and parenteral therapies; CL: Analyze

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

 CN: Health promotion and maintenance;  
CL: Analyze

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

 CN: Safety and infection control;  
CL: Apply

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

 CN: Reduction of risk potential;  
CL: Evaluate


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

 CN: Physiological adaptation; CL: Apply


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

 CN: Basic care and comfort; CL: Apply


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

 CN: Health promotion and maintenance;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Health promotion and maintenance;  
CL: Evaluate

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


 CN: Management of care; CL: Apply

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


 CN: Psychosocial adaptation;  
CL: Evaluate

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


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

 CN: Physiological adaptation;  
CL: Evaluate


**89. 1, 3, 4.** Vitamins B<sub>6</sub>, B<sub>12</sub>, and iron are important in the production of red blood cells. Therefore, the nurse should question the client specifically about food intake that contains these vitamins and minerals. Vitamins K and C have little role in the production of red blood cells.

 CN: Health promotion and maintenance;  
CL: Analyze


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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Analyze

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


 CN: Physiological adaptation;  
CL: Analyze

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


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

 CN: Health promotion and maintenance;  
CL: Synthesize


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

 CN: Pharmacological and parenteral therapies; CL: Analyze


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

 CN: Physiological adaptation;  
CL: Synthesize


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

 CN: Safety and infection control;  
CL: Synthesize

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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Pharmacological and parenteral therapies; CL: Synthesize

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

 CN: Reduction of risk potential;  
CL: Synthesize

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


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

 CN: Basic care and comfort;  
CL: Synthesize

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

 CN: Health promotion and maintenance;  
CL: Analyze

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

 CN: Pharmacological and parenteral therapies; CL: Synthesize


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

 CN: Health promotion and maintenance;  
CL: Analyze


**104. 1.** The pH of 7.24 indicates that the client is acidotic. The carbon dioxide level is normal, but the  $\text{HCO}_3^-$  level is decreased. These findings indicate that the client is in metabolic acidosis.

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Psychosocial adaptation;  
CL: Synthesize

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


 CN: Reduction of risk potential;  
CL: Apply

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


 CN: Reduction of risk potential;  
CL: Evaluate

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


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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Pharmacological and parenteral therapies; CL: Synthesize

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

 CN: Physiological adaptation;  
CL: Analyze

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


 CN: Basic care and comfort;  
CL: Synthesize

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


 CN: Reduction of risk potential;  
CL: Synthesize

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


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

 CN: Physiological adaptation;  
CL: Synthesize


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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Health promotion and maintenance;  
CL: Apply

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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Basic care and comfort;  
CL: Synthesize


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

 CN: Reduction of risk potential;  
CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Apply


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

 CN: Safety and infection control;  
CL: Synthesize

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


 CN: Reduction of risk potential;  
CL: Analyze

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

 CN: Physiological adaptation;  
CL: Analyze

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


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

 CN: Physiological adaptation;  
CL: Synthesize


**127. 2, 3, 4.** Vitamin B<sub>6</sub>, folate, and vitamin B<sub>12</sub> have been shown to reduce homocysteine levels. The effects of vitamins K and D have not been established with regard to homocysteine.

 CN: Health promotion and maintenance;  
CL: Synthesize

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

 CN: Pharmacological and parenteral therapies; CL: Evaluate

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


 CN: Physiological adaptation;  
CL: Analyze

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


 CN: Physiological adaptation;  
CL: Analyze

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


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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Health promotion and maintenance;  
CL: Evaluate

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

 CN: Physiological adaptation;  
CL: Synthesize

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


 CN: Health promotion and maintenance;  
CL: Synthesize

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


 CN: Management of care; CL: Synthesize

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


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

 CN: Physiological adaptation;  
CL: Analyze


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

 CN: Physiological adaptation;  
CL: Synthesize

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

 CN: Physiological adaptation;  
CL: Evaluate


**139. 3.** The most common long-term problem experienced by children with cleft palate repair is speech problems. These children frequently need speech therapy for a period of time. Hearing problems may occur as a result of chronic ear infections and the placement of myringotomy tubes. A poor self-concept may develop in any child. However, if a child with a cleft palate receives adequate parenting and support, this should not occur. Chronic sinus infections are more commonly associated with asthma, not with this defect.

 CN: Physiological adaptation;  
CL: Apply


**140. 2.** Feeding solutions that have not been infused after hanging for 8 hours should be discarded because of the increased risk of bacterial growth. Sitting the client upright during the feeding helps prevent aspiration of the feeding. A gastric residual of 25 mL is considered acceptable. A gastric residual of 100 to 150 mL, or a residual greater than 100% of the previous hour's intake, indicates delayed emptying. The feeding solution should be at room or body temperature.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**141. 3.** Furosemide is a loop diuretic and inhibits the reabsorption of sodium and chloride from the proximal and distal renal tubules and the loop of Henle. Furosemide promotes sodium diuresis, resulting in a loss of potassium and serious electrolyte imbalances. Furosemide does not affect the BUN level.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**142. 3.** Suctioning the respiratory tract for prolonged periods depletes the client's oxygen supply and causes hypoxia. It is recommended that each suctioning period not exceed 15 seconds.

 CN: Reduction of risk potential;  
CL: Apply

**143. 2.** The most appropriate action is to encourage the daughter to talk to her mother about the end-of-life issues first to reach a consensus or agreement. This is a family decision. Immediately informing the physician or preparing to remove the client from life support would be premature if the family is not in agreement. Although a copy of the living will should be on the client's chart, it is up to the daughter to show it to her mother.

 CN: Psychosocial adaptation;  
CL: Synthesize

**144. 2, 3, 4.** Contraindications for t-PA or alteplase recombinant therapy include current active internal bleeding, 3 hours or longer since the onset of symptoms of a stroke, and severe hypertension. Age greater than 65 years or having had an alcoholic beverage are not contraindications for the therapy.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**145. 1.** Extreme muscle weakness is present in both cholinergic crisis and myasthenic crisis. In cholinergic crisis, I.V. edrophonium chloride (Tensilon), a cholinergic agent, does not improve muscle weakness; in myasthenic crisis, it does. Diaphoresis and increased salivation are not present in cholinergic crises.

 CN: Physiological adaptation;  
CL: Analyze

**146. 3.** For a complete breech, the buttocks present, the feet and legs are flexed on the thighs, and the thighs are flexed on the abdomen. For a frank breech, the buttocks present with the hips flexed and the legs extended against the abdomen and chest. This is the most common type of breech presentation. For a compound breech, the buttocks present together with another part, such as a hand. This is a rare occurrence. For an incomplete breech, one or both feet or the knees extend below




the buttocks. This can also be termed a single footling or double footling breech.

 CN: Health promotion and maintenance;  
CL: Analyze


**147. 1.** It is important that the client understand that alcohol should be avoided for at least 1 year after an episode of hepatitis. Sexual intercourse does not need to be avoided, but the client should be instructed to use condoms until the hepatitis B surface antigen measurement is negative. The client will need to restrict activity until liver function test results are normal; this will not occur within 1 to 2 weeks. Jaundice will subside as the client recovers; it is not a permanent condition.

 CN: Reduction of risk potential;  
CL: Evaluate


**148. 4.** The individual who is bulimic is most commonly female and age 15 to 24. She binges and purges to control her weight and to prevent weight gain. Sometimes excessive exercise is also used. Use of regular exercise and calorie counting and occasional use of diet medication to maintain normal weight are not considered dysfunctional in our society.

 CN: Psychosocial adaptation;  
CL: Synthesize

**149. 1, 4, 5, 6.** Diazepam (Valium) is a benzodiazepine that causes symptoms of withdrawal when stopped abruptly. The nurse should assess the client for tremors, agitation, irritability, insomnia, vomiting, sweating, tachycardia, headache, anxiety, and confusion. Euphoria or elevated mood is not a symptom of benzodiazepine withdrawal.


 CN: Pharmacological and parenteral therapies; CL: Analyze

**150. 1.** Parents are typically quick to notice changes in their infant's physical appearance. The removal of the infant's hair may be upsetting to them if they have not been told why it is being done. Hair may be removed on the scalp at the site of needle insertion for I.V. therapy to provide better visualization and a smooth surface on which to attach tape to secure the needle. Sedatives are not ordinarily prescribed before I.V. fluid administration. In most instances, it is acceptable for parents to visit their infant while the I.V. solution is infusing. Holding the infant is encouraged to provide comfort.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**151. 1.** Abdominal pain can be a significant problem in acute pancreatitis. An expected outcome is to decrease or eliminate the pain the client is experiencing. Patterns of bowel elimination and liver

function are not typically affected by pancreatitis. The client should avoid alcohol.

 CN: Physiological adaptation;  
CL: Synthesize

**152. 3.** The most appropriate initial response by the nurse would be to test the child's blood glucose level. The child's symptoms are consistent with hypoglycemia but could also be used by the child to avoid participation in planned activities. Administering milk or fruit juice during a mild reaction may also be appropriate if testing cannot be done. Notifying the physician may be appropriate after the child's glucose level has been obtained and emergency treatment has been initiated if the child is experiencing hypoglycemia. Returning the child to previous activities is not appropriate until either testing or administering treatment has been done.

 CN: Physiological adaptation;  
CL: Synthesize

**153. 3.** Normally, breasts are about the same size. They can vary in size before menstruation due to breast engorgement caused by hormonal changes. It is not necessary for a physician to check this slight change in breast size. The changes in breast size this client described are most likely caused by hormonal changes, not a benign cyst or normal growth and development.

 CN: Health promotion and maintenance;  
CL: Synthesize


**154. 2.** Traditional Chinese medicine describes health as the balance of yin and yang. It describes health as harmony between the mind, body, and soul.

 CN: Health promotion and maintenance;  
CL: Apply


**155. 2.** Before an IVP, the client should be assessed for allergies to iodine. Shellfish is a source of iodine, so people who are allergic to shellfish should not receive an IVP. Asking the client whether he or she has ever had an IVP before can help determine the degree of teaching needed before the procedure, but that is not the most important question. Neither the client's last bowel movement nor urinary incontinence has any relationship to an IVP.

 CN: Reduction of risk potential;  
CL: Analyze


**156. 3.** Progestin alone has no effect on breast milk or breast-feeding once the milk supply is well established. Estrogen suppresses milk output. Testosterone is not given as an oral contraceptive.

 CN: Pharmacological and parenteral therapies; CL: Apply


**157. 2.** In this situation, the client has indicated that she is not willing to leave the abusive boyfriend because of potential economic concerns and other children in the household. The nurse should explain the cycle of abuse (e.g., tension-building phase, battering incident, and honeymoon phase). The priority intervention is to assist the client to make concrete plans for the safety of herself and her children. The client should identify the safest, quickest routes out of the house and be able to identify where she will go once the cycle of violence escalates. Contacting a social worker at this time is not appropriate because the client is not ready to leave the abusive situation. The nurse can tell the client that these services are available, but it is up to the client to determine whether a referral is necessary. Telling the client that she shouldn't allow anyone to hit her or her children does not assist the client to make plans for her safety and the children's safety should the violence escalate. The client may have a flat affect or feel extreme humiliation from the abuse. The client may also be feeling that the abuse is her fault. When the client is ready to leave the abusive situation and receive continuous counseling, efforts can be taken to increase her self-esteem and prevent additional violence. The client should be made aware of the available services in the community for women who are involved in abusive relationships. The location and phone numbers for available shelters should be provided to the client. Giving her a brochure related to the statistics about violence against women is not helpful and, if found by the abuser, may lead to further violence.

 CN: Psychosocial adaptation;  
CL: Synthesize


**158. 2.** The client who is taking sulfadiazine should be instructed to drink at least eight glasses of water a day to prevent the development of crystalluria. Sulfadiazine should be taken on an empty stomach with a full glass of water. It does not require that the client's urine output be measured and does not affect the color of the urine.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**159. 3.** The client is demonstrating loose associations. Therefore, the nurse needs to clarify the meaning of and the connection between ideas. The nurse's statement about Halloween makes the assumption that the client is talking about Halloween from the mention of black cats and black hats. Asking if the client has a black cat is not helpful. The statement about time going faster ignores the client's statement entirely.

 CN: Psychosocial adaptation;  
CL: Synthesize


**160. 1.** MID results from multiple small blood clots in the brain. Therefore, the most critical factor is using anticoagulants to reduce the risk of more infarcts. Administering benzodiazepines such as lorazepam to decrease choreiform movements is associated with Huntington's disease. Although depression is common with MID, managing depression-related symptoms will not slow the progression of MID. Managing symptoms by increasing dopamine availability is appropriate for clients with Parkinson's disease.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**161. 2.** Checking the carotid artery pulse in a child during CPR provides information about perfusion of the brain. The brachial pulse is checked in an infant because the infant's short and typically fat neck makes it difficult to palpate the carotid pulse. The femoral and radial arteries might indicate perfusion to the peripheral body sites, but the critical need is for adequate circulation to the brain.

 CN: Physiological adaptation; CL: Apply

**162. 2.** Nephrotic syndrome is characterized by massive proteinuria caused by increased glomerular membrane permeability. Other symptoms include peripheral edema, hyperlipidemia, and hypoalbuminemia. Because of the edema, clients retain fluid and may gain weight. Hematuria is not a symptom related to nephrotic syndrome.

 CN: Physiological adaptation;  
CL: Analyze

**163. 2.** Because the child has a history of severe hypoxic episodes, having oxygen readily available at the bedside is most important. Should the child experience another hypoxic episode, oxygen could be administered easily and quickly. Although morphine causes peripheral dilation, which causes the blood to remain in the periphery, decreasing system volume, oxygen administration is the priority. Typically a child with tetralogy of Fallot with episodes of hypoxia does not require suctioning.


 CN: Physiological adaptation;  
CL: Synthesize

**164. 1.** Although individuals differ, the most likely attitude of a Mexican-American client is to bear pain stoically, to endure pain as a part of God's will, and to delay seeking treatment.


 CN: Basic care and comfort; CL: Apply

**165. 1.** When a client voids frequent, small amounts, the nurse should suspect that the client is retaining urine. Palpating for a distended bladder is the first assessment that the nurse should perform to verify this suspicion. Obtaining an order

to catheterize for residual urine may be appropriate as a follow-up activity. Obtaining a urine specimen for culture is not a first priority. The nurse would not encourage an increased fluid intake until further assessment of the situation is completed.

 CN: Physiological adaptation;  
CL: Synthesize


**166. 3.** It is appropriate for the client to be on a low-sodium diet to help decrease fluid retention. Dry skin and pruritus are common in renal failure. Lotions are used to relieve the dry skin, and antihistamines may be used to control itching; corticosteroids are not used. Pain is not a major problem in chronic renal failure, but analgesics that are excreted by the kidneys must be avoided. It is not necessary to measure abdominal girth daily because ascites is not a clinical problem in renal failure.

 CN: Reduction of risk potential;  
CL: Synthesize

**167. 5, 4, 3, 2, 1.** The most frequent cause of respiratory distress in a toddler with no previous illness is foreign body aspiration. After having the clerk call for the rapid response team, the nurse should assess the child for breaths, and then begin abdominal thrusts. Next, the nurse (or rapid response team if present) should assess the effectiveness of the abdominal thrusts, and then start an intravenous infusion. Finally, the nurse can notify the surgeon.

 CN: Reduction of risk potential;  
CL: Synthesize

**168. 4.** The traction weights should be hanging freely to maintain pull. The child needs to be moved up in bed with the weights left untouched to continue countertraction. Then the nurse can determine whether blocks are necessary to maintain the child in the correct position. Raising the weights is inappropriate because doing so interferes with countertraction. The physician does not need to be notified. The nurse can easily correct the problem by moving the child up in bed.


 CN: Physiological adaptation;  
CL: Synthesize

**169. 1.** Children ages 6 to 12 have a slower growth rate than do younger children and adolescents. As a result, their food requirements are comparatively less.


 CN: Health promotion and maintenance;  
CL: Apply

**170. 4.** Asking whether the client is thinking about killing herself is the most direct and therefore the best way to assess suicide risk. Knowing whether the client has recently watched movies on suicide and death, what the client thinks about suicide, or


about previous suicides of family members will not tell the nurse whether the client herself is thinking about committing suicide right now.

 CN: Psychosocial adaptation;  
CL: Synthesize


**171. 4.** Proper nutrition before and during pregnancy helps to ensure that the uterus will be able to support the growth of a healthy placenta. If the placenta never develops properly, the fetus will fail to thrive and the infant may have a low birth weight.

 CN: Health promotion and maintenance;  
CL: Analyze


**172. 1.** Return demonstrations are the best way to evaluate a person's ability to perform a skill. This technique enables the teacher to observe not only the learner's sequencing of steps of the procedure but also the learner's ability to perform the skill.

 CN: Pharmacological and parenteral therapies;  
CL: Evaluate


**173. 3.** Ibuprofen (Motrin) should be taken with food or antacids to avoid the development of gastrointestinal distress. Tinnitus is not an adverse effect of ibuprofen; it is a sign of salicylate toxicity. There is no need to increase vitamin B<sub>12</sub> intake. The CBC is not typically monitored monthly, although clients should be told to report signs of unusual bleeding because ibuprofen can prolong bleeding time.

 CN: Pharmacological and parenteral therapies;  
CL: Synthesize


**174. 4.** The nurse concludes that the staff member needs teaching about depression, specifically the biological basis of major depression, when the staff member states the client has no reason to be depressed because "she really has it all." Major depression, or endogenous depression, is caused by alterations of neurotransmitters, primarily serotonin and norepinephrine. Genetics and hereditary also predispose an individual to develop depression. Therefore, there may not be an external cause or a reason for depression to develop. Depression that occurs from an external cause is known as reactive depression and it could be caused by a loss or a life stress.

 CN: Psychosocial adaptation;  
CL: Analyze


**175. 4.** In asthma, the airways react to certain external and internal stimuli, including allergens, infections, exercise, and emotions. Food allergens commonly associated with asthma include wheat, egg white, dairy products, citrus fruits, corn, and chocolate.

 CN: Physiological adaptation;  
CL: Analyze

**176. 4.** When administering an enema, the nurse should position the client in a left Sims position. Placing the client in this position facilitates the flow of fluid into the rectum and colon. It also allows the client to flex the right leg forward, adequately exposing the rectal area.

 CN: Pharmacological and parenteral therapies; CL: Apply

**177. 3.** Risk factors for the development of pressure ulcers include poor nutrition, indicated by a decreased serum albumin level. According to the *Guidelines for Pressure Ulcers* published by the Agency for Healthcare Research and Quality, other risk factors include immobility, incontinence, and decreased sensation. A client who does not ambulate often can be repositioned frequently to prevent pressure ulcers. Having an indwelling urinary catheter does not normally increase the risk of developing a pressure ulcer unless pressure from the tubing impinges on urethral or other tissue. An elevated white blood cell count does not place a client at risk for pressure ulcers.

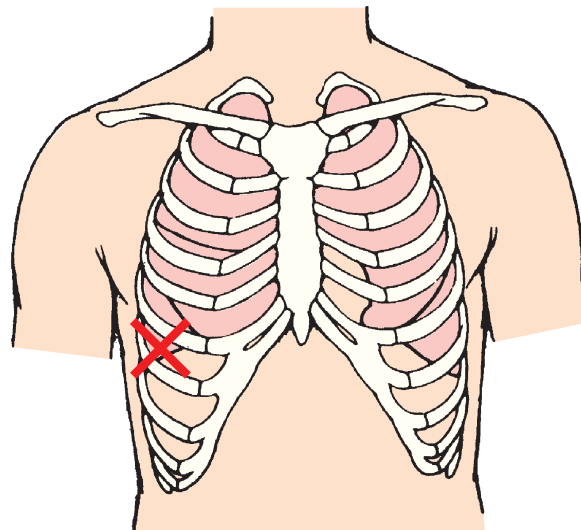
 CN: Reduction of risk potential; CL: Analyze

**178. 2.** Cerebral hypoxia is commonly associated with dizziness. The greatest risk of injury to a client with dizziness is a fall. Frequent rests and energy conservation measures should be included in the client's plan of care, but safety from falls is the greatest need. Checking the shower water temperature is not critical for this client, who will not be showering because of her fall risk.


 CN: Reduction of risk potential; CL: Synthesize

**179.** The nurse should auscultate the right lower lobe and listen as the client inhales and exhales. The nurse should be able to hear vesicular breath sounds.

 CN: Physiological adaptation; CL: Apply



**180. 1, 2, 5.** When an oxygen hood is used, the nurse should be sure the oxygen source is not directed on the infant's face to avoid skin irritation. Mobiles can be used to provide visual stimulation, but they should not be placed inside of the hood where they are a potential choking hazard. It is not necessary to restrain the infant unless there is an indication to do so, and the physician has written the order. There should be as little movement in and out of the hood as possible in order to maintain the warm and humid oxygen levels. The nurse should encourage the parents to visit the child and provide verbal and tactile stimulation.

 CN: Physiological adaptation; CL: Synthesize

**COMPREHENSIVE**

**TEST**

**6**

**1.** A client returns to the recovery room following left supratentorial surgery for treatment of a brain tumor. The nurse should place the client in which position to facilitate venous drainage?

- 1. Lying flat without a pillow with his head turned to the right.
- 2. Lying flat with his head elevated on three pillows.
- 3. Head of the bed elevated to 30 degrees with his head in a neutral position.
- 4. Side-lying on his left side.

**2.** A 57-year-old Hispanic woman with breast cancer who does not speak English is admitted for a lumpectomy. Her daughter, who speaks English, accompanies her. In order to obtain admission information from the client, what should the nurse do?

- 1. Ask the client's daughter to serve as an interpreter.
- 2. Ask one of the Hispanic nursing assistants to serve as an interpreter.
- 3. Use the limited Spanish learned in high school along with nonverbal communication.
- 4. Obtain a trained medical interpreter.

**3.** A nurse is caring for a client who has undergone a total laryngectomy for laryngeal cancer. What information is important to include in his discharge teaching? Select all that apply.

- 1. Providing humidity at home.
- 2. Following a bland diet.
- 3. Learning how to suction himself.
- 4. Having communication rehabilitation with a speech pathologist
- 5. Attending a smoking cessation program.

**4.** The client received electroconvulsive therapy (ECT) an hour ago and tells the nurse that he has a headache. Which response by the nurse is **best**?

- 1. "A headache is common after ECT."
- 2. "I will get some acetaminophen (Tylenol) for you."
- 3. "A nap will help you feel better."
- 4. "Eat your breakfast and then let me know how you feel."

**5.** The staff nurse is reviewing how to manage the last 2 hours of the night shift on an antepartal unit and has the following orders and tasks to complete prior to 7 a.m. The nurse should complete the tasks at which of the following times?

1. Check documentation, final check of each client.

2. Fetal monitor strip for ½ hour q shift.

3. Magnesium sulfate drawn at 6 a.m.

4. Accucheck and sliding scale insulin due at 7, 11, 4, and hs.

5:30

6:00

6:30

7:00

**6.** When assessing speech development, which of the following children should the nurse refer for further examination?

- 1. A 4-month-old who laughs out loud.
- 2. A 10-month-old who says "dada" and "mama."
- 3. A 1-year-old who says 3 to 5 words.
- 4. An 18-month-old who only says "no."

**7.** A family has taken home their newborn and later received a call from the pediatrician that the PKU levels for their newborn daughter are abnormally high. Additional testing confirmed the diagnosis of phenylketonuria. The parents refuse to believe the results as no one else in their family has the disease. The nurse explains that the disease:

- 1. Is carried on recessive genes contributed by each parent.
- 2. Is caused by a recessive gene contributed by either parent.
- 3. Is cured by eliminating dietary protein for this child.
- 4. Will not impact future childbearing for the family.

**8.** During a clinic visit for a postpartum examination, the mother of a 2-week-old infant tearfully tells the nurse she feels very tired and thinks she is not a good mother to her baby. Which statement by the nurse would be **best**?

- 1. "The hormonal changes your body is experiencing are causing you to feel this way."
- 2. "Most new mothers feel the same way that you do. I hear that a lot from others."
- 3. "You need to have your husband and family help you so that you can get some rest."
- 4. "I'm concerned about what you are experiencing. Tell me more about what you are thinking and feeling."

**9.** A client is to receive 2 g of metronidazole (Flagyl) orally in a single dose. The medication is available in 500-mg tablets. How many tablets should the nurse administer?

\_\_\_\_\_ tablets.

**10.** A college student is asking the nurse about his grandfather, who just received a diagnosis of Huntington's disease. The student wants to know if he will have the disease, too. What should the nurse tell the student? Select all that apply.

- 1. "Huntington's disease affects men more than women."
- 2. "Huntington's disease is an autosomal dominant disease."
- 3. "Huntington's disease does not skip a generation."
- 4. "Huntington's disease is a treatable disease."
- 5. "There is a 75% chance you will have the disease."

**11.** The nurse notices drops of a liquid on the hallway floor of a health care facility. The nurse should do which of the following **first**?

- 1. Place paper towels over the drops of liquid.
- 2. Don clean gloves and wipe up the drops of liquid.
- 3. Post "wet floor" signs around the area.
- 4. Call the Environmental Services Department.

**12.** A client is admitted with numbness and tingling of the feet and toes after having an upper respiratory infection and flu for the past 5 days. Within 1 hour of admission, the client states that his legs are numb all the way up to his hips. The nurse should do which of the following **next**? Select all that apply.

- 1. Call his family to come in to visit with him.
- 2. Notify his health care provider of the change.
- 3. Place respiratory resuscitation equipment in the client's room.
- 4. Check for advancing levels of paresthesia.
- 5. Perform ankle pumps to increase circulation and relieve numbness.

**13.** The nurse is caring for a client with an injury to the thalamus. The nurse should plan to:

- 1. Give higher doses of pain medication.
- 2. Keep patches on the client's eyes to prevent corneal abrasion.
- 3. Monitor the temperature of the bathwater.
- 4. Avoid turning the client.

**14.** A client who voluntarily admitted herself to the mental health hospital adamantly demands to be discharged immediately. What is the **most** appropriate response by the nurse?

- 1. "We hate to see you go, but that is your right. I'll get the forms for you so you can go."
- 2. "I'm sorry, but your lawyer or family must request such forms when you are hospitalized."
- 3. "I will get the forms, but your psychiatrist will need to see you before you leave."
- 4. "Are you sure we can't convince you to stay here a few days longer? Your insurance is still valid and there are several issues we need to address."

**15.** A client tells the nurse that he is going to harm his brother-in-law, who called the police on him for threatening to hurt his ex-wife. The nurse should notify which of the following persons? Select all that apply.

- 1. Agency administrators.
- 2. Ex-wife.
- 3. Police.
- 4. Intended victim.
- 5. Social service department.

**16.** The nurse is planning care for a client who has sustained a spinal cord injury. The nurse should assess the client for:

- 1. Anesthesia below the level of the injury.
- 2. Tingling in the fingers.
- 3. Pain below the site of the injury.
- 4. Loss of position and vibratory sense.

**17.** A client who is paraplegic cannot feel her lower extremities and has been positioned on her side. The nurse should inspect which of the following areas that is a potential pressure point when the client is in this position?

- 1. Sacrum.
- 2. Occiput.
- 3. Ankles.
- 4. Heel.

**18.** Which of the following is appropriate when developing a plan of care for promoting the development of a preschooler? Select all that apply.

- 1. Providing anticipatory guidance for parents.
- 2. Helping the parents understand their child's behavior.
- 3. Identifying deviations from normal growth and development patterns.
- 4. Determining the child's future development.
- 5. Sending the child to a day care center.

**19.** A neonate is to receive an I.V. infusion of normal saline solution at 3 mL/hour. The nurse is setting the alarms on an I.V. infusion pump. How should the nurse set the alarms?

- 1. At 5% above and 5% below the keep-vein-open rate.
- 2. Within a 15% range of the keep-vein-open rate
- 3. To sound when the infusion is infiltrating.
- 4. At the exact drip rate as prescribed.

**20.** A client is admitted to the inpatient unit and is exhibiting pressured speech, a labile affect, euphoria, and hyperactivity. The client states, "I am the Savior of the city." The family states that the client has hardly slept or eaten for days. Which of the following client needs is a **priority** in the nurse's plan of care?

- 1. Physical.
- 2. Social.
- 3. Spiritual.
- 4. Cultural.

**21.** A neonate is receiving an I.V. infusion of dextrose 10% in water administered by an infusion pump. The nurse should verify the alarm settings on the infusion pump at which times? Select all that apply.

- 1. When the infusion is started.
- 2. At the beginning of each shift.
- 3. When the neonate returns from X-ray.
- 4. When the neonate moves in the crib.
- 5. After the parents have visited.

**22.** The nurse is caring for a critically ill client with the client's mother and spouse in the room. The spouse begins to shout derogatory comments to the mother, blaming her for her spouse's critical state. What should the nurse do?

- 1. Try to calm both the mother and spouse by speaking in a soft voice.
- 2. Step between the mother and spouse stating emphatically, "Stop!"
- 3. Call the hospital Security Department.
- 4. Report the details immediately to the supervisor.

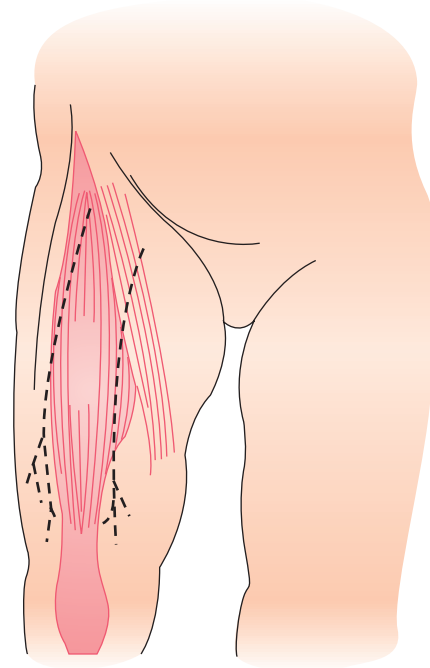
**23.** The nurse is planning care for a neonate to prevent neonatal heat loss immediately after delivery. To conserve heat and help the infant maintain a stable temperature, the nurse should:

- 1. Nestle the neonate against the crib wall.
- 2. Place a hat on the neonate's head and wrap the neonate in a blanket.
- 3. Bathe the neonate with warm water.
- 4. Position the neonate lying in an open crib with a diaper on.

**24.** The nurse observes that the client's right eye does not close completely. Based on this finding, which of the following nursing interventions would be **most** appropriate?

- 1. Making sure the client wears her eyeglasses at all times.
- 2. Placing an eye patch over her right eye.
- 3. Instilling artificial tears once every shift.
- 4. Cleaning the eye with a clean washcloth every shift.

**25.** The nurse is administering an intramuscular injection to an infant. Indicate the appropriate site for this injection.



**26.** A 14-year-old with rheumatic fever who is on bed rest is receiving an I.V. infusion of dextrose 5% in water administered by an infusion pump. The nurse should verify the alarm settings on the infusion pump at which of the following times? Select all that apply.

- 1. When the infusion is started.
- 2. At the beginning of each shift.
- 3. When the child returns from X-ray.
- 4. When the child moves in the bed.
- 5. When the child is sleeping.

**27.** A potential concern when caring for an older adult who has diminished hearing and vision is the client's:

- 1. Feelings of disorientation.
- 2. Cognitive impairment.
- 3. Sensory overload.
- 4. Social isolation.

**28.** Which of the following children should be referred for further assessment regarding language development?

- 1. A 2-year-old who has a vocabulary of 300 words and can combine two or three words in a phrase.
- 2. A 3-year-old who has a vocabulary of 900 words and can make a complete sentence of three or four words.
- 3. A 2-year-old who has a vocabulary of 100 words and can point to objects.
- 4. A 1-year-old who has a vocabulary of 8 words and can say "mommy" and "daddy" with specific reference to the correct person.

**29.** A nurse is taking a medication history on a client with multiple sclerosis before administering an initial dose of baclofen (Lioresal). What should the nurse check **before** administering the drug?

Select all that apply.

- 1. Presence of muscle weakness.
- 2. History of muscle spasms.
- 3. Serum creatinine level.
- 4. Serum potassium level.
- 5. Blood glucose.

**30.** A client has been taking carbamazepine (Tegretol) for 2 years. The nurse should assess the client for which of the following? Select all that apply.

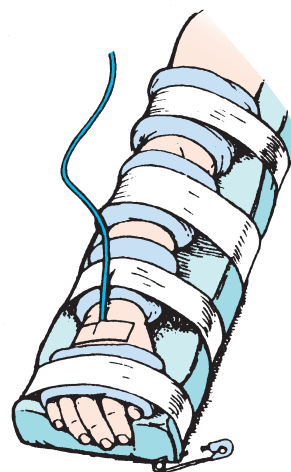
- 1. Bruising.
- 2. Sore throat.
- 3. Urine retention.
- 4. Light-colored stool.
- 5. Hydration status.

**31.** A 12-year-old client says, "Give me my pajamas. I'm not putting your silly gown on." An appropriate response by the nurse should be:

- 1. "I know they're funny but everyone here wears them."
- 2. "You don't mean that, now. A big guy like you knows how hospitals are."
- 3. "You're upset because you feel awkward and embarrassed in these gowns."
- 4. "You're upset because you think we're unreasonable."

**32.** A nursing assistant is taking care of a child in the arm restraint shown below. To provide care for this child, what should the assistant do?

- 1. Unpin the restraint and perform range-of-motion exercises.
- 2. Unwrap the restraint and bathe the arm using warm water.
- 3. Leave the restraint in its current position.
- 4. Remove one tape at a time while bathing the child's arm.



**33.** Which of the following are reasons for the nurse to encourage women to have a "Pap test" (Papanicolaou smear)? Select all that apply.

- 1. To detect precancerous and cancerous cells of the uterus.
- 2. To assess the effects of sex hormonal replacement.
- 3. To identify viral, fungal, and parasitic conditions.
- 4. To evaluate the response to chemotherapy or radiation therapy to the cervix.
- 5. To detect a diminished blood flow to the perineal mucous membrane.

**34.** The nurse is administering prednisone to a child with nephrosis. To assure that the nurse has identified the child correctly, the nurse should do which of the following. Select all that apply.

- 1. Ask another nurse to confirm that this is the correct dose and correct client for whom the prednisone has been prescribed.
- 2. Check the child's identification band against the medical record number.
- 3. Verify the date of birth from the medical record with the date of birth on the client's identification band.
- 4. Compare the room number on the bed with the number on the client's identification band.
- 5. Ask the client to state his first name.



**35.** The nurse is administering propranolol (Inderal) to a client for control of migraine headaches. The client's pulse rate is 56 bpm. What should the nurse do **next**?

- 1. Contact the physician immediately.
- 2. Assess blood pressure.
- 3. Administer oxygen.
- 4. Ask for a relative to contact.

**36.** When a child is able to grasp the idea that a ball continues to exist even though his parent placed the ball under a hat, the child is in which of the following stages in the development of logical thinking, according to Piaget?

- 1. Sensorimotor.
- 2. Preoperational.
- 3. Concrete operations.
- 4. Formal operations.

**37.** A nurse discusses with parents the procedures that will be performed on their neonate immediately after delivery. The nurse determines that the instructions have been understood when the client states that what will be done to the neonate **first**?

- 1. The neonate will be suctioned.
- 2. The neonate will be dried and stimulated to cry.
- 3. The neonate will be given oxygen.
- 4. The neonate's umbilical cord will be cut.

**38.** An infusion of lidocaine hydrochloride (Xylocaine) is running at 30 mL/hour. The dilution is 1,000 mg/250 mL. What dosage is the client receiving per minute?

\_\_\_\_\_ mg/minute.

**39.** A nurse is instructing a client about the use of nitroglycerin patches. The nurse should instruct the client to:

- 1. Remove the patch every night.
- 2. Use the patch only when chest pain occurs.
- 3. Change the site of the patch every day.
- 4. Apply the patch only on alternate days.

**40.** The nursing staff has safely and successfully secluded and restrained a client with acute mania who threatened the nurse and threw a chair against the wall in the community room. Which statement by the nurse is **most** helpful to the client at this time?

- 1. "Threatening others and throwing furniture is not allowed."
- 2. "You have been restrained until you can manage your behavior."
- 3. "Since you have been here before, you know what the rules are."
- 4. "We are only doing this for your own good, so calm down."

**41.** A client is taking 600 mg of valproic acid (Depakene) twice daily. The nurse should assess the client for which of the following? Select all that apply.

- 1. Tremors.
- 2. Hair loss.
- 3. Gastrointestinal upset.
- 4. Anorexia.
- 5. Weight gain

**42.** A client has a cerclage placed at 16 weeks' gestation. She has had no contractions and her cervix is dilated 2 cm. The nurse is preparing the client for discharge. Which statement by the client should indicate to the nurse that the client needs further instruction?

- 1. "I will need more frequent prenatal visits."
- 2. "I should call if I am leaking fluid or have bleeding or contractions."
- 3. "I can have sex again in about 2 weeks."
- 4. "I can have nothing in my vagina until I am at term."

**43.** Which of the following conditions is a potential consequence of a prolonged QT interval?

- 1. Serious electrolyte imbalance.
- 2. Predisposition to torsades de pointes.
- 3. Predisposition to atrial fibrillation.
- 4. Development of orthostatic hypotension.

**44.** A mother calls the clinic after her 4-year-old choked on a peanut. The mother reports that she performed abdominal thrusts and the child is breathing normally now. The nurse should tell the mother to:

- 1. Bring the child to the emergency department to check for airway obstruction.
- 2. Test the child's urine for blood from internal bleeding.
- 3. Call the physician if the child begins to sweat and feels dizzy.
- 4. Observe the child for difficulty breathing because the abdominal thrusts may have caused a pneumothorax.

**45.** A client is taking nonsteroidal anti-inflammatory drugs (NSAIDs) to manage pain from rheumatoid arthritis. What instruction should the nurse give the client about NSAIDs?

- 1. Take the prescribed medication with food and fluids.
- 2. Gradually decrease the medication dosage.
- 3. Rinse the mouth with water after taking NSAIDs.
- 4. Avoid driving and using machinery while taking NSAIDs.

**46.** The nurse is assessing a neonate at 5 minutes after birth. The nurse records the Apgar score based on the findings in the chart below.

Flow Sheets	
Apgar at 5 Minutes After Birth	
Heart rate	100 bpm
Respirations	Irregular
Color	Pink
Muscle tone	Moving all four extremities
Reflexes	Cough

The nurse compares these findings to the Apgar score obtained at birth, as determined by the findings in the chart below.

Flow Sheets	
Apgar at Birth	
Heart rate	120 bpm
Respirations	Slow
Color	Blue extremities
Muscle tone	Flexion of extremities
Reflexes	Grimace

What should the nurse do **next**?

- 1. Notify the neonatologist on call.
- 2. Continue to assess the neonate.
- 3. Apply an oxygen mask.
- 4. Rub the neonate's extremities.

**47.** Communicating with parents and children about health care has become increasingly significant because:

- 1. Consumers of health care cannot keep up with rapid advances in science.
- 2. The influence of the media and specialization have increased the complexity of managing health.
- 3. Nurse educators have recognized the value of communication.
- 4. Clients are more demanding that their rights be respected.

**48.** The **most** appropriate toys to give to a 5-month-old infant are:

- 1. Plastic toy cars.
- 2. Wooden puzzles.
- 3. Stuffed animals.
- 4. Soft, washable toys.

**49.** The nurse is beginning the shift and is assessing the oxygen exchange on a neonate. The nurse reviews the chart for pulse oximetry reading for the last 8 hours.

Flow Sheets					
Pulse Oximetry					
Time	7 am	9 am	11 am	1 pm	3 pm
Reading	95%	90%	90%	85%	80%

The pulse oximetry reading at 3:30 p.m. is 75%.

What should the nurse do **first**?

- 1. Administer oxygen via mask.
- 2. Swaddle the neonate in heated blankets.
- 3. Reassess the oximetry reading in 30 minutes.
- 4. Draw blood gases for oxygen and carbon dioxide levels.

**50.** The nurse reviews the client's laboratory report to determine the client's blood level of valproic acid (Depakene), which is 35 mcg/mL. Based on this report, what should the nurse do **first**?

- 1. Withhold the next dose of valproic acid.
- 2. Notify the physician.
- 3. Give the next dose as ordered.
- 4. Take the client's vital signs.

**51.** After 2 days on a psychiatric unit, a client is still isolating himself in his room, except for meals. The client says he is uncomfortable around crowds of people. Which nursing intervention is the **most** appropriate initially?

- 1. Play a game of checkers with the client in his room.
- 2. Ask the client to attend a group session with the nurse.
- 3. Invite the client to go for a walk with the nurse and one other client.
- 4. Talk with the client in a corner of the crafts room.

**52.** A nurse is caring for a woman who delivered a term neonate at 6 a.m. At 4 p.m., the woman has a distended bladder and is reporting pain of 5 on a scale of 1 to 10. The nurse reviews the client's output record.

Intake and Output				
Output Record				
Time	8 am	10 am	11 am	4 pm
	30 mL	50 mL	30 mL	60 mL

What should the nurse do **first**?

- 1. Apply a warm, moist towel over the bladder.
- 2. Ask the woman to sit on the toilet while the nurse runs water from the faucet.
- 3. Administer Tylenol with codeine.
- 4. Use an in-and-out catheter to empty the bladder.

**53.** The father of a 3-week-old infant who has developed sepsis says that he feels guilty because he did not realize his infant was sick. Which of the following responses by the nurse would be **most** appropriate?

- 1. "You should have realized something was wrong; he is your son."
- 2. "Did you read the booklet on newborns that was sent home with you from the hospital?"
- 3. "What you are feeling is normal; next time, you will know what to look for."
- 4. "Babies can get sick quickly, and parents do not always realize it."

**54.** A mother brings a 15-month-old child to the well-baby clinic. She states the child has been taking approximately 18 to 20 oz of whole milk per day from a bottle with meals and at bedtime. The nurse should suggest that she begin weaning the child from the bottle to avoid risking:

- 1. Malnutrition.
- 2. Anemia.
- 3. Dental caries.
- 4. Malocclusion.

**55.** The nurse is preparing to administer furosemide (Lasix) to a 3-year-old with a heart defect. The nurse verifies the child's identity by checking the arm band and:

- 1. Asking the child to state her name.
- 2. Checking the room number.
- 3. Asking the child to tell her birth date.
- 4. Asking the parent the child's name.

**56.** Diuretic therapy with torsemide (Demadex) is started for a client with heart failure. Two days after the drug therapy is started, the nurse evaluates the torsemide as effective when the client says she has experienced which of the following outcomes?

- 1. She has an improved appetite and is eating better.
- 2. She weighs 6 lb less than she did 2 days ago.
- 3. She is less thirsty than she was before the drug therapy.
- 4. She has clearer urine since starting torsemide.

**57.** Which of the following techniques is correct for the nurse to use when inserting a rectal suppository for an adult client?

- 1. Insert the suppository while the client bears down.
- 2. Place the client in a supine position.
- 3. Position the suppository along the rectal wall.
- 4. Insert the suppository 2 inches into the rectum.

**58.** The nurse is preparing to suction a tracheostomy for a client with methicillin resistant staphylococcus aureus (MRSA) (see figure). The nurse should:

- 1. Wear a powered air purifying respirator (PAPR) face shield.
- 2. Use goggles that include the hairline.
- 3. Change to a surgical mask.
- 4. Proceed to suction the client's tracheostomy.



**59.** A young woman is brought from the emergency department (ED) to the psychiatric unit. ED staff report that she is not answering questions and has been sitting in the same position in the wheelchair for 45 minutes. When her arm was extended to draw blood, she did not move her arm back to a natural position. The client's brother says he found her this way yesterday and couldn't get her to move on her own. Which nursing interventions have a **high** priority in this case? Select all that apply.

- 1. Ask her to describe her stressors.
- 2. Monitor her body positions to prevent injury.
- 3. Offer her nutritional shakes every 3 hours.
- 4. Encourage her to talk about her feelings.
- 5. Assist her to the bathroom every 2 hours.
- 6. Protect her from intrusions by other clients.

**60.** A client who had a total hip placement at 9 a.m. is receiving an autologous blood transfusion that was started at 11 a.m. At the change of shift (3 p.m.), the day nurse reports that there is 50 mL of the unit of blood remaining to be infused. Which of the following is a **priority** action for the evening nurse?

- 1. Keep the blood transfusing at the same rate.
- 2. Increase the rate so it will infuse by 4 p.m.
- 3. Discontinue the blood transfusion at the beginning of the shift.
- 4. Maintain the current rate and discontinue the blood transfusion at 5 p.m.

**61.** A client is admitted with fatigue, shortness of breath, pale skin, and dried, cracked lips, tongue, and mouth. Her hemoglobin is 9 g/dL and red blood cell count is 3.5 million cells/mm<sup>3</sup>. Which of the following foods should the nurse teach this client to include in her diet?

- 1. Beef, beets, and cabbage.
- 2. Lamb, applesauce, and mint jelly.
- 3. Chicken, dumplings, and biscuits.
- 4. Fish, wine, and apples.

**62.** When assessing a neonate 1 hour after birth, the nurse observes that the neonate exhibits slight cyanosis when quiet but becomes pink when crying. The nurse is unable to pass a catheter through the left nostril. The nurse notifies the pediatrician because the neonate most likely is exhibiting signs and symptoms of which of the following?

- 1. Esophageal reflux disorder.
- 2. Unilateral choanal atresia.
- 3. Respiratory distress syndrome.
- 4. Tracheoesophageal fistula.

**63.** When developing a teaching plan for parents of toddlers about poisonous substances, the nurse should emphasize which of the following safety points? Select all that apply.

- 1. Toddlers should be adequately supervised at all times.
- 2. All poisonous substances should be kept out of the reach of children and stored in a locked cabinet if necessary.
- 3. The difference between pediatric and adult dosages of medicines is significant and adult dosages given to children can have serious, harmful effects.
- 4. Syrup of ipecac should be administered following all ingestions of poisonous substances.
- 5. Following any poisoning, the parents should call the Poison Control Center for instructions for appropriate treatment.

**64.** A client on a psychiatric care unit approaches the nurse and complains of muscle spasms in his neck, stiffness in other muscles, and that his eyes are rolling upward. The client had two p.r.n. doses of haloperidol (Haldol) in the last 6 hours. Of the drugs that have been ordered for the client as needed (see chart), the nurse should administer:

#### Prescriptions

Lorazepam (Ativan) 1 mg I.M.  
Amantadine (Symmetrel) 100 mg P.O.  
Diphenhydramine (Benadryl) 25 mg P.O.  
Benztpopine (Cogentin) 0.5 mg I.M

- 1. Lorazepam (Ativan).
- 2. Amantadine (Symmetrel).
- 3. Diphenhydramine (Benadryl).
- 4. Benztpopine (Cogentin).

**65.** After delivery of a male neonate at 38 weeks' gestation, the nurse dries the neonate and places him under the radiant warmer. The nurse performs this action based on the understanding that one neonatal response to cold stress involves which of the following?

- 1. Metabolism of brown adipose tissue.
- 2. Decreased utilization of glycogen stores.
- 3. Decreased utilization of calorie stores.
- 4. Increased shivering to keep warm.

**66.** Twenty-four hours after an appendectomy, a 16-year-old adolescent of Asian ethnicity states that he has no pain but is frowning and has his legs drawn to the fetal position. The nurse should:

- 1. Administer pain medication.
- 2. Ask the adolescent what is troubling him.
- 3. Discuss the adolescent's behavior with the parents.
- 4. Offer a distracting activity such as a videos game.

**67.** When developing the teaching plan for a primiparous client who is bottle-feeding her term neonate for the first feeding, which of the following instructions should the nurse include?

- 1. Fill the entire nipple of the bottle with formula.
- 2. All term babies have well-developed sucking skills.
- 3. Bubble the baby after 2 oz of formula have been taken.
- 4. Propping of the bottle results in too much air being taken in by the baby.

**68.** A client complains of back pain 10 minutes after a unit of packed red blood cells (RBCs) was started. The client's pulse, blood pressure, and respirations are stable, and similar to vital signs obtained before infusing the RBCs. What should the nurse do? Select all that apply.

- 1. Turn off the infusion of the packed RBCs.
- 2. Flush the Y-tubing with normal saline to clear the line.
- 3. Insert an indwelling urinary catheter.
- 4. Prepare for cardiopulmonary resuscitation.
- 5. Obtain a urine specimen to send to the laboratory.

**69.** A primiparous client at 4 hours after a vaginal delivery and manual removal of the placenta voids for the first time. The nurse palpates the fundus, noting it to be 1 cm above the umbilicus, slightly firm, and deviated to the left side, and notes a moderate amount of lochia rubra. The nurse notifies the physician based on the interpretation that the assessment indicates which of the following?

- 1. Perineal lacerations.
- 2. Retained placental fragments.
- 3. Cervical lacerations.
- 4. Urine retention.

**70.** While performing a gestational age assessment for a newly delivered male neonate who was delivered vaginally at 37 weeks' gestation, the nurse should assess the neonate for:

- 1. An anterior transverse crease on the soles.
- 2. Extensive rugae on the scrotum.
- 3. Some cartilage in the ear lobes.
- 4. Coarse and silky scalp hair.

**71.** Two family members are visiting their father who is experiencing acute delirium. They are upset that their father is so disoriented. "He knows who we are, but that's about it. We don't know what to say to him." What should the nurse tell the family? Select all that apply.

- 1. "Answer his questions simply, honestly, slowly, and clearly."
- 2. "Correct him when he is hearing and seeing things that are not there."
- 3. "Occasionally remind him of the time, day, and place when he doesn't remember."
- 4. "Include him in your conversation, instead of talking about him while he is present."
- 5. "Raise your voice a bit so you are sure he hears you."

**72.** A 26-year-old male client is being admitted for treatment of delirium due to acute alcohol intoxication. The client is restless, does not want to stay seated, and has a staggering gait. What should the nurse do **first**?

- 1. Place the client in a chair with a waist restraint.
- 2. Provide one-to-one supervision of the client until detoxification treatment can begin.
- 3. Ask the client to sit in a chair next to the nurses' station.
- 4. Decrease stimuli by putting the client in bed with his room door closed.

**73.** The nurse is monitoring a client receiving a blood transfusion when the client develops a cough with shortness of breath. The client also complains of a headache and a racing heart. What should the nurse do **first**?

- 1. Slow the infusion rate.
- 2. Replace the blood with saline.
- 3. Administer an antihistamine.
- 4. Place the client flat with the feet elevated.

**74.** A nurse is obtaining an ankle-brachial index for a client with arteriosclerosis. Identify the correct order for obtaining the ankle-brachial index.

1. Place a Doppler probe at a 45-degree angle to the correct pulse (dorsalis pedis or posterior tibial).

2. Place the client in the supine position.

3. Record the highest systolic blood pressure readings in both arms.

4. Record the ankle systolic blood pressure reading when the Doppler sound returns.

**75.** A nurse is analyzing a client's intake and output. The client has a temperature of 102° F (38.9° C) and is receiving I.V. fluid therapy because of his nothing-by-mouth status due to acute pancreatitis. Before planning nursing actions, the nurse should first consider which of the following ?

- 1. The client's body mass index.
- 2. Insensible fluid loss through the lungs and skin.
- 3. When the client last ate.
- 4. The number of bags of I.V. fluid for the client.

**76.** Two toddlers are arguing over a toy in the playroom. The nurse should say to the children:

- 1. "If you can't play together, I'll have to put you back in your rooms."
- 2. "Give the toy to me. Now neither of you will have it."
- 3. "Let me see if I can get both of you a similar toy."
- 4. "Let one of you play with it for awhile, then give it to the other."

**77.** A 9-month-old infant whose parents have emigrated from Mexico presents in the clinic with severe dehydration from vomiting. The infant was seen in the clinic just 3 days ago for a well-child visit, but now the family seems very distrustful of the health care team. The nurse should ask the parents:

- 1. "Have you been speaking with a healer?"
- 2. "Did anything concern you about your last visit?"
- 3. "Has immigration been causing you problems?"
- 4. "Are you afraid your baby will be taken from you?"

**78.** A 4-year-old child continues to come to the nurses' station after being told children are not allowed there. What behavior is the child exhibiting?

- 1. Attention-seeking behavior.
- 2. Aggressive behavior.
- 3. Resistive behavior.
- 4. Exaggerated stress behavior.

**79.** A 5-month-old infant is brought to the emergency department with vomiting and diarrhea, which the mother states started 3 days ago. The nurse should conduct a focused assessment for which of the following? Select all that apply.

- 1. Decreased or absent tearing.
- 2. Dry mucous membranes.
- 3. Sunken fontanel.
- 4. Clear, pale yellow urine.
- 5. Bounding pulse.

**80.** A neonate of a primiparous client delivered at 36 weeks' gestation in a small, rural hospital is to be transferred by ambulance to a level III nursery. To prepare the parents for the transfer, which of the following should the nurse include in the plan of care?

- 1. Instruct the parents that the neonate is in critical condition.
- 2. Obtain the mother's consent for the neonate's transfer.
- 3. Allow the parents to touch the neonate before transfer.
- 4. Ask the father if he desires to ride in the ambulance during the transfer.

**81.** A multiparous client delivers a neonate at 24 weeks' gestation. After 12 hours, the neonate's condition deteriorates, and death appears likely within the next few minutes. The parents are Roman Catholic, and they request that the neonate be baptized. Which of the following actions would be **most** appropriate?

- 1. Contact the hospital chaplain to perform the baptism.
- 2. Alert the hospital's director that a neonatal death is imminent.
- 3. Find a health care provider who is Roman Catholic to perform the baptism.
- 4. Baptize the neonate, regardless of the nurse's own religious beliefs.

**82.** A client has bursitis in the subacromial bursa. A nurse determines that the client understands teaching when he makes which of the following statements?

- 1. "I will apply moist heat to my shoulder for 20 minutes three times each day."
- 2. "I will lift 30-pound weights at least three times each day."
- 3. "I will apply dry ice to my shoulder for 20 minutes three times each day."
- 4. "I will perform 360-degree circles with my arms extended at least three times daily."

**83.** A client has just undergone a lumbar puncture. Which finding should the nurse immediately report to the physician?

- 1. The client's oral intake was 1,200 mL in the past 8 hours.
- 2. The client required analgesia for headache.
- 3. A moderate amount of serous fluid was noted on the lumbar dressing.
- 4. The client is concerned about the test results.

**84.** A hospice nurse is caring for a client with breast cancer and brain metastasis. The nurse is reviewing the lab report below. According to the information in the chart, what should the nurse do **next**?

#### Laboratory Results

Test	Result
Potassium	4.0 mEq/L
Sodium	142 mEq/L
Chloride	100 mEq/L
Calcium	12.4 mg/dL

- 1. Document these results on the medical record.
- 2. Report the elevated potassium level immediately.
- 3. Report the elevated calcium level immediately.
- 4. Refrain from reporting the results because the client is in hospice care.

**85.** The nurse on the postpartum unit has delegated the care of a multiparous client and her term neonate at 4 hours postpartum to the licensed practical nurse (LPN). Which of the following findings should the LPN report to the nurse immediately?

- 1. Neonatal regurgitation of 1 tablespoon after a feeding.
- 2. Maternal pulse rate of 100 bpm at rest.
- 3. Neonatal heart rate of 140 bpm while at rest.
- 4. Increased maternal lochia rubra with initial ambulation.

**86.** A child with a cardiac defect assumes a squatting position. The nurse should determine that the position is effective for the child by noting:

- 1. Less energy required to play with toys on the floor
- 2. Less dyspnea.
- 3. Relief of abdominal pressure.
- 4. Improved muscle tone.

**87.** A client was brought to the emergency department following a motor vehicle accident, and has phrenic nerve involvement. The nurse should assess the client for:

- 1. Alteration in level of consciousness.
- 2. Altered cardiac functioning.
- 3. Ineffective breathing pattern.
- 4. Alteration in urinary elimination.

**88.** A primigravid client is seen for her first visit in the antenatal clinic and tells the nurse that her brother was born with cystic fibrosis (CF). When teaching the client about this disorder, the nurse should include which of the following? Select all that apply.

- 1. Inheritance is linked to race/culture.
- 2. To inherit CF, each parent must carry a recessive trait for the disease.
- 3. If both parents carry the trait, each offspring has a 25% chance of inheriting the disease.
- 4. Fetal testing can occur by checking the shape of the red blood cells.
- 5. Chorionic villi sampling (CVS) can identify prenatally if their child carries the trait or has the disease.

**89.** A client with a peritonsillar abscess has been hospitalized. Upon assessment, the nurse determines the following: a temperature of 103° F (39.4° C), body chills, and leukocytosis. The client begins to complain of difficulty breathing. In what order should the nurse perform the following actions?

1. Call the physician.

2. Open the airway.

3. Start an I.V. access site.

4. Explain the situation to the family.

**90.** The nurse is teaching a client who has deep vein thrombosis from limited mobility that caused a pulmonary embolus, which has resolved. Which of the following instructions should nurse give to this client?

- 1. "Report such signs as leg swelling, discomfort, redness, or warmth."
- 2. "Sit with your legs lower than the rest of your body."
- 3. "Walk at least every other day."
- 4. "Limit your fluids to 1 liter each day."

**91.** A multiparous client and her neonate, who has been cared for in the intensive care nursery for the past 3 days because of being small for gestational age, are to be discharged. Before their release, the mother tells the nurse, "I've been living in my car for the past 2 weeks." Which of the following should the nurse do **next**?

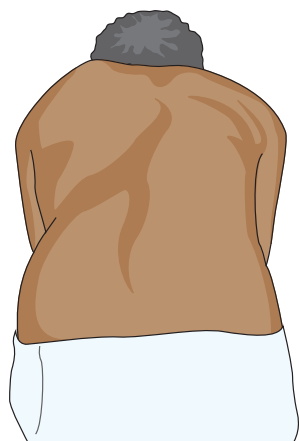
- 1. Notify the director of the birthing unit.
- 2. Contact the hospital's social worker.
- 3. Contact the client's physician.
- 4. Notify the client's family members.

**92.** A nurse is assessing a client who is having her 14th laser surgery for removal of a birthmark from her left cheek. The nurse should ask this client about which food allergy associated with a surgery risk given the circumstance of multiple surgeries?

- 1. Canned peas.
- 2. Frozen carrots.
- 3. Tomatoes.
- 4. Organ meats.

**93.** The nurse is assessing a teenage girl. According to the figure below, the nurse should note that the girl has:

- 1. Kyphosis.
- 2. Arthritis.
- 3. Developmental dysplasia of the hip.
- 4. Scoliosis.



**94.** A client in surgery has an endotracheal tube (ET) in place. The nurse should call a time-out if which of the following requirements is not in place? Select all that apply.

- 1. An identification band.
- 2. Postoperative pain medication.
- 3. An I.V. line.
- 4. Oxygen administration.
- 5. An anesthesiologist.

**95.** A multiparous client at 16 weeks' gestation is diagnosed as having a fetus with probable anencephaly. The client is a devout Baptist and has decided to continue the pregnancy and donate the neonatal organs after the death of the neonate. Which of the following actions by the nurse would be **most** appropriate?

- 1. Explore his or her own feelings about the issues of anencephaly and organ donation.
- 2. Contact the client's minister to discuss the client's options related to the pregnancy.
- 3. Advise the client that the prolonged neonatal death will be very painful for her.
- 4. Ask the client if she has discussed this with her family.

**96.** A 3-month-old infant is being discharged on digoxin (Lanoxin). The nurse should instruct the parents to report which of the following? Select all that apply.

- 1. Signs of constipation or painful straining.
- 2. Decrease in the amount of infant formula taken or a refusal to take it.
- 3. Pulse rate greater than 140 bpm or less than 100 bpm.
- 4. Signs that the infant is not following moving objects.
- 5. Sudden vomiting or sudden drowsiness.

**97.** The nurse receives a report of a serum potassium level on an infant of 6.0 mEq/L. The nurse should:

- 1. Notify the physician of the abnormal level.
- 2. Call the laboratory to see how the specimen was obtained.
- 3. Connect the infant to a cardiac monitor.
- 4. Check the infant's last 24-hour output.

**98.** A client with suicidal thoughts is admitted to an adult inpatient behavioral health unit. What should the nurse do **first**?

- 1. Initiate suicide precautions with face-to-face observation of the client at all times.
- 2. Place the client on suicide watch and have a family member remain with the client.
- 3. Question the client further about his suicidal thoughts and plans.
- 4. Confine the client to his room and post a staff member at the door to observe his actions.

**99.** The nurse manager in a labor and delivery unit is making rounds on a client in early labor. Which of the following indicate that safety procedures are being implemented for this client? Select all that apply.

- 1. Bed in low position.
- 2. I.V. rates at ordered level.
- 3. Mother lying flat on back, if comfortable.
- 4. Client satisfied with support system present.
- 5. Client reports pain is tolerable.
- 6. Continuous fetal monitoring.

**100.** A nurse is planning care for a regressed, chronically ill client diagnosed with schizophrenia. What is the **most** appropriate milieu?

- 1. Confrontation and peer pressure to break down the client's denial.
- 2. Reminder that all clients must participate fully in unit self-governance.
- 3. Required attendance at group activities with equal participation from all clients.
- 4. Nurturance and supportive interaction focusing on individual needs.

**101.** Assessment of a primigravid client in active labor reveals cervical dilation at 9 cm with complete effacement and the fetus at +1 station. Which of the following should the nurse do when the physician orders meperidine (Demerol) 50 mg I.M. for the client?

- 1. Administer the medication in the left ventrogluteal muscle.
- 2. Be certain that naloxone (Narcan) is at the client's bedside.
- 3. Ask the physician to validate the dosage of the drug.
- 4. Refuse to administer the medication to the client.



**102.** A client has been hospitalized with a diagnosis of myasthenia gravis. A friend is visiting the client during lunch. The nurse enters the room after the client recovered from choking on lunch. What should the nurse do **next**?

- 1. Instruct the client to sit at a 30-degree angle in bed when eating.
- 2. Tell the client to swallow when her chin is tipped down on her chest.
- 3. Remind the client to rest after eating.
- 4. Encourage the client to eat alone.

**103.** A nurse is assessing a client with a brain injury. What is a client's cerebral perfusion pressure (CPP) when the blood pressure (BP) is 90/50 mm Hg and the intracranial pressure (ICP) is 21?  
\_\_\_\_\_ mm Hg.

**104.** A client with a T2-to-T3 spinal cord injury suddenly complains of a throbbing headache and blurred vision. The nurse assesses that he is flushed and sweating on his upper trunk and face, and the hairs on his arms are raised. What should the nurse do **first**?

- 1. Raise the head of the bed.
- 2. Assess for hypotension.
- 3. Check the client for a distended bladder.
- 4. Logroll the client to see if he is lying on a foreign object.

**105.** A 17-year-old unmarried primigravida client at 10 weeks' gestation tells the nurse that her family doesn't have much money and her dad just got laid off from his job. Which of the following would be the nurse's **most** appropriate action?

- 1. Instruct the client in methods for low-cost, highly nutritious meal preparation.
- 2. Determine whether the client qualifies for state assistance programs.
- 3. Refer the client to a social worker for enrollment in the Women, Infants, and Children (WIC) program.
- 4. Ask the client if she has a job and the amount of income earned.

**106.** A client has impairments in immediate recall and short-term memory. A nurse is planning for the client's daily activities. Which action by the nurse would be **most** effective?

- 1. Write out the client's schedule in large print, and show the client where the schedule is placed.
- 2. Describe each activity and the time of the events at the beginning of the day.
- 3. Lead the client to each activity if he does not attend on time.
- 4. Tell the client about each activity 10 minutes before it begins.

**107.** A 17-year-old male client is being admitted to the adolescent psychiatric unit. He was brought in by the police after beating up two male peers. The client says, "They said I was gay because I had sex with an older neighbor when I was 8 years old. I am not gay!" Which of the following nursing interventions would be appropriate? Select all that apply.

- 1. Monitor the client's level of anger and potential aggression.
- 2. Help the client express anger safely.
- 3. Assist the client in processing his feelings about the sexual abuse.
- 4. Ask the client if he would like to attend a support group.
- 5. Discuss the client's attitude about going to jail after discharge.

**108.** The nurse has been assigned to care for several postpartum clients and their neonates on a birthing unit. Which of the following clients should the nurse assess **first**?

- 1. A multiparous client at 48 hours postpartum who is being discharged.
- 2. A primiparous client at 2 hours postpartum who delivered a term neonate vaginally.
- 3. A multiparous client at 24 hours postpartum whose infant is in the special care nursery.
- 4. A primiparous client at 48 hours after cesarean delivery of a term neonate.

**109.** A client is admitted to the hospital with malaise, headache, and cough followed by fever, chills, dyspnea, chest discomfort, myalgia, anorexia, vomiting, and diarrhea. The physician makes the diagnosis of legionellosis (legionnaires' disease). The client asks, "How did I get this?" Which response by the nurse is the **most** accurate?

- 1. "The bacteria thrive in warm water environments and are inhaled from contaminated water droplets."
- 2. "You inhaled the bacteria from secondary smoke."
- 3. "As ceiling fans circulate, bacteria are dispersed into the air."
- 4. "You may have swallowed contaminated water."

**110.** A client is scheduled to undergo an upper GI series. Which of the following instructions should the nurse give the client in preparation for the test? Select all that apply.

- 1. "You will need to take a stool softener before the test to promote evacuation of the barium."
- 2. "Do not eat or drink for 8 hours before the test."
- 3. "You can expect white stools for about 48 hours after the test."
- 4. "You will experience mild stomach pain during the test."
- 5. "It is okay for you to smoke before the test."

**111.** To improve the accuracy of client identification, the nurse must use at least two identifiers when providing care, treatment, or services. Which of the following are appropriate? Select all that apply.

- 1. Room number.
- 2. Bed number.
- 3. Medical record number.
- 4. Name band.
- 5. Social security number.

**112.** A client with metastatic cancer of the liver is concerned about his progress. Which of the following nursing interventions is **most** appropriate?

- 1. Provide information for the client to consider a liver transplantation.
- 2. Assure the client that the prescribed medications will shrink all tumor sites.
- 3. Explain the effects of chemotherapy.
- 4. Place emphasis on providing symptomatic and comfort measures.

**113.** The nurse is preparing to give an I.M. injection. Which of the following sites has the **least** amount of blood vessels and major nerves located in the area?

- 1. Deltoid.
- 2. Dorsogluteal.
- 3. Vastus lateralis.
- 4. Triceps.

**114.** The nurse is planning to teach the client how to properly use a metered-dose inhaler to treat asthma. Which of the following instructions should the nurse include in the teaching plan?

- 1. Rinse the mouth after each use of a steroid inhaler.
- 2. Inhale quickly when administering the medication.
- 3. Inhale the medication and then exhale through the nose.
- 4. Cough and deep-breathe before inhaling the medication.

**115.** A client is receiving a transfusion of packed red blood cells. Which of the following actions should the nurse implement to safely administer the blood?

- 1. Keep the blood refrigerated on the nursing unit until ready to administer.
- 2. Stay with the client during the first 15 minutes to detect signs or symptoms of a reaction.
- 3. Do not infuse blood that has been hanging for more than 6 hours.
- 4. Administer the blood quickly to prevent wasting it if the client develops a fever.

**116.** A client is receiving a blood transfusion when he begins to complain of difficulty breathing. The nurse notes an elevated blood pressure and a cough. Based on these signs, the nurse should prepare to manage which of the following complications?

- 1. Anaphylactic reaction.
- 2. Circulatory overload.
- 3. Sepsis.
- 4. Acute hemolytic reaction.

**117.** A client has had sucralfate (Carafate) ordered as treatment for peptic ulcer disease. Which of the following statements indicates that the client understands how to take the medication?

- 1. "I should take the Carafate every evening at bedtime."
- 2. "It is important that I take this drug on an empty stomach."
- 3. "I should avoid milk products while taking this drug."
- 4. "I should have my hemoglobin checked monthly while taking Carafate."

**118.** During the admission interview, an adult client reveals that, as a child, she was sexually abused by her uncle and a male cousin. She reports that when she has flashbacks of this abuse she cuts her arms, legs, and abdomen. In addition to having the client sign a no-harm contract, which nursing intervention is **most** important?

- 1. Assist the client with finding safe ways to express her anger.
- 2. Talk with the client about confronting her uncle and cousin directly.
- 3. Defer talking about the abuse to prevent further self-mutilation.
- 4. Discuss the possibility of the client suing her relatives for their abuse.

**119.** An adult client has bacterial conjunctivitis. What should the nurse teach him to do? Select all that apply.

- 1. Use warm saline soaks four times per day to remove crusting.
- 2. Apply topical antibiotic without touching the tip of the tube to his eye.
- 3. Wash his hands after touching his eyes.
- 4. Avoid touching his eyes.
- 5. Observe isolation procedures and confine himself to his bedroom until the redness in the eye disappears.

**120.** Which of the following actions by the nurse will **most** likely ensure that the correct client receives a medication? Select all that apply.

- 1. Have the client state his or her name.
- 2. Check the name on the arm band with the name on the medication.
- 3. Learn to recognize the client.
- 4. Check the client's room number.
- 5. Compare the date of birth on the client's chart to the date of birth on the client's armband.

**121.** A nurse is counseling a mother with young children after the mother left her abusive husband 6 months ago. The mother says, “My 6-year-old, Kevin, is starting to act just like his father. I just don’t know how to handle this.” Which response by the nurse is **most** appropriate?

- 1. “You’ll have to limit Kevin’s contact with his father.”
- 2. “Counseling for Kevin would be helpful.”
- 3. “Most boys outgrow these behaviors.”
- 4. “Setting limits on his behavior is all you need to do now.”

**122.** The nurse manager is developing a “read-back” procedure to reduce medication administration errors. Which of the following are purposes of the “read-back” requirement? Select all that apply.

- 1. To prohibit orders and test results from being communicated verbally or by telephone.
- 2. To make sure that orders and test results that are communicated verbally or by telephone are clear to the receiver of the information.
- 3. To make sure that orders and test results that are communicated verbally or by telephone are confirmed by the individual giving the information.
- 4. To minimize the risk of non-authorized personnel from giving orders which are communicated verbally or by telephone.
- 5. To encourage the use of electronic medical records.

**123.** A 13-year-old male was kidnapped and held for ransom by two criminals. His parents asked to have him admitted to the adolescent psychiatric unit. He is sleep-deprived, filthy, alternating between sobbing and making threats to kill his captors, suspicious, and easily startled. He signs a no harm contract and then asks to go to sleep. What is the **best** initial plan for this client?

- 1. Encourage him to talk with the Federal Bureau of Investigation (FBI) about the crime details.
- 2. Develop trust and allow him to talk about his memories and feelings.
- 3. Help him and his parents prepare for the future trial.
- 4. Discourage him from making threats toward his captors.

**124.** A 16-year-old primiparous client has decided to place her baby for adoption. The adoptive parents are on their way to the hospital when the mother says, “I want to see the baby one last time.” Which of the following should the nurse do?

- 1. Tell the client that it would be best if she didn’t see the baby.
- 2. Allow the client to see the baby through the nursery window.
- 3. Contact the physician for advice related to the client’s visitation.
- 4. Allow the client to see and hold the baby for as long as she desires.

**125.** A 10-year-old child is admitted with a brain tumor. Which assessment made by the nurse is **most** critical to report to the child’s physician?

- 1. Vomiting after lunch.
- 2. Difficulty in recalling the day of the week.
- 3. Blood pressure of 102/62 mm Hg.
- 4. 100 mL of concentrated urine voided at one voiding.

**126.** The nurse is teaching a 17-year-old girl who has a severe gonorrheal infection. The nurse realizes that the girl understands the implications of her disease when she tells the nurse:

- 1. “Once I’m treated, I’ll have immunity.”
- 2. “My partner doesn’t need treatment.”
- 3. “I won’t have any more problems once I learn to protect myself.”
- 4. “I could have trouble getting pregnant.”

**127.** The nurse-manager on the medical unit is teaching the staff about the medication reconciliation policy. The nurse teaches the staff that reconciliation is needed to ensure that clients are on the correct medications in which situations? Select all that apply.

- 1. Admission to the hospital.
- 2. Transfer to the nursing home.
- 3. Transfer of a client from surgery to the surgical unit.
- 4. Admission to a home health agency from the hospital.
- 5. Move from a double room to a single room on the same unit.

**128.** A client was treated for a streptococcal throat infection 2 weeks ago. The client now has been diagnosed with acute poststreptococcal glomerulonephritis. The client asks the nurse how he could have prevented this condition. What should the nurse tell the client?

- 1. “See your physician for an early diagnosis and treatment of a sore throat.”
- 2. “As long as you do not have a fever, it is sufficient to gargle daily with an antibacterial mouthwash.”
- 3. “You may continue to utilize the previously prescribed antibiotics until they are gone.”
- 4. “Unscented bar soap may be used in showers.”

**129.** Assessment of a primigravid client in active labor reveals a cervix dilated to 5 cm and completely effaced, with the fetus at –1 station. The client has indicated that she wants a “natural childbirth” with no analgesia or anesthesia. The client’s husband has been present since their arrival at the birthing unit. The physician enters the room and tells the client that it is time for an epidural anesthetic. Which of the following would be the nurse’s **best** action at this time?

- 1. Ask the client if she desires an epidural anesthetic.
- 2. Tell the physician that the client desires a “natural childbirth.”
- 3. Tell the client that her labor will be more comfortable with an anesthetic.
- 4. Ask the client to discuss this with her husband and then make a decision.

**130.** A client is ready to be discharged from same-day surgery following an inguinal hernia repair. Which criteria must the client meet before the nurse can discharge the client?

- 1. The client has transportation home via a taxicab.
- 2. The client has pain no greater than 5 on a scale of 1 to 10.
- 3. The client can walk to the bathroom by himself.
- 4. The client states he will urinate later when he has more fluids.

**131.** The nurse is administering eyedrops to a client with glaucoma. Which of the following is a correct technique for instilling the eyedrops? The eyedrops are placed:

- 1. In the lower conjunctival sac.
- 2. Near the opening of the lacrimal ducts.
- 3. On the cornea.
- 4. On the scleral surface.

**132.** A client has an anaphylactic reaction to penicillin that results in respiratory distress. Which of the following medications should the nurse anticipate administering?

- 1. Dopamine (Intropin).
- 2. Diphenhydramine (Benadryl).
- 3. Cimetidine (Tagamet).
- 4. Epinephrine.

**133.** The nurse is designing a benchmarking study to gather information about nursing care practices for wound care. Which of the following sources of information are used for benchmarking? Select all that apply.

- 1. Government reports.
- 2. Literature reviews.
- 3. Standard-setting organizations.
- 4. Databases.
- 5. Clinical organization recommendations.

**134.** A client is using an over-the-counter nasal spray containing pseudoephedrine to treat allergic rhinitis. Which instruction about this medication would be **most** appropriate for the nurse to provide for the client?

- 1. Prolonged use of nasal spray can lead to nasal infections.
- 2. Pseudoephedrine is an addictive drug and must be used cautiously.
- 3. Overuse of pseudoephedrine can lead to increased nasal congestion.
- 4. A common side effect of pseudoephedrine nasal spray is thrush.

**135.** A 6-year-old child is admitted for an appendectomy. What is the **most** appropriate way for the nurse to prepare the child for surgery?

- 1. Explain how to use a patient-controlled analgesia (PCA) pump for pain control.
- 2. Permit the child to play with the blood pressure cuff, electrocardiogram (ECG) pads, and a face mask.
- 3. Show the child a video about the surgery.
- 4. Show the child a visual analog scale (VAS) based on a scale from 0 to 10.

**136.** The nurse is working on a hospital’s birthing unit when a primigravid client in active labor is ordered to receive meperidine (Demerol) 75 mg I.M. As the nurse enters the medication room, the nurse observes a female coworker slipping a vial of morphine into the side pocket of her uniform. Which of the following actions would be **most** appropriate?

- 1. Contact the hospital’s security chief.
- 2. Notify the supervisor of the unit.
- 3. Tell the coworker of the incident.
- 4. Notify the federal drug agents about the incident.

**137.** Which of the following should the nurse include when teaching the family and a client who was prescribed benzotropine (Cogentin), 1 mg P.O. twice daily, about the drug therapy?

- 1. The drug can be used with over-the-counter cough and cold preparations.
- 2. The client should not discontinue taking the drug abruptly.
- 3. Antacids can be used freely when taking this drug.
- 4. Alcohol consumption with benzotropine therapy need not be restricted.

**138.** Which of the following should the nurse include in a teaching plan that addresses the adverse effects of antipsychotic medication?

- 1. Information about all potential adverse effects.
- 2. Research data about rare adverse effects.
- 3. Adverse effects that can be seen or felt.
- 4. Percentages associated with each adverse effect.

**139.** A client has nephrotic syndrome. To aid in the resolution of the client's edema, the physician orders 25% albumin. In addition to an absence of edema, the nurse should evaluate the client for which expected outcome?

- 1. Crackles in the lung bases.
- 2. Blood pressure elevation.
- 3. Cerebral edema.
- 4. Cool skin temperature in lower extremities.

**140.** A client has polycystic kidney disease. The client asks the nurse, "How did I get these fluid-filled bubbles on my kidneys? I have not had any X-ray type tests." How should the nurse respond to help the client understand risk factors for this disease process?

- 1. "Second-hand smoke puts you at greater risk for developing cysts."
- 2. "Exposure to dyes used to color fruits and vegetables increases the risk of polycystic kidney disease."
- 3. "There is a higher incidence of polycystic kidney disease among blood relatives."
- 4. "Drinking alcohol daily allows the kidneys to develop cysts."

**141.** A nurse is administering I.V. fluids to a dehydrated client. When administering an I.V. solution of 3% sodium chloride, what should the nurse do? Select all that apply.

- 1. Measure the intake and output.
- 2. Inspect the jugular veins for distention.
- 3. Evaluate the client for neurologic changes.
- 4. Force fluids, especially water.
- 5. Insert an indwelling urinary catheter.

**142.** The nurse is working on a birthing unit that has several unlicensed assistive personnel (UAP). The nurse determines that the UAP understands the type of information to report to the nurse when the the UAP reports which of the following about one of the clients?

- 1. An episode of nausea after administration of an epidural anesthetic.
- 2. Contractions 3 minutes apart and lasting 40 seconds.
- 3. Evidence of spontaneous rupture of the membranes.
- 4. Sleeping after administration of I.V. nalbuphine (Nubain).

**143.** A 9-year-old child is scheduled for an electromyelogram. To prepare the child for this procedure, what should the nurse do?

- 1. Wait until just before the test to tell the child what will be done.
- 2. Ask the child to draw a picture of the body structures involved.
- 3. Show the child the equipment that will be used in the test.
- 4. Verbally explain what will be done during the test.

**144.** The nurse is planning a program about women's health and cancer prevention for a community health fair. The nurse should include information about? Select all that apply.

- 1. Regular self-exams of the breast and vulva are important self-care activities.
- 2. Cancer can be prevented by removing precancerous lesions of the vulva, cervix, or endometrium.
- 3. Girls, age 11 to 12, should receive immunization for human papilloma virus (HPV) to prevent cervical cancer.
- 4. Smoking cessation reduces the risk of cervical cancer.
- 5. There is limited evidence that cancer in women is inherited.

**145.** A 10-year-old client with rheumatic fever is on bed rest. Which of the following would be an appropriate diversion activity for the nurse to encourage?

- 1. Watching television with his roommate.
- 2. Coloring picture books with his brother.
- 3. Keeping up with his school work.
- 4. Building a bird house.

**146.** Clients who are receiving total parenteral nutrition (TPN) are at risk for development of which of the following complications?

- 1. Hypostatic pneumonia.
- 2. Pulmonary hypertension.
- 3. Orthostatic hypotension.
- 4. Fluid imbalances.

**147.** The nurse is to administer a bolus starting dose of heparin to a child who is taking penicillin. What should the nurse do? Select all that apply.

- 1. Check that the dose is appropriate for the child's weight.
- 2. Note that the onset of the medication will be immediate.
- 3. Follow the administration of the bolus of heparin with an I.V. infusion of heparin 10 units/kg/hour.
- 4. Monitor partial thromboplastin time (PTT).
- 5. Discontinue the penicillin until the PTT is at a therapeutic level.

**148.** The client is receiving propantheline bromide (Pro-Banthine) to treat cholecystitis. The nurse should evaluate the client's response to the medication by observing for which of the following adverse effects?

- 1. Urine retention.
- 2. Diarrhea.
- 3. Hypertension.
- 4. Diaphoresis.

**149.** The nurse is preparing to start an I.V. infusion. Before inserting the needle into a vein, the nurse should apply a tourniquet to the client's arm to accomplish which of the following?

- 1. Distend the veins.
- 2. Stabilize the veins.
- 3. Immobilize the arm.
- 4. Occlude arterial circulation.

**150.** Prochlorperazine (Compazine) is prescribed postoperatively. The nurse should evaluate the drug's therapeutic effect when the client expresses relief from which of the following?

- 1. Nausea.
- 2. Dizziness.
- 3. Abdominal spasms.
- 4. Abdominal distention.

**151.** A 17-year-old client has been admitted to the hospital for a biopsy to confirm the diagnosis of bone cancer. The nurse should assess the client for which conditions? Select all that apply.

- 1. Cough.
- 2. Dyspnea.
- 3. Pain.
- 4. Swelling.
- 5. Fever.
- 6. Anorexia.
- 7. Decreased range of motion.

**152.** A nurse on the labor-and-delivery unit transfers a primiparous client and her term neonate to the mother-baby unit 2 hours after the client delivered the neonate by vaginal delivery. Which of the following information is a **priority** for the nurse to report to the nurse receiving the client on the mother-baby unit?

- 1. Firm fundus when gentle massage is used.
- 2. Evidence of bonding well with the neonate.
- 3. Labor that lasted 12 hours with a 1-hour second stage.
- 4. Temperature of 99° F (37.4° C) and pulse rate of 80 bpm.

**153.** A client who underwent cardiac surgery 2 days ago is recovering well. His wife, who is assisting with his care, says, "He is doing too much. I told him to let me help, but he won't let me." The nurse says to the wife, "It sounds like you need to feel you can be more helpful to him." In order to make her nonverbal behavior complement her words, the nurse should:

- 1. Direct the eyes at the client.
- 2. Direct the body and eyes at the wife and client.
- 3. Avoid direct eye contact with the client and wife.
- 4. Shift the eyes back and forth between the client and wife.

**154.** A nurse is having difficulty establishing a relationship with an aggressive client. What strategy will **most** likely improve the relationship?

- 1. The nurse and the client agree to work to improve their involvement in the therapeutic relationship.
- 2. The nurse establishes goals for having only positive interactions with the client.
- 3. The nurse agrees to be submissive so the client can dominate the relationship.
- 4. The nurse seeks assistance from colleagues to become more aware of the quality of the interactions and more sensitive to the dynamics of communication.

**155.** The charge nurse on the postpartum unit has received report about a client with a fetal demise who has just delivered and will be ready for transfer out of Labor and Delivery in about 2 hours. The client has asked her primary nurse if she can stay on the obstetrical unit since she has found support from the nursing staff there. What action should the charge nurse on the postpartum unit take?

- 1. Request a room for this client on a unit without newborns.
- 2. Ask the nurse in labor and delivery to discharge the mother as soon as she is physically able to leave.
- 3. Talk to the mother first and decide on a location that is mutually agreeable.
- 4. Admit the mother to a private room on the postpartum unit.

**156.** A nurse is about to conduct a sexual history for a 16-year-old female who is accompanied by her mother. What is an appropriate question for the nurse to ask this client or her mother?

- 1. "What do you think about having your mother leave the room now?"
- 2. "Mother, do you think your daughter is sexually active?"
- 3. "Mother, I am going to ask you to wait a few minutes in the waiting room now so I can complete the health history with your daughter."
- 4. "The two of you seem like you share everything. I am going to ask questions about sexual history now."

**157.** A nurse is admitting an older female client to the gynecology surgical unit. When the nurse asks the client what medication she is taking at home, the client responds that she is taking a little red pill in the morning and a white capsule at night for her blood pressure. What action by the nurse is focused on safe, effective care of this client?

- 1. Consult the pharmacist regarding identification of the medications.
- 2. Show pictures to the client from the *Physician's Desk Reference* to identify the medications.
- 3. Consult the previous medical record from 2 years ago and notify the physician regarding medications that must be ordered.
- 4. Ask a family member to bring the medications from home in the original vials for proper identification and administration times.

**158.** A client who had undergone an abdominal hysterectomy is in the recovery room. The surgeon has ordered a 250-mL bolus of normal saline over 1 hour to replace blood loss. The I.V. solution infusing in the client was 1,000 mL normal saline with 40 mEq of potassium chloride at 100 mL/hour. The nurse should: Select all that apply.

- 1. Increase the I.V. infusion rate to 250 mL/hour for 1 hour.
- 2. Add 250 mL of normal saline to the current infusion bag and continue at 100 mL/hour.
- 3. Connect a 250-mL bag of normal saline to the Y-connection and calculate to infuse over 1 hour.
- 4. Contact the physician regarding continuation of the primary I.V. infusion during the bolus infusion.
- 5. Administer the normal saline bolus via an I.V. infusion pump.

**159.** The nurse is working in a newborn nursery and caring for several neonates. Precautions that should be taken to prevent an infant abduction include which of the following?

- 1. Notifying the hospital's security staff about anyone who appears unusual.
- 2. Taking several neonates to their mothers at the same time.
- 3. Placing the infant near the doorway of the mother's room.
- 4. Contacting the hospital's security staff if an exit alarm is triggered.

**160.** Clozapine (Clozaril) therapy has been initiated for a client with schizophrenia who has been unresponsive to other antipsychotics. The client states, "Why do I have to have a blood test every week?" Which of the following responses by the nurse would be **most** appropriate?

- 1. "Weekly blood tests are necessary to determine safe dosage and to monitor the effect of the medication on the blood."
- 2. "Weekly blood tests are done so that you can receive another week's supply of the medication."
- 3. "Your physician will want to know how well you are progressing with the medication therapy."
- 4. "Everyone taking clozapine (Clozaril) has to go through the same procedure because it is required by the drug company."

**161.** The nurse administers an intradermal injection to a client. Proper technique has been used if the injection site demonstrates which of the following?

- 1. Minimal leaking.
- 2. No swelling.
- 3. Tissue pallor.
- 4. Evidence of a bleb.

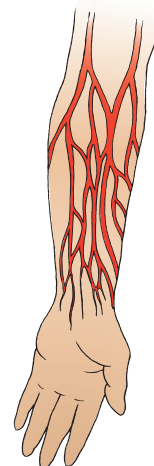
**162.** The sudden onset of which of the following indicates a potentially serious complication for the client receiving an I.V. infusion?

- 1. Noisy respirations.
- 2. Pupillary constriction.
- 3. Halitosis.
- 4. Moist skin.

**163.** The nurse is planning to initiate a blood transfusion. Which of the following solutions should the nurse select to prime the tubing when preparing to administer the blood?

- 1. Lactated Ringer's solution.
- 2. Normal saline.
- 3. 5% dextrose in half-normal saline.
- 4. 5% dextrose in water.

**164.** When preparing to insert an I.V. catheter to administer fluids to a client who is going to surgery, the nurse selects the median cubital vein. Identify the location of the median cubital vein on the illustration below.



**165.** The mother of a 28-year-old client who is taking clozapine (Clozaril) states, “Something is wrong. My son is drooling like a baby.” Which of the following responses by the nurse would be **most** helpful?

- 1. “I wonder if he’s having an adverse reaction to the medicine.”
- 2. “Excess saliva is common with this drug; here’s a paper cup for him to spit into.”
- 3. “Don’t worry about it; this is only a minor inconvenience compared to its benefits.”
- 4. “I’ve seen this happen to other clients who are taking Clozaril.”

**166.** The physician is calling in an order for ampicillin for a neonate. The nurse should do which of the following? Select all that apply.

- 1. Write down the order.
- 2. Ask the physician to come to the hospital and write the order on the chart.
- 3. Repeat the order to the physician over the telephone.
- 4. Ask the physician to confirm that the order is correct.
- 5. Ask the nursing supervisor to cosign the telephone order as transcribed by the nurse.

**167.** A client taking clozapine (Clozaril) states, “I think I’m getting the flu. I have a fever and feel weak.” Which of the following should the nurse do **next**?

- 1. Tell the client to wait another day to see if other symptoms of the flu appear.
- 2. Advise the client to take over-the-counter medication for the flu.
- 3. Discuss the importance of maintaining an adequate fluid intake.
- 4. Report the client’s symptoms to the physician after taking the client’s temperature.

**168.** Which of the following medications should the nurse anticipate administering in the event of a heparin overdose?

- 1. Warfarin sodium (Coumadin).
- 2. Protamine sulfate.
- 3. Acetylsalicylic acid (ASA).
- 4. Atropine sulfate.

**169.** The nurse has administered aminophylline to a client with emphysema. The medication is effective when there is:

- 1. Relief from spasms of the diaphragm.
- 2. Relaxation of smooth muscles in the bronchioles.
- 3. Efficient pulmonary circulation.
- 4. Stimulation of the medullary respiratory center.

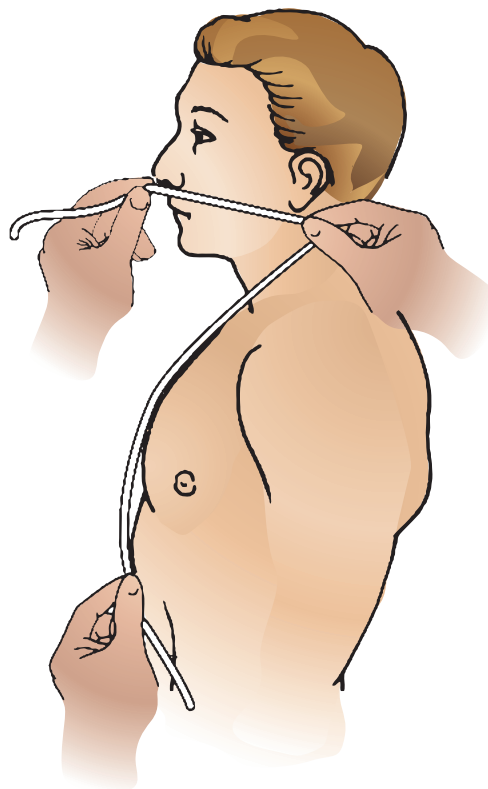
**170.** The nurse is conducting health assessments for school-age children. A characteristic behavior of a 7-year-old girl is that she:

- 1. Likes to play only with other girls.
- 2. Prefers to play with her sister.
- 3. Prefers to play team games.
- 4. Likes to play alone.

**171.** A nurse is planning care for a 7-year-old who is hospitalized for a hernia repair. The nurse should assess the client for which of the following fears common in this age group?

- 1. Separation from parents.
- 2. Trying something new.
- 3. Injury and pain.
- 4. Opposite-sex relationships.

**172.** Before inserting a nasogastric (NG) tube in an adult client, the nurse estimates the length of tubing to insert. Identify the point on the illustration where the nurse would end the measurement.



**173.** A woman who delivered a healthy baby 6 hours ago tells the nurse that she is having cramps in her legs. Upon further assessment, the nurse identifies leg pain on dorsiflexion. The nurse should:

- 1. Tell the woman to massage the area.
- 2. Apply warm compresses to the area.
- 3. Instruct the woman on how to do ankle pumps.
- 4. Notify the physician.



**174.** The nurse interprets the rhythm strip below from a client's bedside monitor as which of the following?

- 1. Normal sinus rhythm.
- 2. Sinus tachycardia.
- 3. Ventricular tachycardia.
- 4. Ventricular fibrillation.

**175.** A young adult is hospitalized with a seizure disorder. The client, who is in a bed with padded side rails, has a tonic-clonic seizure. In what order should the nurse take the following actions?

1. Loosen clothing around the client's neck.

2. Turn the client on his or her side.

3. Clear the area around the client.

4. Suction the airway.

**176.** The nurse interprets the rhythm strip below from a client's bedside monitor as which of the following?

- 1. Normal sinus rhythm.
- 2. Sinus tachycardia.
- 3. Atrial fibrillation.
- 4. Ventricular tachycardia.

**177.** The nurse delegates the care of a multiparous client who delivered a viable term neonate vaginally 30 hours ago and is preparing to be discharged to a licensed practical nurse (LPN). The nurse should instruct the LPN to notify the nurse if the client exhibits which of the following?

- 1. Pulse rate of 100 bpm.
- 2. Oral temperature of 99° F (36.8° C).
- 3. Excessive perspiration during the assessment.
- 4. Frequent voiding in large amounts.

**178.** An woman with a history of a left radical mastectomy is being admitted for abdominal surgery. The woman has a swollen left arm. The nurse should:

- 1. Take the blood pressure only in the unaffected arm.
- 2. Start an I.V. line in the affected arm.
- 3. Encourage a dependent position of the affected arm.
- 4. Allow blood draws in the affected arm.


**179.** A 36-month-old child weighing 44 lb is to receive ceftriaxone (Rocephin) 2 g I.V. every 12 hours. The recommended dose of Rocephin is 50 to 75 mg/kg/day in divided doses. The nurse should:

- 1. Administer the medication as ordered.
- 2. Administer half the ordered dose.
- 3. Call the laboratory to check the therapeutic serum level of Rocephin.
- 4. Withhold administering the Rocephin and notify the child's physician.

**180.** The nurse has provided an in-service presentation to ancillary staff about standard precautions on the birthing unit. The nurse determines that one of the staff members needs further instructions when the nurse observes which of the following?

- 1. Use of protective goggles during a cesarean delivery.
- 2. Placement of bloody sheets in a container designated for contaminated linens.
- 3. Wearing of sterile gloves to bathe a newly delivered neonate at 1 hour of age.
- 4. Disposal of used scalpel blades in a puncture-resistant container.


## Answers, Rationales, and Test Taking Strategies

The answers and rationales for each question follow below, along with keys () to the client need (CN) and cognitive level (CL) for each question. Use these keys to further develop your test-taking skills. For additional information about test-taking skills and strategies for answering questions, refer to pages 10–21, and pages 25–26 in Part 1 of this book.

**1. 3.** The head of the bed should be elevated 30 degrees to promote venous drainage and decrease intracranial pressure. The client's head should be in a midline, or neutral, position. Clients with supratentorial surgery should be positioned on the nonoperative side to prevent displacement of the cranial contents by gravity.

 CN: Reduction of risk potential;  
CL: Synthesize


**2. 4.** A trained medical interpreter is required to ensure safety, accuracy of history data, and client confidentiality. The medical interpreter knows the client's rights and is familiar with the client's culture. Using the family member as interpreter violates the client's confidentiality. Using the nursing assistant or limited Spanish and nonverbal communication do not ensure accuracy of interpretation and back-translation into English.

 CN: Management of care; CL: Synthesize

**3. 1, 3, 4, 5.** Home care for a client with a total laryngectomy should include a high-humidity environment, laryngectomy tube care and suctioning, speech rehabilitation, and smoking cessation. The client is not restricted to a bland diet.

 CN: Management of care; CL: Create

**4. 2.** Administering acetaminophen to the client with a post ECT headache is the best action. Stating a headache is common after ECT and that napping will help the client feel better may be true, but it does not offer the client pain relief. Telling the client to eat breakfast and then to let the nurse know how the client feels conveys a lack of understanding to the client and dismisses the client's concern.

 CN: Psychosocial adaptation;  
CL: Synthesize

**5.**

5:30	2
6:00	3
6:30	1
7:00	4

The two tasks/orders that have time frames associated with them are the accucheck and insulin, and the magnesium sulfate blood draw. The fetal monitor strip can be obtained when convenient. Checking documentation and seeing each client should be done so that any client needs can be met and documentation completed prior to the 7 a.m. accucheck and insulin, yet close enough to the end of the shift that there will be minimal changes before change of shift.

 CN: Management of care; CL: Synthesize

**6. 4.** An 18-month-old child should be able to say 10 or more words. Lack of speech development may indicate a lack of social stimulation, a hearing deficiency, or developmental delay. Referring the child for an evaluation may increase the child's chance of reaching his potential. A 4-month-old child with a healthy central nervous system and normal mental development should be able to laugh out loud if his environment has been caring and his needs are met safely and consistently. Children at age 10 months should be able to say the words "dada" and "mama" in response to the appropriate person. A 1-year-old child should have the ability to speak 3 to 5 words plus "mama" and "dada."


 CN: Health promotion and maintenance;  
CL: Analyze

**7. 1.** Phenylketonuria is a disease that is carried on the recessive genes of each parent. In order to be transmitted to a newborn, the infant inherits a recessive gene from each parent. Control of the disease is

by reduction of the amino acid phenylalanine, which is present in all protein foods. The disease cannot be cured, but controlled. With each pregnancy, there is a 25% chance a child will inherit the disease.

 CN: Reduction of risk potential;  
CL: Apply

**8. 4.** The nurse should convey empathy and invite the client to share more about her thoughts and feelings so that the nurse can assess the mother for possible postpartum depression, which usually occurs between 2 weeks and 3 months after the baby's birth but also can occur later. Postpartum depression is a mood disorder with symptoms of tearfulness, mood swings, despondency, feelings of inadequacy, inability to cope with the baby, and guilt about performance as a mother. Postpartum depression commonly goes undetected because of poor recognition and lack of knowledge. Hormonal changes during and after childbirth may account for some of the symptoms; however, the nurse should not assume that that is the case. Stating the client's husband and family should help her is an assumption that they are not and dismisses the client's concerns. Saying most new mothers feel the same way minimizes the client's concerns and decreases the likelihood of further disclosure by the client.


 CN: Psychosocial adaptation;  
CL: Synthesize

**9. 4 tablets**

$$1,000 \text{ mg} = 1 \text{ g}$$

$$2 \text{ g} = 2,000 \text{ mg}$$

$$2,000 \text{ mg} \div 500 \text{ mg} = 4$$

 CN: Pharmacological and parenteral therapies; CL: Apply

**10. 2, 3.** Huntington's disease, or *Huntington's chorea*, is an autosomal dominant genetic neurologic disease that affects descendants of an affected person at a 50% rate. Huntington's disease does not skip generations and affects men and women equally. Huntington's disease is genetically transmitted on chromosome 4, and death usually results from respiratory complications related to aspiration.

 CN: Physiological adaptation; CL: Apply

**11. 2.** Liquids found on the floor should be removed immediately. The nurse should first put on gloves and then wipe up the liquid. Following removal, Environmental Services should be contacted to thoroughly cleanse the floor with a disinfectant solution. Placing paper towels over the drops is a safety hazard. "Wet floor" signs will be posted after the floor is cleansed by Environmental Services.

 CN: Safety and infection control;  
CL: Synthesize

**12. 2, 3, 4.** A client who has been admitted for numbness and tingling in his lower extremities that advances upward, especially after having a viral infection, has clinical manifestations characteristic of Guillain-Barré syndrome. The health care provider must be notified of the change immediately because this disease is progressively paralytic and should be treated before paralysis of the respiratory muscles occurs. The nurse must assess the client continuously to determine how fast the paralysis is advancing. The family does not need to be called in to visit until the client is stabilized and emergency equipment is placed at the bedside. Performing ankle pumps will not relieve the numbness or change the course of the disease.

 CN: Management of care; CL: Synthesize

**13. 3.** The spinal cord connects the brain to the periphery. The thalamus is located in the midbrain and integrates all sensory impulses except olfaction. The afferent impulses are received and then transmitted from the thalamus. Destruction or interruption of the neurosensory pathway results in loss of communication between the two systems. Monitoring the temperature of the bathwater is important because the client cannot feel whether the water is too hot or too cold. Damage to the thalamus does not result in loss of the corneal reflex. Loss of position and vibratory sense usually occurs with degeneration of the posterior column of the spinal cord; therefore, turning every 2 hours is critical to prevent skin breakdown related to increased capillary pressure. The nurse can give only the prescribed dosage of pain medication.

 CN: Physiological adaptation;  
CL: Synthesize

**14. 3.** The client needs to know her request is being met but also should be informed that discharge will not be immediate and that the client's psychiatrist will be notified to discuss the matter with the client. While it is true that a client admitted voluntarily has the right to leave, the client cannot leave immediately. It is inaccurate that a lawyer or family member must request forms for release against medical advice. Although it is acceptable for the nurse to try to convince the client to stay, the mention of insurance implies the client is hospitalized because of having insurance, rather than the psychiatric issues being treated.


 CN: Management of care; CL: Synthesize

**15. 1,2,4,5.** Compliance with the Tarasoff rule involves wide notification and careful documentation of the notification. The nurse should notify the potential victim. The police must be notified, making it less possible for the client to follow through on his threat. The nurse must also notify


key administrators and service departments in the health care facility so they are aware of the issue and the potential hazards related to the client's threat. The client is not a threat to the ex-wife at this time so she does not need to be notified.

 CN: Management of care; CL: Synthesize


**16. 1.** The spinal cord connects the brain to the periphery. Destruction or interruption of the neurosensory pathway results in loss of communication between the two systems. Transection of the spinal cord renders the individual in a complete state of anesthesia below the level of injury. Tingling in the fingers may be related to spinal cord disease or to improper positioning of the extremity. Loss of position and vibratory sense usually occurs when the individual has degeneration of the posterior column of the spinal cord.

 CN: Physiological adaptation;  
CL: Analyze

**17. 3.** Common pressure points in the side-lying position include the ears, shoulders, ribs, greater trochanter, medial and lateral condyles, and ankles. The sacrum, occiput, and heel are pressure points in the supine position.

 CN: Physiological adaptation;  
CL: Analyze

**18. 1, 2, 3.** Goals for promoting healthy development in preschoolers include anticipatory guidance, helping parents understand their child's behavior, identifying deviations from the norm, and assessing parent-child interaction. No one can assess or determine the child's future development and trying to do so can limit the potential the child may achieve. Although learning to interact with others is important, sending the child to a day care center is not essential to promote healthy development. The nurse can encourage the parents to provide opportunities for the child to play with others.


 CN: Psychosocial adaptation; CL: Create

**19. 1.** Alarms on infusion pumps should be set at 5% above and 5% below the prescribed infusion rate. A wider range is not safe. The alarms must be set to indicate a change in the drip rate, not infiltration. Setting the alarms for the exact drip rate will cause the alarms to trigger when the client moves, and this exact range is not needed to alert the nurse to an unsafe rate.

 CN: Safety and infection control;  
CL: Apply

**20. 1.** The client's physical needs are a priority in the nurse's plan of care. The lack of fluid and caloric intake can lead to dehydration and cardiac collapse. The lack of sleep and rest can lead to

exhaustion and death. Social, spiritual, and cultural needs are important client needs but not as important as the physical needs during an acute manic episode.

 CN: Psychosocial adaptation;  
CL: Synthesize

**21. 1, 2, 3.** The alarm settings on infusion pumps should be verified at the time the infusion is started, at the beginning of each shift, and when the client is moved. The neonate can move in bed, but if the alarm is triggered, the nurse should verify the settings. Unless the neonate has moved or been taken out of the crib, it is not necessary to check alarm settings after the parents visit.

 CN: Safety and infection control;  
CL: Apply

**22. 3.** Contacting the Security Department is a proactive response in a situation that may become more volatile. A soft voice by the nurse may not even be heard in this situation. To state, “Stop!” in this situation is not helpful and does not deal with the escalating risk. Once Security has been notified, the nurse should also report the incident to the supervisor.

 CN: Management of care; CL: Synthesize


**23. 2.** Thermoregulation of the neonate is a critical intervention for the nurse caring for neonates. A hat on the neonate conserves heat as the majority of heat is lost through the top of the head. Wrapping will also conserve heat and prevent heat loss. With the neonate lying against a crib wall, heat transfers away from the infant to the cooler surface (conduction). If the neonate is wet, the warmer water on the surface of the neonate evaporates to the cooler air (evaporation). If the neonate is lying in an open crib with a diaper on, the body naturally loses heat to the surrounding cooler air as it radiates from the warm body to the cooler room (radiation).

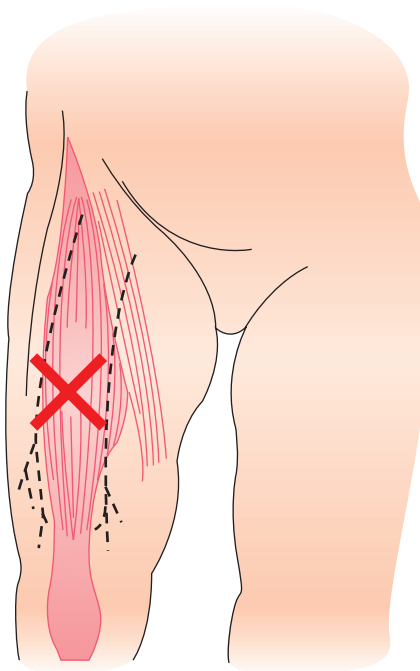
 CN: Management of care; CL: Synthesize

**24. 2.** When the blink reflex is absent or the eyes do not close completely, the cornea may become dry and irritated. Placing a patch over the eye is the most appropriate intervention to prevent eye injury. Making sure the client wears her eye-glasses at all times will not help protect the eye from injury. A once-per-shift intervention will not adequately relieve the potential for injury from a dry and irritating ocular environment. A normal saline solution should be used to moisten the eye, not tap water.


 CN: Health promotion and maintenance;  
CL: Synthesize

**25.** The rectus femoris is a safe site for injections for infants. The site is free from most nerves and blood vessels. The nurse should use a needle that is 1 inch or smaller, and inject the needle at a 45-degree angle.


 CN: Safety and infection control;  
CL: Apply



**26. 1, 2, 3.** The alarm settings on infusion pumps should be verified at the time the infusion is started, at the beginning of each shift, and when the client is moved. The child can move in bed or sleep, but if the alarm is triggered, the nurse should verify the settings.

 CN: Safety and infection control;  
CL: Apply

**27. 4.** Social isolation is a concern for an older adult who has diminished hearing and vision. Feeling disoriented may be related to cognitive problems rather than diminished hearing and vision. Diminished hearing and vision is related to the aging process and does not result in impairment of the older adult's thought processes. The client with impaired hearing and vision is unlikely to experience sensory overload.


 CN: Psychosocial adaptation;  
CL: Synthesize

**28. 3.** According to the Denver Developmental Screening Examination, a child age 2 years should have a vocabulary of 300 words, be able to combine two or three words, and ask for what he wants by name. By age 3, the child should have a vocabulary of 900 words and can use a complete sentence of


three or four words. A 1-year-old has a vocabulary of at least 8 words and can reference people and objects.

 CN: Health promotion and maintenance;  
CL: Analyze


**29. 1, 2, 3, 5.** The nurse should ask the client with multiple sclerosis about areas of muscle weakness because baclofen may increase the weakness. The nurse should ask the client about a history of muscle spasms. Baclofen is effective against involuntary spasms resistant to passive movement for clients with multiple sclerosis and paralysis. Baclofen is not effective against the spasticity of cerebral origin, such as with cerebral palsy and Parkinson's disease. The nurse should ask the client about his liver and renal function because baclofen is metabolized and excreted by these organs. The nurse should check the laboratory values reflecting the function of the kidneys and liver, which include serum creatinine and blood urea nitrogen levels. The nurse should also check blood glucose levels because baclofen can increase blood glucose. Clients with diabetes taking antidiabetic medication may need to adjust the dosage. Potassium is not affected by the drug, so the nurse does not need to check the serum potassium level.

 CN: Pharmacological and parenteral therapies; CL: Apply


**30. 1, 2, 4.** The nurse should assess the client for signs of bone marrow depression, manifested by bruising or unusual bleeding, and signs of infection such as a sore throat. The nurse should also assess the client for signs of hepatic dysfunction, such as light-colored stool or dark-colored urine. Although the nurse may want to check the client's urinary function and hydration status, urine output and hydration are not specific monitoring needs related to long-term use of carbamazepine (Tegretol).

 CN: Pharmacological and parenteral therapies; CL: Analyze

**31. 3.** The nurse uses active listening, in which the client's feelings are reflected back to him. Telling the client that everyone wears them does not consider the client's feelings. Telling the client that what he said is not what he meant discounts the validity of his statement. Interpreting the reason for the client being upset as the rule being unreasonable does not take into account how it affects the client personally.

 CN: Psychosocial adaptation;  
CL: Synthesize


**32. 3.** The restraint should remain in position. Removing the restraint or untaping the restraint will risk dislodging the I.V.

 CN: Safety and infection control;  
CL: Apply


**33. 2, 3, 4.** The purposes of the Pap (Papanicolaou) smear include: to detect precancerous and cancerous cells of the cervix; to assess the effects of sex hormonal replacement; to identify viral, fungal, and parasitic conditions; and to evaluate the response to chemotherapy or radiation therapy to the cervix.

 CN: Health promotion and maintenance;  
CL: Apply

**34. 2, 3.** The nurse should use at least two sources of identification before administering medication to any client. The identification can include the medical record number and the client's date of birth. It is not necessary to check the client and dose for this drug with another nurse. It is also not safe to use the room number or bed number as a source of identification as clients' locations in the hospital are frequently changed. The nurse should not assume that the child will give a correct first name.

 CN: Safety and infection control;  
CL: Apply

**35. 2.** One of the actions of propranolol (Inderal), a drug used in the treatment of migraine headaches, is to decrease the heart rate. The nurse should assess the client's blood pressure to evaluate overall circulatory response to the medication. Until the blood pressure value is assessed, there is no immediate need to contact the physician. The nurse should complete the blood pressure assessment before administering the drug. There is no immediate need to administer oxygen or contact a relative because a slowed pulse rate is an expected action of propranolol.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**36. 1.** During the tertiary circular reaction stage of the sensorimotor stage (12 to 18 months of age), the infant comes to understand causality and object performance, recognizing that objects placed out of sight continue to exist. During the preoperational stage (ages 2 to 6), the child's perception is based on how he views an event. The concrete operational stage (ages 6 to 12) is the beginning of concrete, logical thinking. During the formal operations stage (ages 13 to 18), the child is able to perform abstract reasoning.

 CN: Health promotion and maintenance;  
CL: Analyze

**37. 2.** The neonate will be simultaneously dried and stimulated to cry immediately upon delivery. If the neonate does not cry as a result of these measures, the ABCs (airway, breathing, and circulation) of cardiopulmonary resuscitation will be followed. Positioning the neonate and suctioning or clearing the airway ensure that the airway is clear so that the

first breath the neonate takes is air, rather than fluid or particulate matter. Breathing will be stimulated once the airway is clear and then heart rate will be validated either apically or through the cord. The cord may be cut in order to hand the neonate to the mother for nursing. In many instances, the infant is placed on the mother's abdomen before the cord is cut.

 CN: Health promotion and maintenance;  
CL: Evaluate

### 38. 2 mg/minute

First, calculate the concentration of mg/mL:


$$\frac{4}{\frac{1,000 \text{ mg}}{250 \text{ mL}}} = 4 \text{ mg/mL}$$

Next, multiply the number of milligrams per milliliter by the pump setting in milliliters per hour:


$$\frac{4 \text{ mg}}{1 \text{ mL}} \times \frac{30 \text{ mL}}{1 \text{ hour}} = 120 \text{ mg/hour}$$

Next, divide the milligrams per hour by 60 to obtain milligrams per minute:


$$120 \text{ mg/hour} \div 60 \text{ minutes} = 2 \text{ mg/minute}$$

 CN: Pharmacological and parenteral therapies; CL: Apply


**39. 1.** The client may become tolerant of the antianginal effects of nitrates. Removing nitrates for 8 hours each day is usually effective in preventing tolerance. Nitrate patches should not be used on an as-needed basis. Sites should be rotated daily to prevent skin irritation, but this is not related to tolerance. Removing the patch for only 8 hours is sufficient to prevent tolerance and skipping days could impact the drug's effectiveness.

 CN: Pharmacological and parenteral therapies; CL: Apply

**40. 2.** The nurse should tell the client in a simple, matter-of-fact manner the purpose of the restraints to help the client understand why restraints are necessary. Long explanations and interactions with the acutely manic and agitated client are not appropriate or therapeutic at this time because the client with a high level of anxiety has difficulty focusing and processing. Saying "threatening others and throwing furniture is not allowed" could lead the client to believe he is being punished. Reminding the client that he's "been here before and knows what the rules are" and "we are only doing this for your own good, so calm down" are condescending and verbalizing the expectation that he can control his illness.

 CN: Psychosocial adaptation;  
CL: Synthesize


**41. 1,2, 3 5.** Anorexia or loss of appetite is not associated with valproic acid. Adverse effects include tremors, transient hair loss, gastrointestinal upset, and weight gain.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**42. 3.** Intercourse commonly stimulates uterine contractions. The prostaglandins found in semen can also initiate contractions. After placement of a cerclage for advanced dilation and contractions, the client is considered at high risk for preterm delivery and should be seen by her health care provider more frequently. The client should call the health care provider immediately if she sees signs of complications, such as leaking fluid (rupture of membranes), vaginal bleeding, and contractions (particularly with a cerclage in place). Anything in the vagina may initiate contractions and the labor process.

 CN: Reduction of risk potential;  
CL: Evaluate


**43. 2.** A prolonged QT interval is significant because it can lead to the development of polymorphic ventricular tachycardia, also known as *torsades de pointes*. A prolonged QT interval may result from electrolyte imbalance but it does not lead to the development of an electrolyte imbalance, atrial fibrillation, or orthostatic hypotension.

 CN: Physiological adaptation;  
CL: Analyze

**44. 1.** The nurse should instruct the mother to bring the child to the emergency department. If aspirated, nuts may swell leading to an airway obstruction after the initial event; endoscopy may be required to remove remaining fragments. Bleeding from trauma to internal organs after abdominal thrusts is rare. There are no signs of shock to suggest anaphylaxis. There is no indication of the presence of a pneumothorax.

 CN: Physiological adaptation;  
CL: Synthesize

**45. 1.** Gastric upset is an adverse effect of NSAIDs. Taking these drugs with food and fluids minimizes this effect. The dosage of NSAIDs does not need to be tapered. Because NSAIDs do not cause drowsiness or stomatitis, the client does not need to restrict driving or rinse the mouth.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**46. 2.** The neonate's Apgar score has been improving since birth. (The birth score is 6; the current score is 9.) The nurse should continue to assess the neonate. There is no indication that oxygen is


needed since the color is improving, and stimulating the baby is not necessary as the he is now flexing his extremities.

 CN: Management of care;  
CL: Synthesize


**47. 2.** Today's health care network includes many specialized areas, such as respiratory therapy, medicine, laboratory, social services, and technical monitoring, to name a few. Due to expanded media coverage of health care issues, parents are more aware of health care issues but cannot understand all the ramifications of possible health care decisions. Because of this expanded media coverage, health care consumers are more aware of advances in the science of health care. Nurses have always recognized the value of communication and that all nurses are teachers. Clients are more aware of their rights through media exposure and information disseminated by health care facilities. However, respect for the client's rights should be the nurse's concern as well and communicating with parents and children should not be impacted by a client's knowledge or demand for those rights.

 CN: Health promotion and maintenance;  
CL: Apply

**48. 4.** Soft, washable toys are appropriate for infants, who tend to place everything in their mouths. These toys are not harmful. Plastic toys cannot be manipulated by a child of this age and the child would put the car in his mouth, which may not be safe due to small parts that may be swallowed or aspirated. Games and puzzles are too advanced for a 5-month-old and he could put the pieces in his mouth and swallow them. Some stuffed animals have eyes that can be swallowed or aspirated.


 CN: Reduction of risk potential;  
CL: Apply

**49. 1.** The oxygen levels for this neonate have dropped during the last 8 hours; the nurse should administer oxygen, as the neonate is not obtaining adequate oxygenation on room air. The recommended pulse oximetry reading in a term neonate is 95% to 100%. Keeping the neonate warm may improve the oxygen saturation if that is the cause of the poor gas exchange, but overheating with warm blankets may increase oxygen demand. Waiting to reassess the neonate could cause the neonate to have inadequate oxygen levels unnecessarily. While blood gases may be drawn, the first action is to administer the oxygen.


 CN: Management of care;  
CL: Synthesize

**50. 3.** The nurse should give the next dose as ordered because the blood level is 35 mcg/mL, which is lower than the normal range of 50 to 100 mcg/mL.

Withholding the next dose, notifying the physician, and taking the client's vital signs are not indicated in this situation.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**51. 3.** Going for a walk with the nurse and another client is a more gradual introduction to being with others. The goal is to gradually encourage interaction with others; playing games in the client's room promotes continued isolation. Going to a group session and participating in crafts is exposing the client to large groups too rapidly.

 CN: Psychosocial adaptation;  
CL: Synthesize

**52. 4.** The client is not emptying her bladder after repeated attempts. The nurse should now use an in-and-out catheter to empty the bladder. While the other comfort measures may be helpful, this client has not completely emptied her bladder since delivery and will be at risk for a urinary tract infection.

 CN: Management of care; CL: Synthesize

**53. 4.** The signs and symptoms of sepsis in a neonate, such as changes in appearance and behavior, are almost imperceptible. Often, the parents' only complaint is that the neonate does not look "right." Fever and localized response, which are clues to infections in older children, are often absent in the neonate. Telling the father that he should have realized something was wrong is condescending and serves only to further the father's guilt feelings. Asking the father whether he read the booklet from the hospital implies that the father is at fault. One experience would not necessarily ensure that the father would be able to detect sepsis another time.


 CN: Psychosocial adaptation;  
CL: Synthesize

**54. 3.** Nursing bottle caries occur when a child is routinely given a bottle of milk or juice at nap and bedtime. When teeth become coated in sugar before sleep, the lack of activity in the child's mouth for several hours during sleep allows the sugar to convert to acid, leading to decay. A child drinking 18 to 20 oz of whole milk in a day should not be malnourished, although she may lack essential vitamins and iron. Anemia may occur if she is only drinking milk because it contains no iron; however, the mother indicates she is eating meals. Regardless, children of this age should be taking no more than 16 oz of milk per day, and most children at this age should be drinking from a cup. The mother should be instructed to wean the child to a cup one feeding at a time until the child is completely weaned to a cup for all feedings. The last bottle-feeding to be replaced is usually the night bottle. Malocclusion of


the teeth does not occur at 15 months. If the child were to continue to suck on a bottle until age 4 years or later, then malocclusion may occur.

 CN: Psychosocial adaptation; CL: Apply


**55. 4.** Safety standards require the use of two identifiers prior to medication administration. A parent can be used as the second identifier. Many young children will only answer to a nickname that does not coincide with the medical identification band, or may answer to any name. It is common for children on a pediatric floor to go into each other's rooms. A small child may not know their birth date.

 CN: Safety and infection control;  
CL: Apply


**56. 2.** The primary reason to give a diuretic to a client with heart failure is to promote sodium and water excretion through the kidneys. As a result, the excessive body water that tends to accumulate in a client with heart failure is eliminated, which causes the client to lose weight. Monitoring the client's weight daily helps evaluate the effectiveness of diuretic therapy. The client should be advised to weigh herself daily. An increased appetite or decreased thirst does not establish the effectiveness of the diuretic therapy, nor does having clearer urine after starting torsemide.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**57. 3.** The client should be placed in a side-lying position and encouraged to take a deep breath during the insertion of the suppository. Placing the suppository along the rectal wall promotes absorption of the medication and helps avoid placing it into a stool mass. The nurse should insert the suppository 3 to 4 inches into the rectum of an adult client.

 CN: Reduction of risk potential;  
CL: Apply


**58. 4.** The nurse is wearing protective personnel equipment appropriately for suctioning the client: goggles, gown and respirator mask. It is not necessary to wear a powered air purifying respirator face shield to suction a tracheostomy. A surgical mask does not provide maximum protection.

 CN: Safety and infection control;  
CL: Apply

**59. 2, 3, 5, 6.** Safety and physiological needs are crucial initially for a client who is unable to meet her own needs. Identifying her stressors and feelings will be important later when she is responding to questions and her environment.

 CN: Psychosocial adaptation;  
CL: Synthesize

**60. 4.** In most agencies, it is a policy to discard the autologous blood after 4 hours of transfusing, due to an increased risk of infection. Increasing the infusion rate could cause fluid overload. Monitoring blood transfusions is a serious nursing responsibility, and because it is the change of shift, there is increased risk of error.

 CN: Safety and infection control;  
CL: Synthesize


**61. 1.** The client is demonstrating signs of anemia. Beef, beets, and cabbage are good sources of iron. Chicken, dumplings, biscuits, fish, applesauce, jelly, and wine are not major iron sources.

 CN: Health promotion and maintenance;  
CL: Synthesize

**62. 2.** Infants are obligatory nose breathers except when crying. The observation that the infant has slight cyanosis when quiet but becomes pink when crying and the inability to pass a catheter through the left nostril suggest that the neonate is exhibiting symptoms of unilateral choanal atresia. With this condition, one of the nasal passages is blocked by an abnormality of the septum. Surgical intervention is necessary to open the nostril. Typically, a neonate with esophageal reflux disorder exhibits episodes of apnea and vomiting after eating. Respiratory distress syndrome commonly occurs in preterm neonates who lack surfactant to maintain lung expansion. Common findings include sternal retractions, tachypnea, grunting respirations, nasal flaring, cyanosis, pallor, hypotonia, and bradycardia. A neonate with tracheoesophageal fistula commonly exhibits cyanosis during feedings and vomiting.

 CN: Reduction of risk potential;  
CL: Analyze

**63. 1, 2, 3, 5.** Safety measures for poisonous substances include close supervision of children, safely storing toxic substances, teaching proper dosages and differences between adult and child doses, and the proper way to contact the Poison Control Center for instructions. Poison Control should be notified as soon as the poisoning has occurred and airway and circulation have been assessed. Poison Control will direct any further treatment. Syrup of ipecac is rarely used today in the treatment of ingested substances due to the potential for aspiration. It is contraindicated in cases of arsenic poisoning, seizures, and the ingestion of petroleum or corrosive substances.

 CN: Safety and infection control;  
CL: Create

**64. 4.** Dystonic adverse effects of haloperidol, especially oculogyric crises, are painful and frightening. I.M. benztropine is the fastest and most




effective drug for managing dystonia. Lorazepam is an antianxiety medication and is not effective for treatment of dystonia. Although amantadine and diphenhydramine can be used for extrapyramidal symptoms, oral medications do not work as quickly, and amantadine may worsen psychotic symptoms.

 CN: Psychosocial adaptation;  
CL: Synthesize

**65. 1.** Neonates burn brown adipose tissue (fat) as a response to cold stress. In addition, there is increased utilization of glycogen and calorie stores. Hypoglycemia may result from becoming stressed by a cold environment. Neonates do not have the ability to shiver.

 CN: Health promotion and maintenance;  
CL: Apply

**66. 1.** While the adolescent is denying pain, he is displaying objective signs of pain. Adults of Asian ethnicity typically display stoic behavior and the 16-year-old most likely would try to conform to this cultural norm. The nurse should administer an analgesic and assure the client that taking medication will speed the recovery process. The nurse must also reassess the client after administering the pain medication and document the response. The reassessment is typically done 30 minutes after a parenteral analgesic and an hour after an oral analgesic. People who identify with the Asian culture infrequently complain and, therefore, asking the client about what is troubling him is unlikely to provide the nurse with additional information. The adolescent's behavior is consistent with post-operative pain. If the parents are stoic, discussing the adolescent's behavior may be not be productive. At this stage of treatment, distractions can be used in conjunction with medication, but should not be substituted for them.


 CN: Basic care and comfort;  
CL: Synthesize

**67. 1.** Formula should fill the entire nipple of the bottle while the baby is sucking. This decreases the amount of air taken in by the baby; taking in too much air can lead to regurgitation. Not all babies at term are born with well-developed sucking skills. Some neonates are sleepy and do not suck well. For the first feeding, the baby should be bubbled after taking one-fourth to one-half ounce of formula and then again when the infant has finished the feeding. Bottle propping can lead to aspiration, decreased infant bonding, and aspiration of formula. However, it is not associated with the intake of too much air.

 CN: Health promotion and maintenance;  
CL: Synthesize

**68. 1, 4, 5.** When a client complains of back pain with administration of blood, the nurse should suspect a hemolytic reaction, and the blood transfusion

should be stopped immediately. The nurse should prepare for a reaction from mild to severe, including the need for cardiopulmonary resuscitation, because even a small amount of mismatched blood can lead to a major reaction. The nurse should obtain a urine specimen to send to the laboratory to check for hemoglobin because RBC hemolysis filters through the kidneys from the reaction. The nurse should stop the I.V. line with the Y-tubing for the blood and not flush the line with saline so that the client does not receive any more blood. The tubing should be changed so that a tube without blood can be used for infusions. The nurse should anchor an indwelling urinary catheter to monitor hourly urine output.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**69. 2.** At 4 hours postpartum, the fundus should be midline and at the level of the umbilicus. Whenever the placenta is manually removed after delivery, there is a possibility that all of the placenta has not been removed. Sometimes small pieces of the placenta are retained, a common cause of late postpartum hemorrhage. The client is exhibiting signs and symptoms associated with retained placental fragments. The client will continue to bleed until the fragments are expelled. Perineal and cervical lacerations are characterized by bright red bleeding and a firmly contracted fundus at the level that is expected. Urine retention is characterized by a full bladder, which can be observed by a bulge or fullness just above the symphysis pubis. Also, the client's fundus would be deviated to one side and boggy to the touch.

 CN: Reduction of risk potential;  
CL: Analyze


**70. 3.** A neonate born at 37 weeks' gestation will have some cartilage in the ear lobes, fine and fuzzy hair, scant to moderate rugae in the scrotum, and a breast nodule diameter of 4 mm. Neonates born before 36 weeks' gestation will have only an anterior transverse crease on the soles of the feet. Extensive rugae on the scrotum are a typical finding in neonates born at 39 weeks' gestation or later. Coarse and silky scalp hair typically is found in neonates that are born at 39 weeks or later.

 CN: Health promotion and maintenance;  
CL: Analyze


**71. 1, 3, 4.** Clear communication is crucial for a client with delirium. The family must include the client in all conversations and keep him oriented to time and place. It is inappropriate to argue with a client's hallucinations because they are real to the client. Speaking more loudly will not help this client hear more distinctly and may increase his confusion.

 CN: Management of care; CL: Synthesize

**72. 2.** One-to-one supervision provides safety until appropriate detoxification can be given. Restraints are the last intervention after less restrictive alternatives have been tried. It is unlikely that the client can cooperate with staying in a chair. Putting the client in bed in his room puts him at risk for falling and a closed door prevents close observation.

 CN: Safety and infection control;  
CL: Synthesize

**73. 1.** The nurse should recognize that the client's clinical manifestations indicate fluid overload, and decrease the infusion rate so the client's circulation can handle the extra fluid. Antihistamines are used for allergic reactions. The nurse should place the client in an upright position with his feet down so that blood or fluid volume can drain to his lower extremities and relieve some of the extra fluid load on his heart. The nurse does not need to replace the blood with another type of fluid because the client's response is not a blood transfusion reaction.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**74.**

2. Place the client in the supine position.

3. Record the highest systolic blood pressure readings in both arms.

1. Place a Doppler probe at a 45-degree angle to the correct pulse (dorsalis pedis or posterior tibial).

4. Record the ankle systolic blood pressure reading when the Doppler sound returns.


The nurse should first place the client in a supine position. Next the nurse should assess blood pressures in both arms and record the highest systolic blood pressure as the brachial pressure. To obtain the brachial pressure, the nurse should place the blood pressure cuff around the affected leg just above the malleolus and then place a Doppler probe at a 45-degree angle to the dorsalis pedis or posterior tibial pulse. The nurse should then inflate the blood pressure cuff until the Doppler sound stops and then deflate it until the Doppler sound returns. The point when sound returns is recorded as the ankle systolic pressure. The ankle-brachial index is the ankle (dorsalis pedis or posterior tibial) pressure divided by the highest arm pressure. A pressure above .90 is normal; anything lower indicates obstruction.

 CN: Physiological adaptation;  
CL: Synthesize


**75. 2.** Insensible fluid loss is invisible vaporization from the lungs and skin, and assists in regulating body temperature. The amount of water loss is increased by accelerated body metabolism, which occurs with increased body temperature. The client's body mass index does not directly influence calculating fluid therapy. When the client's last meal was consumed and the availability of I.V. fluids have no influence on the analysis of intake and output.

 CN: Management of care; CL: Analyze

**76. 3.** A toddler has not developed the concept of sharing, so two similar toys must be provided to prevent disagreements. Playing together in harmony is not the developmental level of a toddler. They play side by side, but not together. Threatening to put the children in their rooms does not solve the problem, nor does taking away the toy.

 CN: Health promotion and maintenance;  
CL: Synthesize

**77. 2.** In order to reestablish trust, the nurse should first try to determine if something happened at the last visit that was upsetting for the family. Dislocation of a body part can be seen as a source of illness among persons of Mexican ethnicity. At a well-child visit the health care provider would have palpated the fontanel. If it is now sunken from dehydration, the parents may blame the provider for the illness. This belief is referred to as *Caida de la mollera*. The family may have talked with a traditional healer, but following this line of questioning first may appear that the nurse considers the healer as an adversary. Asking about immigration makes a stereotypical assumption. Asking if the family is afraid the baby will be taken from them may be suggesting something the family has never considered and may cause unnecessary distress.

 CN: Psychosocial adaptation;  
CL: Synthesize

**78. 1.** The child wants attention from the nurse, even if the behavior is met by a negative response. Aggression, resistance against authority, and exaggerated stress are behaviors that can be associated with a 4-year-old. However, coming to the nurses' station after being told not to do so is not an example of these behaviors.

 CN: Psychosocial adaptation; CL: Analyze

**79. 1, 2, 3.** Clinical manifestations of dehydration include decreased tearing; dry mucous membranes; sunken fontanelles; weight loss; behavioral changes; scanty, concentrated urine; and a thready, fast pulse. Clear, pale yellow urine would indicate adequate hydration. A bounding pulse would indicate fluid volume excess.

 CN: Physiological adaptation; CL: Analyze

**80. 3.** When a neonate is being transferred to a neonatal care center (level III nursery), the parents should be allowed to see and touch the neonate, if possible, before transfer. The parents should be given the location and telephone number of the unit to which the neonate is being transferred. This helps to keep the parents informed. The parents are already aware of the neonate's condition and should recognize that it is critical if the neonate is being transferred to a neonatal care center. The parents have signed consent for treatment on admission, and in most states another consent is not necessary. Asking whether the father would like to ride in the ambulance with the neonate during the transfer is inappropriate. Most ambulances or transferring vehicles (e.g., helicopters, airplanes) do not allow family members to accompany the ill client. Space in the motor vehicle, helicopter, or plane is limited. In addition, most transferring vehicles do not have insurance to cover family members should an accident occur during transfer.

 CN: Management of care; CL: Synthesize

**81. 4.** Tenets of the Roman Catholic Church hold that it is acceptable for anyone, regardless of religious belief, to baptize a neonate. For Roman Catholic families, baptism ensures entry into heaven. Local practice may vary, and in some situations the parents may prefer to have a Roman Catholic person perform the rites; however, this person may not be available until after the death. The parents may wish to have a priest contacted for grief support. Notification of the hospital's director is not necessary.

 CN: Management of care; CL: Synthesize

**82. 1.** Moist heat is a nonpharmacologic pain management strategy that may alleviate pain and reduce the dose of analgesic, if required. Heat dilates blood vessels, and decreases inflammation. Lifting and circular exercises will aggravate the already-inflamed joint. Cold constricts blood vessels, and dry ice is not used on the body.

 CN: Basic care and comfort; CL: Evaluate

**83. 3.** For a lumbar puncture (LP), a needle is inserted into the subarachnoid space to obtain a specimen of spinal fluid for diagnostic testing. Fluid on the lumbar dressing indicates cerebrospinal fluid (CSF) leakage, and must be reported to the physician immediately. The client should be encouraged to drink fluids after an LP to facilitate production of CSF. It is normal to have a mild headache due to the removal of CSF samples for laboratory analysis. Although the concerns of the client should be discussed with the physician at some point, the CSF leakage is a priority and should be reported immediately.

 CN: Reduction of risk potential;  
CL: Analyze


**84. 3.** The normal calcium level is 9.0 to 10.5 mg/dL. Hypercalcemia is commonly seen with malignant disease and metastases. The other laboratory values are normal. Hypercalcemia can be treated with fluids, furosemide (Lasix), or administration of calcitonin. Failure to treat hypercalcemia can cause muscle weakness, changes in level of consciousness, nausea, vomiting, abdominal pain, and dehydration. Although the client is on hospice care, she will still need palliative treatment. Comfort and risk reduction are components of hospice care.

 CN: Reduction of risk potential;  
CL: Synthesize

**85. 2.** The LPN should report a maternal pulse rate of 100 bpm at rest because it could potentially indicate shock or hemorrhage. Typically, the pulse rate of a postpartum client slows after delivery and continues to be slow for about 1 week because of an increase in central circulation that results in increased stroke volume to provide adequate maternal circulation. The normal pulse rate is 60 to 70 bpm. Neonatal regurgitation of 1 tablespoon after a feeding, a neonatal heart rate of 140 bpm at rest, and increased maternal lochia rubra when the mother initially ambulates are normal findings.

 CN: Management of care; CL: Analyze

**86. 2.** A child with a cardiac defect finds that squatting decreases venous return and workload to the heart and increases comfort and blood flow to the lungs. Squatting traps blood in the lower extremities so less blood is returned to the right atrium. Squatting does not make it easier for the child to play with toys. Squatting does not relieve abdominal pressure; it may even increase it slightly. Squatting has no effect on muscle tone. When done by a child with a cardiac defect, it is not meant as an exercise but is a compensatory process used to reduce dyspnea.

 CN: Physiological adaptation;  
CL: Evaluate

**87. 3.** The diaphragm is the major muscle of respiration; it is made up of two hemidiaphragms, each innervated by the right and left phrenic nerves. Injury to the phrenic nerve results in hemidiaphragm paralysis on the side of the injury and an ineffective breathing pattern. Consciousness, cardiac function, and urinary elimination are not affected by the phrenic nerve.

 CN: Management of care; CL: Analyze

**88. 2, 3, 5.** Tay-Sachs disease is associated with a particular cultural background, Eastern European Jewish descent. As an autosomal recessive disease, for an infant to be affected, each parent must carry a recessive trait. If both parents carry the trait, each

offspring has a 25% chance of inheriting the disease, a 50% chance of being a carrier, and a 25% chance of being unaffected. The shape of red blood cells is altered with Sickle Cell Disease rather than cystic fibrosis. Chorionic villi sampling (CVS) testing can identify whether a fetus is or is not affected.

 CN: Health promotion and maintenance;  
CL: Create

**89.**

2. Open the airway.

3. Start an I.V. access site.

1. Call the physician.

4. Explain the situation to the family.

An open airway is essential to survival. The nurse should first ensure an open airway. Next, the nurse should start an I.V. and then notify the physician. Finally, the nurse should inform the family of the situation and, if appropriate, allow them to remain with the client.

 CN: Management of care; CL: Synthesize

**90. 1.** Prevention of another pulmonary embolus is important; the nurse should teach the client to observe for signs of clot formation to prevent a potentially fatal episode and maintain cardiopulmonary integrity and adequate ventilation and perfusion. Elevation of the lower extremities, not lowering them, promotes venous return to the heart. Ambulation must be done several times each day. Limiting fluid intake increases blood viscosity, promoting clot formation.

 CN: Health promotion and maintenance;  
CL: Synthesize


**91. 2.** When a client is being released from the hospital with her neonate and the nurse learns that the client is homeless, the nurse should contact the hospital's or unit's social worker. Social workers have access to resources to assist the client to find temporary shelter in emergencies. The director of the birthing unit does not need to be notified. The director's responsibilities are primarily administrative. The client's physician can be notified once the social worker has offered assistance to the client. The physician may cancel the release of the neonate until temporary housing is located. Notifying the client's family is inappropriate. The client may not have any immediate family members, or there may be some stress between the client and family.

 CN: Management of care; CL: Synthesize


**92. 2, 3.** A client who has had numerous surgical or medical procedures is more prone to latex exposure and thus latex sensitivity or allergy. People who are allergic to latex may also have an allergy to fresh fruits and vegetables such as tomatoes. If a client denies a latex allergy, the nurse should ask about food allergies to fresh fruits and vegetables as well as for latex allergies and shellfish for iodine allergies. The client with one allergy commonly has more than one allergy, so the nurse must specifically ask the client about food allergies related to other allergies.

 CN: Reduction of risk potential;  
CL: Analyze

**93. 4.** The teenage girl has scoliosis, the lateral deviation of the spine. Kyphosis is noted by a forward curvature of the shoulders. Arthritis is diagnosed by radiographs. Hip dysplasia is noted in older children by pain, but is usually diagnosed before the child walks by noting excessive gluteal folds and limited hip abduction.

 CN: Health promotion and maintenance;  
CL: Analyze

**94. 1, 3, 4, 5.** The nurse is responsible for the client's safety in the operating room. The nurse should call a time-out if the client is not properly identified with an identification band. In addition, an I.V. line and oxygen should always be established when an ET tube is placed. This practice applies whenever a client's airway is compromised enough for intubation to occur, not only in the operating room environment. An anesthesiologist should be present during surgery to manage the airway. Post-operative pain medication is administered in the recovery room.


 CN: Safety and infection control;  
CL: Synthesize

**95. 1.** Anencephaly is a neural tube defect that is not compatible with life, although some infants with anencephaly live for several days before death occurs. When the client has decided to continue the pregnancy and donate the neonatal organs after the death of the neonate, the nurse should remain nonjudgmental. The nurse should explore his or her feelings about the issue of anencephaly and organ donation. The nurse should not make judgments about the client's position, nor should the nurse try to persuade the client to terminate the pregnancy. Contacting the client's minister to explore the client's options is not appropriate. As a devout Baptist, the client probably has already discussed the matter with her minister. Telling the client that the neonatal death will be prolonged and painful to her is not helpful. Death may occur very soon after birth. Contacting the client's family members is not

appropriate. The client may wish to maintain confidentiality and privacy related to the birth.

 CN: Management of care; CL: Synthesize


**96. 2, 3, 4, 5.** Anorexia is commonly the first indication of digoxin toxicity. Arrhythmias are also common with digoxin toxicity. Although bradycardia is the most common sign of toxicity, other tachycardic arrhythmias can occur. A normal pulse rate for a 3-month-old child at rest is about 120 bpm. Blurred vision can be associated with digoxin toxicity and may be detected in an infant if he stops following moving objects. Sudden vomiting or drowsiness can be associated with digoxin toxicity. Constipation is not associated with digoxin toxicity and is not an adverse effect of digoxin.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**97. 2.** If the specimen was from a fingerstick and not a venous sample, the potassium level can be falsely elevated. Because the finger is squeezed to obtain the sample, cells may have been broken from the pressure of squeezing. When the cells break, they release potassium, which will falsely elevate the potassium level in the result. Calling the physician without first checking the source of the sample would not give the physician accurate and complete information. A cardiac monitor would not be necessary if the potassium level is falsely elevated. The last 24-hour output would only indicate that the infant is voiding in an adequate amount. This may or may not have an influence on the infant's potassium level.


 CN: Reduction of risk potential;  
CL: Synthesize

**98. 3.** The level of lethality of a client's suicidal thoughts depends on the presence or absence of a plan. If the client has a plan, the nurse must know what it is and whether or not the client has access to the means to complete suicide. The initiation of suicide precautions is necessary whenever a client threatens suicide, but first it is important to discover more information about what the client is thinking and planning. Unless the client has at his disposal the means to harm himself or is constantly trying to harm himself with objects on the unit, placing him on a suicide watch or confining him to his room are overreactions to the client's disclosure of suicidal ideation.


 CN: Safety and infection control;  
CL: Synthesize

**99. 1, 2, 4.** The safest position for a hospital bed is in the low position if the client is not being attended by the nurse. All I.V. rates should be running at the prescribed level or changed to that level. The laboring client should be able to determine who

is with her during the labor process and nursing serves as the advocate for the client if the client wishes to have changes made. Laboring mothers should not be lying flat on their backs as this creates compression of the vena cava and decreases oxygenation to both the mother and the infant at a time when the best perfusion is desired. Pain should be relieved or expressed to be tolerable at any point in the labor process. It is not necessary to use continuous fetal monitoring in the early stages of a low risk pregnancy and labor.

 CN: Safety and infection control;  
CL: Evaluate

**100. 4.** Due to the client's psychosis and difficulties coping, a positive, supportive environment is essential to limit further regression and help the client engage in her own treatment. Confrontation and peer pressure are the type of milieu more suited to a chemically dependent client. While involvement in self-governance can be therapeutic, forcing a psychotic client to participate in self-governance before she is ready could actually hinder treatment and recovery. Although group activities are commonly required in treatment programs, a client who is very disturbed or confused is not forced to attend. Also, the client must participate when and how she feels comfortable, rather than mandating a specific amount of participation. Equal participation by clients does not ensure a therapeutic milieu or speed the client's recovery.

 CN: Psychosocial adaptation;  
CL: Synthesize

**101. 4.** The nurse should refuse to administer the medication to the client because of the risk of respiratory depression in the neonate. Meperidine, given I.M., peaks in 30 to 60 minutes and lasts 2 to 4 hours. Based on the assessment findings, the client most likely will be delivering within that time frame, increasing the risk of respiratory depression in the neonate, a serious consequence. Therefore, the nurse should not administer the drug. Naloxone (Narcan) should be readily available whenever opioids that can result in respiratory depression are used. Asking the physician to validate the dosage is not necessary. For clients in early labor, meperidine can be given I.M. in dosages ranging from 50 to 100 mg.

 CN: Management of care; CL: Synthesize

**102. 2.** Bending the chin down toward the chest decreases the risk of food entering the trachea and causing aspiration into the lungs. The client should sit up at a 90-degree angle when eating. Although eating and talking increase the risk of aspiration as well as muscle fatigue, the nurse should encourage the client to have visitors but avoid talking while chewing and swallowing. The client should rest

before eating because muscle fatigue can contribute to choking.

 CN: Reduction of risk potential;  
CL: Synthesize

### 103. 42.3 mm Hg

To obtain CPP, use this formula:

CPP = mean arterial pressure (MAP) – ICP.

To obtain the MAP, use this formula:

$$\text{MAP} = [\text{systolic BP} + (2 \times \text{diastolic BP})] \div 3$$

$$\text{MAP} = [90 + (2 \times 50)] \div 3 = 63.3$$

$$\text{CPP} = 63.3 - 21 = 42.3 \text{ mm Hg.}$$

 CN: Physiological adaptation; CL: Apply

**104. 1.** The client with a spinal cord injury above T6 who suddenly experiences clinical manifestations of autonomic stimulation, such as flushing, sweating, and piloerector muscle contraction, is demonstrating life-threatening autonomic dysreflexia. The cluster of manifestation results from noxious stimuli, such as a full bladder, or lying on a foreign object, such as a plastic cap or crinkled paper, which the client cannot feel. As soon as the noxious stimulus is removed, the manifestations begin to subside. When the client demonstrates clinical manifestations of autonomic dysreflexia, the nurse should first elevate the head of the bed immediately to decrease the intracerebral pressure caused by the hypertension that developed from autonomic stimulation. The nurse can next check for a distended bladder or foreign object. The client's blood pressure will be elevated; the nurse should assess vital signs frequently.


 CN: Management of care; CL: Synthesize

**105. 3.** The nurse should refer the client to a social worker for assistance in enrolling in the WIC program. This program provides assistance for foods such as milk, cereal, and infant formula. Instructing the client in low-cost, highly nutritious meal preparation will not meet the client's need for additional funds for food. Determining whether the client qualifies for state assistance is part of the role of the social worker, not the nurse. Asking the client if she has a job and the amount of income earned is not within the role of the nurse. The social worker can determine whether the family income guidelines are met for state and federal assistance.

 CN: Management of care; CL: Synthesize

**106. 4.** Telling the client about one activity at a time with 10 minutes' notice gives the client time to prepare for that activity. Writing out the schedule does not ensure that the client will remember to look at it. It is overwhelming to explain an entire day's schedule all at once to a client diagnosed with


dementia. Leading a client to an activity after the fact doesn't allow the client to prepare.

 CN: Psychosocial adaptation;  
CL: Synthesize

**107. 1, 2, 3, 4.** Safety of others is a priority and the nurse must monitor the client's anger and potential for aggression. The nurse should also find safe ways for the client to express his anger and any other feelings about the abuse. A referral to a support group is appropriate because anger management groups are one way to assist the client in learning to manage anger. Nothing about jail is mentioned in the question. Discussion of jail does not help the client address his issues with anger and the abuse causing the anger.

 CN: Management of care; CL: Synthesize

**108. 2.** The primiparous client at 2 hours postpartum who delivered a term neonate vaginally should be assessed first because this client is at risk for postpartum hemorrhage. Early postpartum hemorrhage typically occurs during the first 24 hours postpartum. Once the nurse has assessed the client's fundus, lochia, and vital signs, a determination about the stability of the client can be made. After this assessment, the nurse can provide care to the other clients, who are of lesser priority than the newly delivered primiparous client.

 CN: Management of care;  
CL: Synthesize


**109. 1.** Legionellosis is a pneumonia caused by the bacterium *Legionella pneumophila* that thrives in water that is 95° to 115° F (35° to 46° C). When a building's hot water plumbing has water at this temperature, the bacteria thrive; then they may be transmitted via inhalation from air conditioning, showers, spas, and whirlpools. The bacteria are not transmitted via smoke or ceiling fan blades or by swallowing contaminated water.

 CN: Health promotion and maintenance;  
CL: Synthesize


**110. 2, 3.** The client should be instructed not to eat or drink for 8 to 12 hours before the test. Stools will be white for up to 72 hours following the procedure as the barium is eliminated from the body. Laxatives and fluids will be encouraged after the procedure to help prevent barium impaction, but the client will not be given stool softeners or laxatives before the procedure. The client should not experience pain during the procedure. The nurse should also instruct the client to stop smoking at midnight the night before the test.

 CN: Reduction of risk potential;  
CL: Apply


**111. 3, 4.** A National Patient Safety Goal of The Joint Commission is to improve the accuracy of client identification; to attain that goal, health care personnel must use at least two client identifiers when providing care, treatment, or services. The medical record number and name as printed on the client's name band are appropriate identifiers. Because the client can change rooms and beds, these are not to be used as identifiers. Social security number is not used as an identifier for health care or treatment purposes.

 CN: Safety and infection control;  
CL: Apply


**112. 4.** There is no cure for metastatic cancer of the liver; palliative nursing care is required. Liver transplants are not recommended for the client with widespread malignant disease. Prescribed medications will not make metastatic lesions shrink. There is nothing to indicate that the client is receiving chemotherapy; therefore, explaining its effects would not be helpful.

 CN: Physiological adaptation;  
CL: Synthesize


**113. 3.** The vastus lateralis site is the preferred I.M. site for all ages because it does not have any major nerves or blood vessels located near it. The deltoid and dorsogluteal muscles have major nerves and blood vessels located nearby. The triceps is not an acceptable muscle for I.M. injections because it is not well developed in most clients.

 CN: Pharmacological and parenteral therapies; CL: Apply


**114. 1.** Clients should be instructed to rinse their mouths after using a steroid inhaler to avoid developing thrush. Clients should also be instructed to inhale slowly through the mouth and then hold the breath as they count to 10 slowly. It is not necessary for the client to cough and deep-breathe before using the inhaler.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**115. 2.** The nurse should stay with the client during the first 15 minutes of a blood transfusion because this is when reactions are most likely to occur. Blood products should never be refrigerated on the nursing unit. Blood that has not been infused after 4 hours should not be infused. The blood should be infused over the specific time ordered by the physician. If a fever develops, the transfusion should be stopped immediately and the blood reaction policy of the facility should be followed.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**116. 2.** The symptoms of difficulty breathing, elevated blood pressure, and cough are indicative of circulatory overload. Circulatory overload occurs when blood is infused more rapidly than the circulatory system can accommodate. Anaphylactic reactions are manifested by urticaria, wheezing, and shock. Sepsis begins with a rapid onset of chills and fever. Acute hemolytic reaction is typically manifested by chills, fever, low back pain, and flushing.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**117. 2.** Sucralfate (Carafate) should be taken on an empty stomach 1 hour before or 2 hours after meals, and at bedtime. It is usually taken four times a day. There is no need to avoid milk products while taking the drug. Sucralfate does not affect hemoglobin levels.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**118. 1.** Anger is a common feeling that may lead to self-mutilation. Anger must be expressed in safe ways to diminish self-mutilation. Confronting the abusers directly is rarely successful and must be done with much preparation. Talking about the abuse typically decreases, not increases, self-mutilation. Civil suits are possible, but should only be undertaken after significant recovery from the abuse.

 CN: Psychosocial adaptation;  
CL: Synthesize


**119. 1, 2, 3, 4.** The client with conjunctivitis can use warm soaks to remove crusting. The nurse should teach the client to dispose of the soaks by wrapping them in a separate bag to avoid spreading bacteria. Topical antibiotics are used to treat the infection. The client should avoid contaminating the tip of the medication dispenser. Bacterial conjunctivitis requires containing the spread of the infection. The client should wash his hands after touching his eyes, but he does not need to be isolated.

 CN: Reduction of risk potential;  
CL: Create


**120. 2, 5.** Two sources of identification must be confirmed before administering medication to a client. A source of information can be the client's record number, name, or date of birth, as noted on the client's armband. A client may be confused or hard of hearing and may give a wrong name or answer to a wrong name, thus having the client state his name or respond to his name is not safe practice. Client recognition is not sufficient identification for administering medication. Clients change rooms frequently, so a room number is not a source of identification for administering medication.

 CN: Pharmacological and parenteral therapies; CL: Apply


**121. 2.** Children who witness domestic violence commonly grow up to be victims or abusers. Counseling helps interrupt the pattern of violence in families. Limiting contact between the father and child does not address the child's behavior, and outgrowing violent behaviors is not likely without other interventions. Setting limits on violent behaviors alone does not address the child's feelings and needs.

 CN: Psychosocial adaptation;  
CL: Synthesize

**122. 2, 3.** A National Patient Safety Goal of The Joint Commission is to improve the effectiveness of communication among caregivers. The requirement for verbal or telephone orders, or for telephonic reporting of critical test results, is to verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. Effective communication which is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved client safety. "Read-back" procedures are not intended to discourage or prohibit telephone communications among health care providers or to promote use of electronic medical records. Safety procedures, such as provider identification codes, are in place for health care providers to give verbal or telephone orders.

 CN: Safety and infection control;  
CL: Apply


**123. 2.** After such a crime, talking about his memories and feelings is an early part of the emotional recovery process. Encouraging him to talk to the FBI and helping him prepare for the trial may be appropriate later as he reorganizes his life for a trial. It is important for him to express his anger, even fantasies of revenge, rather than repress it.

 CN: Psychosocial adaptation;  
CL: Synthesize


**124. 4.** The nurse should allow the client to see and hold the baby for as long as she desires. Such activities provide memories for the mother and assist in the grieving process. There is a possibility that the client may change her mind about the adoption. In most states, there is a defined period (6 months to 1 year or longer) before an adoption becomes final. If the client changes her mind about the adoption, the nurse should accept the client's decision and notify the physician and social worker. Telling the client that it would be best if she didn't see the baby is imposing the nurse's value system on the client. Allowing the client to see the baby through the nursery window is inappropriate because the client should be allowed to touch and hold the baby. Contacting the physician for advice related to the client's visitation is not necessary.

 CN: Management of care; CL: Synthesize


**125. 2.** A decrease or change in the level of consciousness is an early indication of increased intracranial pressure (ICP) and should be reported to the child's physician as soon as possible to try and control the pressure so it doesn't increase further. Vomiting can be a sign of increased ICP that occurs with a brain tumor, but it usually occurs unrelated to food and in the morning upon arising. Blood pressure increases with a brain tumor due to pressure on the brain stem. Concentrated urine is a sign of dehydration and is not related to the signs of a brain tumor.

 CN: Physiological adaptation;  
CL: Analyze

**126. 4.** With a severe gonorrheal infection, scarring of the fallopian tubes may occur, and becoming pregnant may be difficult or impossible. If the girl's partner is not treated, she can be reinfected. There is no immunity against gonorrhea and, if exposed again, the girl can again become infected. Although a condom may provide some protection against contracting gonorrhea, it is not an adequate protection against the condition and will not help clear up an existing infection. It is only with proper antibiotic administration that the condition can be eradicated.

 CN: Safety and infection control;  
CL: Evaluate

**127. 1, 2, 3, 4.** The goal of "medication reconciliation" is to ensure that clients are on the right medication after any transfer, admission, or going in and out of a health care facility. It is not necessary to reconcile the medications if the client moves to a different room on the same floor. It is estimated that more than half of medication errors occur during these transitions, and medication reconciliation can reduce errors by 70% or more. The Joint Commission requirements mandate medication reconciliation programs.

 CN: Pharmacological and parenteral therapies; CL: Apply

**128. 1.** Acute poststreptococcal glomerulonephritis usually follows a streptococcal throat or skin infection by 1 to 2 weeks. Streptococcus-type infections require medical intervention with antibiotics. Antibacterial mouthwashes do not kill streptococci. Previously prescribed antibiotics may not be effective against streptococci, and may also be expired. Bar soap fragrance has no impact on its ability to kill bacteria that reside on skin.

 CN: Health promotion and maintenance;  
CL: Synthesize


**129. 1.** To be a true client advocate, the nurse should ask the client if she desires an epidural anesthetic even though the client has indicated a desire for "natural childbirth." The client has a




right to change her mind and also a right to refuse treatment. The client, not the nurse, should be the one to tell the physician that she does not want an epidural anesthetic; the nurse should support the client's decision. Although telling the client that her labor will be more comfortable with an anesthetic provides the client with information, a statement such as this can be viewed as an attempt to change the client's mind. The client may wish to discuss this situation with her husband, but she does not have to do so.

 CN: Management of care; CL: Synthesize


**130. 2, 3.** In order to meet the criteria for discharge from same-day surgery, the postoperative client must be able to take fluids by mouth, walk without hypotension, void, and be escorted by a responsible adult who will drive him home. Transportation home via a taxicab is not a sufficient escort to assist a client home after surgery. The client may be discharged with severe pain. The nurse should make sure the client has a prescription for pain medication. Because a client has been on nothing-by-mouth status and thinks he is dry is not a sufficient reason for being unable to urinate postoperatively. The inability to void in the first 8 hours after surgery is one of the potential complications for all surgical clients and is related to the stress response.

 CN: Safety and infection control;  
CL: Evaluate

**131. 1.** Eyedrops are correctly instilled by placing them in the lower conjunctival sac. Eyedrops should not be placed near the lacrimal ducts, to decrease the chance of the medication's being systemically absorbed. Placing the drops on the cornea or sclera is uncomfortable for the client and may cause the medication to run out of the eye socket instead of being absorbed.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**132. 4.** To treat anaphylactic reactions, epinephrine is administered to counteract the effects of histamine. Epinephrine is a rapid-acting sympathomimetic drug that has a bronchodilator effect. Dopamine may be used if hypotension develops. Diphenhydramine may also be given, but not as the initial drug of choice. Cimetidine is not administered to treat an anaphylactic reaction resulting in shortness of breath.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**133. 1, 2, 3, 4.** Benchmarking is a technique for learning from the success of others in an area where care improvement is desired by comparing the data from others with the data about the nursing problem for which improvement is sought. Sources


of information for benchmarking include: literature reviews, databases, unions, standard-setting organizations, local organizations, universities, the government, staff or customer interviews, and questionnaires. A recommendation from a clinical organization does not necessarily indicate that success has been attained.

 CN: Management of care; CL: Apply

**134. 3.** Overuse of nasal spray containing pseudoephedrine can lead to rhinitis medicamentosa, which is a rebound effect causing increased swelling and congestion. Use of pseudoephedrine nasal spray does not cause infections or thrush. Pseudoephedrine is not addictive.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**135. 2.** The best way to teach a child about surgery is through play. The nurse can let the child handle the items that will be used for monitoring, such as the blood pressure cuff and the ECG pads. The child will become more familiar with the face masks he sees the surgical team wearing in the operating room after playing with one and wearing it before surgery. A child of this age-group does not understand detailed explanations of how to use equipment, such as a PCA, a VAS, or even a video. The pain scale that should be used for children is the FACES scale.

 CN: Basic care and comfort;  
CL: Synthesize

**136. 2.** When a nurse observes the theft of an opioid, it is the responsibility of the nurse to report the incident to the supervisor of the unit. The supervisor of the unit can confront the coworker and notify the hospital's chief of security about the incident. In some situations, the drug-abusing coworker may be offered drug counseling. In situations in which the drugs are being sold, the police should be notified. The nurse should not confront the coworker because this may put the nurse in danger. It is not the responsibility of the nurse to notify federal drug agents about the incident.

 CN: Management of care; CL: Synthesize


**137. 2.** The nurse should teach the client and family the importance of not discontinuing benzotropine abruptly. Rather, the drug should be tapered slowly over a 1-week period. Benzotropine should not be used with over-the-counter cough and cold preparations because of the risk of an additive anticholinergic effect. Antacids delay the absorption of benzotropine, and alcohol in combination with benzotropine causes an increase in central nervous system depression; concomitant use should be avoided.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**138. 3.** The nurse needs to focus on adverse effects that can be seen or felt, using a simple, brief, written description of the benefits of the medication and a list of common adverse effects and how to cope with them. The written format helps the client and family feel more in control by participating in treatment. They also can use the written information as a helpful resource for review. Information about all potential adverse effects, including percentages associated with each, will cause undue anxiety in the client and possibly overwhelm the client and family, negatively affecting compliance. The nurse should use discretion in selecting the content of educational sessions.

 CN: Health promotion and maintenance;  
CL: Synthesize

**139. 2.** Albumin is a colloid that remains in the intravascular space, pulling fluid out of the intracellular and interstitial space. The client with nephrotic syndrome loses excessive amounts of protein, mainly albumin, in the urine. Because fluid is drawn into the intravascular space, blood pressure will increase. Crackles in the lung bases and cerebral edema are signs of circulatory overload or fluid volume excess. When edema is present in lower extremities, the skin feels cool to the touch unless an infection is present.

 CN: Physiological adaptation;  
CL: Evaluate

**140. 3.** Although inherited, it is not clearly understood why cysts form in polycystic kidney disease. Environmental exposures promote development of bladder cancer. Although drinking alcohol requires the kidneys to excrete the alcohol, it is not thought to cause the kidneys to develop cysts.

 CN: Physiological adaptation;  
CL: Synthesize

**141. 1, 2, 3.** A 3% sodium chloride solution is hypertonic; it will pull fluid into the intravascular compartment and may increase renal perfusion, so intake and output should be monitored. As fluid is pulled into the vasculature, the client may demonstrate signs of fluid overload such as jugular vein distention. Hyponatremia and hyperchloremia will produce neurologic signs and symptoms. Fluids should not be forced in a client with fluid overload. There is no need for an indwelling urinary catheter.


 CN: Reduction of risk potential;  
CL: Apply

**142. 3.** The nurse expects the UAP assigned to several clients in labor to notify the nurse if the UAP observes that one of the clients has evidence of spontaneous rupture of the membranes. When the membranes rupture spontaneously, there is danger

of a prolapsed cord, a medical emergency requiring a cesarean delivery. Nausea may occur after administration of an epidural anesthetic, but this is not a priority or emergency. Having contractions that are 3 minutes apart and last for 40 seconds is normal during active labor. Because nalbuphine (Nubain) is an analgesic, it is normal for a client to fall asleep after I.V. administration of this drug.

 CN: Management of care; CL: Evaluate


**143. 2.** Before teaching a school-age child about a medical or nursing procedure, it is best to become familiar with the child's knowledge level. The nurse can then begin by explaining about the body structure involved in the procedure. Children of this age should be told about the unknown procedures far enough in advance for them to prepare for what is going to happen to them. Showing the child the equipment and explaining what is going to be done during the test should be done after the child is allowed to express what he knows about what is going to happen to him.

 CN: Psychosocial adaptation;  
CL: Synthesize

**144. 1, 2, 3, 4.** Educating women about risk factors for cancers of the reproductive system is important. The nurse should encourage women to do breast and vulva self-exams. Limiting sexual activity during adolescence, using condoms, having fewer sexual partners, and not smoking reduces the risk of cervical cancer. Cancer can be prevented from occurring when screening reveals precancerous conditions of the vulva, cervix, or endometrium. Also, routine screening increases the chance that a cancer will be identified in its early stage. Immunization against HPV is recommended for preteen girls to prevent cervical cancer. Many cancers in women, particularly breast cancer, have a genetic basis and the woman's genetic history is an important tool in identifying risk.


 CN: Health promotion and maintenance;  
CL: Create

**145. 3.** The client should be encouraged to keep up with his school work. The developmental task of the school-age child is industry versus inferiority. Keeping up with his peers is very important to this age-group. Watching television does provide rest, but it does not lead to a feeling of accomplishment. Coloring pictures is not an appropriate pastime for this age-group. Making crafts may be too strenuous of an activity for a client on bed rest.


 CN: Health promotion and maintenance;  
CL: Synthesize

**146. 4.** Clients receiving TPN are at risk for a number of complications, including fluid imbalances such as fluid overload and hyperosmolar diuresis.


Other common complications include hyperglycemia, sepsis, pneumothorax, and air embolism. Hypostatic pneumonia, pulmonary hypertension, and orthostatic hypotension are not complications of TPN.

 CN: Pharmacological and parenteral therapies; CL: Analyze


**147. 1, 2, 4.** Heparin dosage in children is based on the child's weight. A bolus of heparin is administered by the I.V. route and the onset of action is immediate. The PTT is an indicator of the effectiveness of heparin. Following the heparin with a continuous infusion of heparin would cause life-threatening anticoagulation in this child. Penicillin and cephalosporins potentiate the effects of heparin, so the heparin must be carefully titrated to obtain maximum effect without causing an overdose. However, the antibiotic should not be discontinued.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**148. 1.** Proprantheline bromide (Pro-Banthine) is an anticholinergic drug. Common adverse effects include urine retention and constipation; flushed, dry skin; and dry mouth, nose, and throat. Orthostatic hypotension may also occur. Diarrhea and diaphoresis are adverse effects of cholinergic drugs.

 CN: Pharmacological and parenteral therapies; CL: Analyze

**149. 1.** Applying a tourniquet obstructs venous blood flow and, as a result, distends the veins. A tourniquet does not stabilize veins or immobilize the arm, nor is it applied to occlude arterial circulation.

 CN: Pharmacological and parenteral therapies; CL: Apply

**150. 1.** Prochlorperazine is administered postoperatively to control nausea and vomiting. Prochlorperazine is also used in psychotherapy because of its effects on mood and behavior. It is not used to treat dizziness, abdominal spasms, or abdominal distention.

 CN: Pharmacological and parenteral therapies; CL: Evaluate

**151. 1, 2, 3, 4.** Cough and dyspnea can be present at the time of diagnosis of bone cancer, indicating that the cancer has metastasized to the lungs. About one-quarter of all adolescents with bone cancer have lung metastasis at the time of diagnosis. Pain and swelling result from the inflammation caused by the bone tumor and the increased vascularity of the tumor. At the time of diagnosis, fever, anorexia, and decreased range of motion have not occurred. The tumor involves the bone, so there is pain when pressure is exerted on the involved bone, but range of

motion is not affected. Fever and anorexia can occur if extensive metastasis has occurred.

 CN: Health promotion and maintenance; CL: Analyze


**152. 1.** The priority assessment is that the client has a firm fundus when gentle massage is used. This indicates that the client's fundus may be soft or "boggy" when it is not massaged. The receiving nurse should assess the client's fundus soon after admission and continue to monitor the client's fundus, lochia, and pulse rate. Postpartum hemorrhage is associated with uterine atony. Maternal-infant bonding is a process that usually starts on day 2 and ends at week 1. A 12-hour labor is normal. The temperature and pulse are within normal limits.

 CN: Management of care; CL: Analyze

**153. 2.** Assuming cultural appropriateness of eye contact with the client and his wife, this body language would make the nurse's nonverbal message congruent with the nurse's verbal message and demonstrate empathy. Directing their eyes only toward the client, rather than including the wife, ignores the wife. Avoiding eye contact with the client and wife or shifting the gaze between the client and wife conveys a lack of assurance about the nurse's focus and comments.

 CN: Psychosocial adaptation; CL: Apply

**154. 4.** Colleagues can be a source of suggestions and validation of communication strategies. The nurse has identified difficulty with the relationship and should seek assistance before discussing improved involvement with the client because improved involvement may not be the most appropriate approach. Positive and negative interactions occur in relationships. The frequency of both types of interactions determines the quality of an interpersonal relationship. In a therapeutic relationship, both parties contribute to the relationship; neither one should dominate or be submissive.


 CN: Psychosocial adaptation; CL: Synthesize

**155. 3.** The nurse on the postpartum unit should discuss with the client what her wishes are and mutually agree on a location. The charge nurse better understands the current and future needs of the client experiencing this type of loss as the client may or may not be thinking well or clearly at the moment. The postpartum unit is full of sounds of infants, and although being in a room by herself may support the need for separation, it is often in the best interest of the client to locate her away from the noise of the babies. Placing the client on another unit will remove her from the support she is seeking. On the other hand, she will not be hearing crying infants. This has often been the location


for someone experiencing a loss. Discharging the mother home as soon as she is stable physically is also a possibility, but the nurse must also assess the client's emotional stability and preferences for grieving.

 CN: Management of care; CL: Synthesize


**156. 3.** Confidentiality and privacy are critical developmental needs for the adolescent. These needs are important to enable the nurse to establish a relationship of trust with the adolescent. A sexual history should be conducted with a teen without parents. Therefore, the nurse should not ask the mother to provide information or put the daughter in a position of having to make a decision about her mother remaining in the room. Inform the adolescent that this information is confidential, and will not be shared with the parent. Inform the adolescent that issues of abuse or life-threatening issues are required by law to be disclosed to the authorities, and all other information is private.

 CN: Management of care; CL: Synthesize

**157. 4.** It is critical for medication safety to know the name, dosage, and times of administration of the medication taken at home. The family should bring the medication bottles to the hospital. The nurse should document the medication on the medical record from the bottles to ensure accuracy before the medication is ordered and administered. The pharmacist is a helpful resource, but the safest way to identify the medication is in its original container. It is not safe to assume the client could correctly identify the medications from a drug book. The medication regimen may have changed since the record 2 years ago.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**158. 3, 4, 5.** The additional fluids should run through a separate line using a Y connector. The nurse must contact the surgeon to clarify if the client should receive the additional 100 mL/hour of I.V. fluids containing potassium chloride during the bolus infusion. Rapid infusion of potassium chloride can cause hyperkalemia with adverse cardiac outcomes such as arrhythmias. Bolus infusions of I.V. fluids should be run via an infusion pump to avoid excess fluid administration. Increasing the current I.V. infusion rate or adding additional fluids to the existing infusion is not safe because the current infusion contains potassium.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**159. 1.** The nurse should notify the hospital's security staff about anyone who appears unusual. Typically the abductor is an older woman who wishes to have a baby. The nurse should take


only one baby at a time to a mother to prevent the neonate being taken to the wrong mother. Infants should never be left in the hallway. When in the mother's room, the infant should be placed away from the doorway to prevent or minimize the risk of abduction of the neonate. If an exit alarm is triggered, it is possible that an abductor is running away with an infant. Staff members should investigate the alarm immediately and stop the potential abductor. Hospital security can be alerted if someone is seen exiting the unit carrying a large bag or an infant.

 CN: Management of care; CL: Apply


**160. 1.** The client needs specific information about the effects of the drug, specifically its effect on the blood. The statement about weekly blood tests to determine safe dosage and monitoring for effects on the blood gives the client specific information to ensure follow-up with the required protocol for clozapine (Clozaril) therapy. Lack of accurate knowledge can lead to noncompliance with necessary follow-up procedures and noncompliance with medication. The supply of medication is not dependent on blood testing. Telling the client that his physician wants to know the progress does not provide specific information for this client. The blood tests are not required by the drug company.

 CN: Pharmacological and parenteral therapies; CL: Synthesize


**161. 4.** A properly administered intradermal injection shows evidence of a bleb at the injection site. There should be no leaking of medication from the bleb; it needs to be absorbed into the tissue. Lack of swelling at the injection site means that the injection was given too deeply. The presence of tissue pallor does not indicate that the injection was given correctly.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**162. 1.** A serious complication of I.V. therapy is fluid overload. Noisy respirations can develop as a result of pulmonary congestion. Additional symptoms of fluid overload include dyspnea, crackles, hypertension, bounding pulse, and distended neck veins.

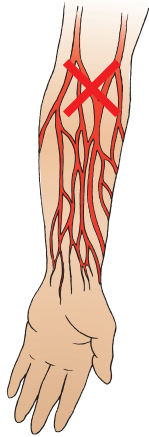
 CN: Pharmacological and parenteral therapies; CL: Analyze

**163. 2.** Only isotonic (normal) saline should be used when administering a blood transfusion. The use of dextrose or lactated Ringer's will cause the hemolysis of red blood cells.


 CN: Pharmacological and parenteral therapies; CL: Apply

**164. 3.** The median cubital vein is located in the approximate center of the antecubital space.


 CN: Pharmacological and parenteral therapies; CL: Apply



**165. 2.** Telling the mother that excess saliva is a common adverse effect of the drug is most helpful because it gives her information about the problem, thereby helping to decrease her anxiety about what is occurring with her son. By offering the paper cup, the nurse also demonstrates concern for the client, thereby leading to increased trust. Saying “I wonder if he’s having an adverse reaction to the medicine” shows the nurse’s lack of knowledge about the drug, decreases confidence in the nurse, and indicates poor judgment. Saying, “Don’t worry about it, it’s only a minor inconvenience compared to its benefits,” or telling the mother that the nurse has seen this happening to other clients is insensitive and does not assuage the mother’s anxiety.


 CN: Pharmacological and parenteral therapies; CL: Synthesize

**166. 1, 3, 4.** The nurse should write down the order, read the order back to the physician, and receive confirmation from the physician that the order is correct as understood by the nurse. It is not necessary for the physician to come to the hospital to write the order on the chart or to have the nursing supervisor cosign the telephone order.


 CN: Safety and infection control; CL: Apply

**167. 4.** The nurse should take the client’s temperature and report the symptoms to the physician. Flulike symptoms of weakness, malaise, fever, sore throat, and lethargy may indicate leukopenia. An elevated temperature could also indicate an infection. Either condition requires medical intervention by the physician. Telling the client to wait another


day or to take over-the-counter flu medication is inappropriate because the client is at risk for leukopenia secondary to clozapine therapy and serious consequences could occur. Although it would be important to encourage the client to consume adequate fluids, the priority is to report the symptoms and check the temperature.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**168. 2.** Protamine sulfate is a heparin antagonist. It is administered intravenously very slowly (over at least 10 minutes). Warfarin sodium and ASA have anticoagulant properties and would be contraindicated. Atropine sulfate is an anticholinergic drug and would not be effective in treating a heparin overdose.

 CN: Pharmacological and parenteral therapies; CL: Apply


**169. 2.** Aminophylline, a bronchodilator that relaxes smooth muscles in the bronchioles, is used in the treatment of emphysema to improve ventilation by dilating the bronchioles. Aminophylline does not have an effect on the diaphragm or the medullary respiratory center and does not promote pulmonary circulation.

 CN: Pharmacological and parenteral therapies; CL: Evaluate


**170. 1.** Seven-year-olds like to play with friends of the same sex. In early school-age years, children enjoy the company of same-sex friends. Relatives become second-choice friends to those from school. Team games can be competitive, and the ego of a 7-year-old may be too fragile to endure losing the game without losing self-confidence. Infants enjoy solitary play. The school-age child enjoys cooperative play with friends of the same sex and age.

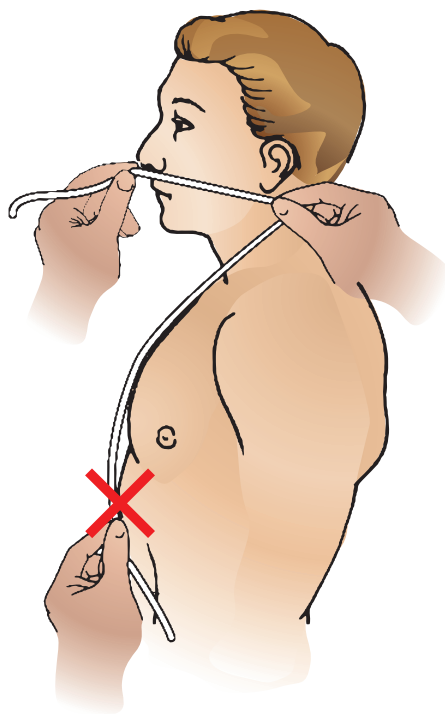
 CN: Health promotion and maintenance; CL: Analyze

**171. 2.** Trying something new is usually frightening for a 7-year-old. Separation anxiety is the most common fear between the ages of 5 months and 5 years of age. Injury and pain are a common fear of the preschool child. Fear of the opposite sex is common during adolescence.

 CN: Health promotion and maintenance; CL: Analyze

**172.** When measuring for NG tube insertion, the nurse would end the measurement at the xiphoid process.


 CN: Safety and infection control; CL: Apply



**173. 4.** The client is experiencing signs of thrombophlebitis. The nurse should notify the physician because emboli formation is a potential risk. Massaging the area may cause the thrombus to dislocate and become an embolus. Warm compresses will increase circulation to the area and may precipitate embolus formation. Ankle pump exercises are helpful in preventing thrombophlebitis but will not prevent further risk of embolus formation at this time.

 CN: Reduction of risk potential;  
CL: Synthesize

**174. 3.** This rhythm is ventricular tachycardia, which is characterized by an absent P wave and a heart rate of 140 to 220 bpm. Ventricular tachycardia requires immediate intervention, usually with lidocaine (Xylocaine).

 CN: Physiological adaptation;  
CL: Analyze

**175.**

3. Clear the area around the client.

1. Loosen clothing around the client's neck.

2. Turn the client on the side.

4. Suction the airway.

The goal of care for a client who is having a seizure is to prevent respiratory arrest and aspiration. The nurse should first clear the area around the client. Next, the nurse should loosen clothing around the client's neck


and turn the client on the side. As needed, the nurse can then suction the airway and administer oxygen.

 CN: Reduction of risk potential;  
CL: Synthesize


**176. 3.** This rhythm is atrial fibrillation. It is characterized by an irregular QRS interval, no definite P waves before the QRS waves, and a ventricular rate greater than 100 bpm.

 CN: Reduction of risk potential; CL: Analyze


**177. 1.** During the first week postpartum, the client's pulse rate should be slow, with an average of 60 to 70 bpm. A pulse of 100 bpm warrants further investigation to rule out a possible infectious process or postpartum hemorrhage. An oral temperature of 99° F (36.8° C) is within normal limits. Excessive perspiration and frequent voiding in large amounts are caused by the normal diuresis that occurs as the body returns to its pre-pregnant state.

 CN: Management of care; CL: Synthesize


**178. 1.** Lymphedema occurs frequently after radical mastectomy when lymph nodes are removed. Aplasia, or the absence of lymph nodes, prevents proper lymph drainage. The tissue swelling is caused by obstructed lymph flow in the extremity. The blood pressure is taken in the unaffected arm to avoid further accumulation of lymphedema. An I.V. line should not be started in the affected arm. The nurse would encourage the client to elevate the extremity above the level of the heart. Blood draws in the affected arm should not be allowed.

 CN: Physiological adaptation;  
CL: Synthesize

**179. 4.** The child's physician should be notified because the maximum daily recommended dosage for ceftriaxone (Rocephin) for this child's weight would be 3.3 g/day and giving this dose would administer 4 g/day. The nurse cannot administer a different dose than that ordered by the physician. There is no therapeutic serum level of Rocephin.

 CN: Pharmacological and parenteral therapies; CL: Synthesize

**180. 3.** One of the staff members needs further instructions when the nurse observes the staff member wearing sterile gloves to bathe a newly delivered neonate at 1 hour of age. Clean gloves should be worn, not sterile gloves. Sterile gloves are more expensive than clean gloves and are not necessary when bathing a newly delivered neonate. Goggles should be worn when there is a possibility of blood and body fluid spatter. Bloody sheets should be placed in labeled containers for contaminated linens. Scalpel blades are disposed of in specified containers.

 CN: Safety and infection control;  
CL: Evaluate

# Appendices

■ State and Territorial Boards of Nursing 1064

■ Bibliography 1068

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## State and Territorial Boards of Nursing

### Alabama Board of Nursing

770 Washington Avenue  
RSA Plaza, Suite 250  
Montgomery, AL 36130-3900  
Phone: (334) 242-4060  
Fax: (334) 242-4360  
Website: <http://www.abn.state.al.us/>

### Alaska Board of Nursing

Dept. of Comm. & Econ. Development  
Div. of Occupational Licensing  
3601 C Street, Suite 722  
Anchorage, AK 99503  
Phone: (907) 269-8161  
Fax: (907) 269-8196  
Website: <http://www.dced.state.ak.us/occ/pnur.htm>

### Arizona State Board of Nursing

4747 N. 7th St.  
Suite 200  
Phoenix, AZ 85014  
Phone: (602) 889-5150  
Fax: (602) 889-5155  
Website: <http://www.azbn.gov/>

### Arkansas State Board of Nursing

University Tower Building  
1123 S. University, Suite 800  
Little Rock, AR 72204-1619  
Phone: (501) 686-2700  
Fax: (501) 686-2714  
Website: <http://www.arsbn.arkansas.gov/Pages/default.aspx>

### California State Board of Registered Nursing

400 R Street, Suite 4030  
PO Box 944210  
Sacramento, CA 95814  
Phone: (916) 322-3350  
Fax: (916) 327-4402  
Website: <http://www.rn.ca.gov/>

### Colorado Board of Nursing

1560 Broadway, Suite 880  
Denver, Colorado 80202  
Phone: (303) 894-2430  
Fax: (303) 894-2821  
Website: <http://www.dora.state.co.us/Nursing/>

### Connecticut Board of Examiners for Nursing

Dept. of Public Health  
410 Capitol Avenue, MS# 13PHO  
PO Box 340308  
Hartford, CT 06134-0328  
Phone: (860) 509-7624  
Fax: (860) 509-7553  
Website: <http://www.ct.gov/dph/site/default.asp>

### Delaware Board of Nursing

861 Silver Lake Blvd  
Cannon Building, Suite 203  
Dover, DE 19904  
Phone: (302) 739-4522  
Fax: (302) 739-2711  
Website: <http://dpr.delaware.gov/boards/nursing/index.shtml>

### District of Columbia Board of Nursing

Department of Health  
825 N. Capitol Street, N.E., 2nd Floor  
Room 2224  
Washington, DC 20002  
Phone: (202) 442-4778  
Fax: (202) 442-9431  
Website: <http://hpla.doh.dc.gov/hpla/cwp/view,a,1195,q,488526,hplanav,|30661|,asp>

### Florida Board of Nursing

4052 Bald Cypress Way, Bin #A07  
Tallahassee, FL 32399-1708  
Phone: (850) 245-4244  
Website: <http://www.doh.state.fl.us/mqa/>

### Georgia Board of Nursing

237 Coliseum Drive  
Macon, GA 31217-3858  
Phone: (478) 207-1640  
Fax: (478) 207-1660  
Website: <http://sos.georgia.gov/plb/rn/>

### Hawaii Board of Nursing

Professional & Vocational Licensing Division  
PO Box 3469  
Honolulu, HI 96801  
Phone: (808) 586-3000  
Fax: (808) 586-2689  
Website: <http://hawaii.gov/dcca/pvl/boards/nursing/>



**Idaho Board of Nursing**

280 N. 8th Street, Suite 210  
 PO Box 83720  
 Boise, ID 83720  
 Phone: (208) 334-3110  
 Fax: (208) 334-3262  
 Website: <http://ibn.idaho.gov/>

**Illinois Department of Professional Regulation**

James R. Thompson Center  
 100 West Randolph, Suite 9-300  
 Chicago, IL 60601  
 Phone: (312) 814-2715  
 Fax: (312) 814-3145  
 Website: <http://www.idfpr.com/>

**Indiana State Board of Nursing**

Health Professions Bureau  
 402 W. Washington Street, Room W041  
 Indianapolis, IN 46204  
 Phone: (317) 232-2960  
 Fax: (317) 233-4236  
 Website: <http://www.in.gov/pla/>

**Iowa Board of Nursing**

River Point Business Park  
 400 S.W. 8th Street  
 Suite B  
 Des Moines, IA 50309-4685  
 Phone: (515) 281-3255  
 Fax: (515) 281-4825  
 Website: <http://www.state.ia.us/government/nursing/>

**Kansas State Board of Nursing**

Landon State Office Bldg.  
 900 SW Jackson, Suite 551 S.  
 Topeka, KS 66612-1230  
 Phone: (785) 296-4929  
 Fax: (785) 296-3929  
 Website: <http://www.ksbn.org/>

**Kentucky Board of Nursing**

312 Whittington Parkway, Suite 300  
 Louisville, KY 40222  
 Phone: (502) 329-7000  
 Fax: (502) 329-7011  
 Website: <http://kbn.ky.gov/>

**Louisiana State Board of Nursing**

3510 N. Causeway Boulevard, Suite 501  
 Metairie, LA 70003  
 Phone: (504) 838-5332  
 Fax: (504) 838-5349  
 Website: <http://www.lsbns.state.la.us/>

**Maine State Board of Nursing**

158 State House Station  
 Augusta, ME 04333  
 Phone: (207) 287-1133  
 Fax: (207) 287-1149  
 Website: <http://www.maine.gov/boardofnursing/>

**Maryland Board of Nursing**

4140 Patterson Avenue  
 Baltimore, MD 21215  
 Phone: (410) 585-1900  
 Fax: (410) 358-3530  
 Website: <http://www.mbon.org/main.php>

**Massachusetts Nursing State Board**

Commonwealth of Massachusetts  
 239 Causeway Street  
 Boston, MA 02114  
 Phone: (617) 973-0800  
 Fax: (617) 727-1630  
 Website: <http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Provider&L2=Certification%2c+Licensure%2c+and+Registration&L3=Occupational+and+Professional&L4=Nursing&sid=Eeohhs2>

**Michigan CIS/Office of Health Services**

Ottawa Towers North  
 611 W. Ottawa, 4th Floor  
 Lansing, MI 48933  
 Phone: (517) 373-9102  
 Fax: (517) 373-2179  
 Website: <http://www.michigan.gov/dleg>

**Minnesota Board of Nursing**

2829 University Avenue SE  
 Suite 500  
 Minneapolis, MN 55414  
 Phone: (612) 617-2270  
 Fax: (612) 617-2190  
 Website: <http://www.state.mn.us/portal/mn/jsp/home.do?agency=NursingBoard>

**Mississippi Board of Nursing**

1935 Lakeland Drive, Suite B  
 Jackson, MS 39216-5014  
 Phone: (601) 987-4188  
 Fax: (601) 364-2352  
 Website: <http://www.msbn.state.ms.us/>

**Missouri State Board of Nursing**

3605 Missouri Blvd  
 P.O. Box 656  
 Jefferson City, MO 65102-0656  
 Phone: (573) 751-0681  
 Fax: (573) 751-0075  
 Website: <http://www.pr.mo.gov/>

**Montana State Board of Nursing**

PO Box 200513  
 Helena, MT 59620-0513  
 Phone: (406) 841-2345  
 Fax: (406) 841-2305  
 Website: [http://bsd.dli.mt.gov/license/bsd\\_boards/nur\\_board/board\\_page.asp](http://bsd.dli.mt.gov/license/bsd_boards/nur_board/board_page.asp)

**Nebraska Health and Human Services System**

Dept. of Regulation & Licensure, Nursing Section  
301 Centennial Mall South  
Lincoln, NE 68509-4986  
Phone: (402) 471-4376  
Fax: (402) 471-3577  
Website: <http://www.hhs.state.ne.us/crl/nursing/nursingindex.htm>

**Nevada State Board of Nursing**

License Certification and Education  
4330 S. Valley View Blvd  
Suite 106  
Las Vegas, NV 89103  
Phone: (702) 486-5800  
Fax: (702) 486-5803  
Website: <http://www.nursingboard.state.nv.us/>

**New Hampshire Board of Nursing**

P.O. Box 3898  
78 Regional Drive, BLDG B  
Concord, NH 03302  
Phone: (603) 271-2323  
Fax: (603) 271-6605  
Website: <http://www.nh.gov/nursing/>

**New Jersey Board of Nursing**

P.O. Box 45010  
124 Halsey Street, 6th Floor  
Newark, NJ 07101  
Phone: (973) 504-6586  
Fax: (973) 648-3481  
Website: <http://www.state.nj.us/lps/ca/medical.htm>

**New Mexico Board of Nursing**

4206 Louisiana Boulevard, NE  
Suite A  
Albuquerque, NM 87109  
Phone: (505) 841-8340  
Fax: (505) 841-8347  
Website: <http://www.bon.state.nm.us/>

**New York State Board of Nursing**

Education Bldg.  
89 Washington Avenue  
2nd Floor West Wing  
Albany, NY 12234  
Phone: (518) 474-3817 Ext. 120  
Fax: (518) 474-3706  
Website: <http://www.op.nysed.gov/prof/nurse/>

**North Carolina Board of Nursing**

3724 National Drive, Suite 201  
Raleigh, NC 27612  
Phone: (919) 782-3211  
Fax: (919) 781-9461  
Website: <http://www.ncbon.com/>

**North Dakota Board of Nursing**

919 South 7th Street, Suite 504  
Bismark, ND 58504  
Phone: (701) 328-9777  
Fax: (701) 328-9785  
Website: <http://www.ndbon.org/>

**Ohio Board of Nursing**

17 South High Street, Suite 400  
Columbus, OH 43215-3413  
Phone: (614) 466-3947  
Fax: (614) 466-0388  
Website: <http://www.nursing.ohio.gov/>

**Oklahoma Board of Nursing**

2915 N. Classen Boulevard, Suite 524  
Oklahoma City, OK 73106  
Phone: (405) 962-1800  
Fax: (405) 962-1821  
Website: <http://www.ok.gov/nursing/>

**Oregon State Board of Nursing**

800 NE Oregon Street, Box 25  
Suite 465  
Portland, OR 97232  
Phone: (503) 731-4745  
Fax: (503) 731-4755  
Website: <http://www.osbn.state.or.us/>

**Pennsylvania State Board of Nursing**

124 Pine Street  
Harrisburg, PA 17101  
Phone: (717) 783-7142  
Fax: (717) 783-0822  
Website: [http://www.dos.state.pa.us/portal/server.pt/community/bureau\\_of\\_professional\\_occupational\\_affairs/12483](http://www.dos.state.pa.us/portal/server.pt/community/bureau_of_professional_occupational_affairs/12483)

**Rhode Island Board of Nursing**

Registration and Nursing Education  
105 Cannon Building  
Three Capitol Hill  
Providence, RI 02908  
Phone: (401) 222-5700  
Fax: (401) 222-3352  
Website: <http://www.healthri.org/>

**South Carolina State Board of Nursing**

110 Centerview Drive  
Suite 202  
Columbia, SC 29210  
Phone: (803) 896-4550  
Fax: (803) 896-4525  
Website: <http://www.llr.state.sc.us/pol/nursing/>

**South Dakota Board of Nursing**

4300 South Louise Ave., Suite C-1  
Sioux Falls, SD 57106-3124  
Phone: (605) 362-2760  
Fax: (605) 362-2768  
Website: <http://doh.sd.gov/boards/nursing/>

**Tennessee State Board of Nursing**

426 Fifth Avenue North  
1st Floor - Cordell Hull Building  
Nashville, TN 37247  
Phone: (615) 532-5166  
Fax: (615) 741-7899  
Website: <http://health.state.tn.us/boards/nursing/>

**Texas Board of Nurse Examiners**

333 Guadalupe, Suite 3-460  
Austin, TX 78701  
Phone: (512) 305-7400  
Fax: (512) 305-7401  
Website: <http://www.bne.state.tx.us/>

**Utah State Board of Nursing**

Heber M. Wells Bldg., 4th Floor  
160 East 300 South  
Salt Lake City, UT 84111  
Phone: (801) 530-6628  
Fax: (801) 530-6511  
Website: <http://www.dopl.utah.gov/licensing/nursing.html>

**Vermont State Board of Nursing**

109 State Street  
Montpelier, VT 05609-1106  
Phone: (802) 828-2396  
Fax: (802) 828-2484  
Website: <http://www.vtprofessionals.org/opr1/nurses/>

**Virginia Board of Nursing**

6606 W. Broad Street, 4th Floor  
Richmond, VA 23230  
Phone: (804) 662-9909  
Fax: (804) 662-9512  
Website: <http://www.dhp.state.va.us/>

**Washington State Nursing Care Quality Assurance Commission**

Department of Health  
1300 Quince Street SE  
Olympia, WA 98504-7864  
Phone: (360) 236-4740  
Fax: (360) 236-4738  
Website: <http://www.doh.wa.gov/hsqa/professions/nursing/default.htm>

**West Virginia Board of Examiners for Registered Professional Nurses**

101 Dee Drive  
Charleston, WV 25311  
Phone: (304) 558-3596  
Fax: (304) 558-3666  
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