NCLEX 150 QUESTIONS ANSWERS AND CLINICAL REASONING

EXAM PREP # 4

1. A young adult who was in a motorcycle accident is brought to the emergency room with a closed head injury with suspected subdural hematoma. Although the client complains of a severe headache, he is alert and answers questions appropriately. The nurse would question which of the following orders?

1. "Promethazine (Phenergan) 25 mg IM 3 h."
2. "Morphine sulfate 10 mg IM q3-4h."
3. "Docusate sodium (Colace) 50 mg PO bid."
4. "Ranitidine (Zantac) 50 mg IVPB q12h."

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) H1 receptor blocker, used as an antiemetic
(2) correct–narcotic analgesic, causes CNS and respiratory depression, contraindicated in head
injury because it masks signs of increased intracranial pressure
(3) stool softener, used for an immobilized patient
(4) H2 histamine antagonist, reduces acid production in stomach, prevents stress ulcers

2. The nurse has just returned to the desk and has four phone messages to return. Which of the following messages should the nurse return FIRST?

1. A woman in her first trimester of pregnancy complaining of heartburn.
2. A man complaining of heartburn that radiates to his jaw.
3. A woman complaining of hot flashes and difficulty sleeping.
4. A boy complaining of knee pain after playing basketball.

Strategy: Determine the least stable client.
(1) caused by reflux of gastric contents into esophagus, treatment is small frequent meals, don't
consume fluids with food, don't wear tight clothing
(2) correct–indicates chest pain, needs to seek medical attention immediately
(3) caused by menopause, treat with hormone replacement therapy (HRT)
(4) should treat with rest and ice

3. A patient is admitted to the surgical unit with a diagnosis of rule out intestinal obstruction. The nurse is preparing to insert a Salem sump NG tube as ordered. In which of the following positions would it be BEST for the nurse to place this patient during the procedure?

1. Head of bed elevated 30°–45°.
2. Head of bed elevated 60°–90°.
3. Side-lying with head elevated 15°.
4. Lying flat with head turned to the left side.

Strategy: Remember the positioning strategy.
(1) not the best position
(2) correct–facilitates swallowing and movement of tube through GI tract
(3) not the best position
(4) not the best position

4. The nurse is monitoring the fluid status of a 63-year-old woman receiving IV fluids following surgery. Which of the following symptoms would suggest to the nurse that the patient has fluid volume overload?

1. Temperature 101°F (38.3°C), BP 96/60, pulse 96 and thready.
2. Cool skin, respiratory crackles, pulse 86 and bounding.
3. Complaints of a headache, abdominal pain, and lethargy.
4. Urinary output 700 cc/24 h, CVP of 5, and nystagmus.

Strategy: Determine how each answer choice relates to fluid volume overload.
(1) indicates dehydration
(2) correct–will see bounding pulse, elevated BP, distended neck veins, edema, headache, polyuria, diarrhea, liver enlargement
(3) symptoms could be from causes other than volume overload
(4) slightly reduced output, CVP would be elevated, normal CVP 4-10 mm/H2 O, involuntary eye movements not seen

5. A woman has been recently diagnosed with systemic lupus and shares with the nurse, "I am thinking about getting pregnant, but I don't know how I will be able to tolerate a pregnancy since I have lupus." Which of the following responses by the nurse is BEST?

1. "Most women find that they feel better when they are pregnant."
2. "How long have you been in remission?"
3. "Women with lupus frequently have slightly longer gestations."
4. "It is best to become pregnant within the first six months of diagnosis."

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes.
(1) maternal morbidity and mortality are increased with SLE
(2) correct–should be in remission for at least 5 months prior to conceiving
(3) gestation not affected by SLE
(4) recommended that a woman wait two years following diagnosis before conceiving

6. The multidisciplinary team decides to implement behavior modification with a client. Which of the following nursing actions is of primary importance during this time?

1. Confirm that all staff members understand and comply with the treatment plan.
2. Establish mutually agreed upon, realistic goals.
3. Ensure that the potent reinforcers (rewards) are important to the client.
4. Establish a fixed interval schedule for reinforcement.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–to implement a behavior modification plan successfully, all staff members need to be included in program development, and time must be allowed for discussion of concerns from each nursing staff member; consistency and follow-through is important to prevent or diminish the level of manipulation by the staff or client during implementation of this program
(2) not of primary importance in designing an effective behavior modification program
(3) not of primary importance in designing an effective behavior modification program
(4) not of primary importance in designing an effective behavior modification program

7. A client received six units of regular insulin three hours ago. The nurse would be MOST concerned if which of the following was observed?

1. Kussmaul respirations and diaphoresis.
2. Anorexia and lethargy.
3. Diaphoresis and trembling.
4. Headache and polyuria.

Strategy: "MOST concerned" indicates a complication.
(1) Kussmaul respirations are signs of hyperglycemia
(2) not indicative of hypoglycemia
(3) correct–regular insulin peaks in two to four hours; indicates hypoglycemia; give skim milk
(4) not indicative of hypoglycemia

8. The nursing assistant reports to the nurse that a client who is one-day postoperative after an angioplasty is refusing to eat and states, "I just don't feel good." Which of the following actions, if taken by the nurse, is BEST?

1. The nurse talks with the client about how he is feeling.
2. The nurse instructs the nursing assistant to sit with the client while he eats.
3. The nurse contacts the physician to obtain an order for an antacid.
4. The nurse evaluates the most recent vital signs recorded in the chart.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Is the assessment appropriate? Yes.
(1) correct–assessment required; monitor for closure of vessel, bleeding, hypotension, dysrhythmias
(2) assess cause of problem before implementing
(3) assess cause of problem before implementing
(4) more important to assess what is happening now

9. The nurse prepares a 25-year-old woman for a cesarean section. The patient says she had major surgery several years ago and asks if she will receive a similar "shot" before surgery. The nurse's response should be based on an understanding that the preoperative medication given before a cesarean section

1. contains a lower overall dosage of medication than is given before general surgery.
2. contains reduced amounts of sedatives and hypnotics than are given before general surgery.
3. contains reduced amounts of narcotics than are given before general surgery.
4. contains medications similar in type and dosages to those given before general surgery.

Strategy: Think about the action of the medications.
(1) decreased dosage of narcotics are used
(2) dosages of sedatives and hypnotics will be similar
(3) correct–decreased so less narcotic crosses the placental barrier causing respiratory depression
in the infant
(4) dosages of narcotics are reduced

10. The nurse is caring for an 11-year-old patient being treated for a fractured right femur with balanced suspension traction with a Thomas splint and Pearson attachment. The nurse notes that the patient's left leg is externally rotated. The nurse should

1. place a trochanter roll on the outer aspect of the thigh.
2. perform resistive range of motion of the left leg.
3. adduct and internally rotate the left leg.
4. instruct the patient to maintain the left leg in a neutral position.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–holds hip in neutral position and leg in normal alignment, entire weight of leg cannot be held by props placed below knee
(2) exercise would not prevent future external rotation of the leg
(3) adduct (add to midline of body) does not change external rotation, internal rotation is not beneficial, normal alignment is required
(4) leg will externally rotate unless propped in proper alignment

11. The nurse is preparing a five-year-old child for surgery. The nurse notes that the child's parents are divorced and have joint legal custody. The informed consent for surgery has been signed by the mother. Which of the following actions by the nurse is BEST?

1. Notify the physician.
2. Inform surgery.
3. Contact the father to obtain consent.
4. Continue the child's preoperative preparation.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) no reason to notify the physician
(2) no reason to call the OR
(3) consent from either divorced parent is sufficient
(4) correct–parent or legal guardian required to give informed consent prior to surgical procedure

12. The nurse is caring for clients on the neurology unit. What would be the MOST appropriate action for the nurse to take after noting that a client suddenly developed a fixed and dilated pupil?

1. Reassess in five minutes.
2. Check the client's visual acuity.
3. Lower the head of the client's bed.
4. Contact the physician.

Strategy: Answers are a mix of assessments and implementations. Is this a situation that requires assessment or validation? No. Determine the outcome of the implementations.
(1) assessment, situation does not require validation
(2) assessment, has symptoms of increased ICP
(3) implementation, would increase the intracranial pressure
(4) correct–implementation, fixed and dilated pupil represents a neurological emergency

13. A mother brings her two-year-old boy to the pediatrician's office. Which of the following symptoms would suggest to the nurse that the child has strabismus?

1. When the child draws, he places his head close to the table.
2. The child rubs his eyes frequently.
3. The child closes one eye to see a poster on the wall.
4. The child is unable to see objects in the periphery of his visual field.

Strategy: Think about each answer choice.
(1) suggestive of refractive error, myopia (nearsightedness), able to see objects at close range
(2) suggestive of refractive error
(3) correct–visual axes are not parallel so the brain receives two images
(4) suggestive of cataracts or problem with peripheral vision

14. A client is given morphine 6 mg IV push for postoperative pain. Following administration of this drug, the nurse observes the following: pulse 68, respirations 8, BP 100/68, client sleeping quietly. Which of the following nursing actions is MOST appropriate?

1. Allow the client to sleep undisturbed.
2. Administer oxygen via facemask or nasal prongs.
3. Administer naloxone (Narcan).
4. Place epinephrine 1:1,000 at the bedside.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should be given Narcan for low respiratory rate
(2) problem is low respirations, this may be administered after medication
(3) correct–IV naloxone (Narcan) should be given to reverse respiratory depression; respiratory rate
of 8 is too low and necessitates a nursing action
(4) unnecessary

15. The school nurse is teaching a group of preschool mothers about poison prevention in the home. Which of the following statements, if made by a mother to the nurse, indicates that further teaching is necessary?

1. "I should have a bottle of Ipecac for each of my children."
2. "I should induce vomiting if my child swallows lighter fluid."
3. "Giving my child water or milk may help dilute the poison."
4. "Proper storage is the key to poison prevention in the home."

Strategy: "Further teaching is necessary" indicates an incorrect statement.
(1) Ipecac is available in 30 cc vials, advise parents to have available full doses for each child, doses range from 10 to 30 cc
(2) correct–vomiting contraindicated when child ingests hydrocarbons due to danger of aspiration
(3) small amounts of water or milk may dilute toxins
(4) store in locked cabinets

16. The nurse is caring for a manic client in the seclusion room, and it is time for lunch. It is MOST appropriate for the nurse to take which of the following actions?

1. Take the client to the dining room with 1:1 supervision.
2. Inform the client he may go to the dining room when he controls his behavior.
3. Hold the meal until the client is able to come out of seclusion.
4. Serve the meal to the client in the seclusion room.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should remain in the seclusion room
(2) should have meal at regular time
(3) should have meal at regular time
(4) correct–should eat at regular time; remain in the seclusion room for client's safety

17. Which of the following nursing actions has the HIGHEST priority for a teenager admitted with burns to 50% of his body?

1. Counseling regarding problems of body image.
2. Maintain airborne precautions.
3. Maintain aseptic technique during procedures.
4. Encourage peers to visit on a regular basis.

Strategy: Think "Maslow."
(1) psychosocial, not highest priority
(2) physical, use standard precautions
(3) correct–safety is a priority for the client who is at high risk for infection
(4) psychosocial, important for an adolescent, but is not highest priority

18. The home health care nurse is caring for a 30-year-old woman with type I diabetes mellitus. The client has been maintained on a regimen of NPH and regular insulin and a 1,800-calorie diabetic diet with normal blood sugar levels. Morning self-monitoring blood sugar (SMBG) readings the past two days were 205 mg/dL and 233 mg/dL. The nurse expects the physician to

1. reduce the client's diet to 1,500 calorie ADA.
2. order 3 additional units of NPH insulin at 10 PM.
3. order an additional 10 units of regular insulin at 8 PM.
4. eliminate the client's bedtime snack.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) diet should not be reduced
(2) correct–dawn phenomena, treatment is to adjust evening diet, bedtime snack, insulin dose,
and exercise to prevent early morning hyperglycemia
(3) peaks in 4–6 hours, would not prevent dawn phenomena
(4) would adjust snack, not eliminate it

19. After sustaining a closed head injury and numerous lacerations and abrasions to the face and neck, a five-year-old child is admitted to the emergency room. The client is unconscious and has minimal response to noxious stimuli. Which of the following assessments, if observed by the nurse three hours after admission, should be reported to the physician?

1. The client has slight edema of the eyelids.
2. There is clear fluid draining from the client's right ear.
3. There is some bleeding from the child's lacerations.
4. The client withdraws in response to painful stimuli.

Strategy: Think about how each answer choice relates to a head injury.
(1) not priority
(2) correct–indicates a rupture of meninges and presents a potential complication of meningitis
(3) not priority
(4) is not a change in assessment

20. A psychiatric nurse is assigned to conduct an admission nursing history on a new client. The admission should include which of the following?

1. The nurse's opinion regarding the mental and emotional status of the client.
2. Data addressing the client's emotional state.
3. Data that address a biopsychosocial approach, including a family system assessment.
4. Specific data detailing the client's mental status.

Strategy: Think about each answer choice.
(1) depends on opinions that are not based on a complete assessment
(2) limits the degree of information that is obtained from the client
(3) correct–complete nursing history includes biopsychosocial data; client's psychosocial and physical status are evaluated along with an assessment of the client's family system and social support network; evaluation of the client's cognitive ability is important during the physiological status assessment
(4) is necessary information about mental status, but is also an incomplete assessment

21. Prochlorperazine maleate (Compazine) 10 mg IM has been ordered for a client. The client is also to receive Stadol 2 mg IM. Before administering these medications, the nurse should

1. obtain respirations and temperature.
2. dilute with 9 ml of NS.
3. draw the medications in separate syringes.
4. verify the route of administration.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should monitor blood pressure and heart rate for orthostatic hypotension; respiration and temperature are not as high a priority
(2) inappropriate
(3) correct–Compazine should be considered incompatible in a syringe with all other medications
(4) unnecessary

22. The nurse is caring for clients in the student health center. A client confides to the nurse that the client's boyfriend informed her that he tested positive for hepatitis B. Which of the following responses by the nurse is BEST?

1. "That must have been a real shock to you."
2. "You should be tested for hepatitis B."
3. "You'll receive the hepatitis B immune globulin (HBIG)."
4. "Have you had unprotected sex with your boyfriend?"

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Is there an appropriate assessment? Yes.
(1) nurse is interjecting own feelings
(2) will require testing, not best response initially
(3) implementation, receive HBIG for postexposure prophylaxis; may also receive HBV vaccine
(4) correct–assessment, transmitted through parenteral drug abuse and sexual contact; determine exposure before implementing

23. A young adult patient constantly seeks attention from the nurses, stomping away from the nurses' station and pouting when her requests are refused. Which of the following responses by the nurse is MOST appropriate?

1. Have the patient establish trust with one staff person with whom therapeutic interventions should occur.
2. Give the patient unsolicited attention when she is not exhibiting the unacceptable behaviors.
3. Ignore the patient when she exhibits attention-seeking behavior.
4. Rotate the staff so the patient will learn to relate to more than one nurse.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) staff should use a consistent undivided approach
(2) correct–reward nonseeking attention behaviors by giving the patient unsolicited attention
(3) remain nonjudgmental, carry out limit-setting
(4) staff should use a consistent undivided approach

24. After abdominal surgery, a client has a nasogastric tube attached to low suctioning. The client becomes nauseated, and the nurse observes a decrease in the flow of gastric secretions. Which of the following nursing interventions would be MOST appropriate?

1. Irrigate the nasogastric tube with distilled water.
2. Aspirate the gastric contents with a syringe.
3. Administer an antiemetic medicine.
4. Insert a new nasogastric tube.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) tube would be irrigated with normal saline after the position of the tube was evaluated
(2) correct–to confirm placement, nurse should aspirate and test the pH of the aspirate, results should be 0-4
(3) does not assess status of nasogastric tube
(4) does not assess status of nasogastric tube

25. A 38-year-old woman, mother of two, has a mastectomy for breast cancer. When she returns to the physician's office a month later for a routine check-up, the nurse asks the client how she has been. Which of the following responses, if made by the client to the nurse, indicates that the client is experiencing a normal reaction to the surgery?

1. "I have been helping my family deal with their feelings about the surgery."
2. "I have been having difficulty coping with the surgery and cry frequently."
3. "I have been unable to leave the house or talk to my friends about the surgery."
4. "I am doing just great since the surgery and have gone back to work at my job."

Strategy: Think about each answer choice. Does it describe an expected response to a crisis situation?
(1) will not be able to help others this soon after surgery
(2) correct–normal reaction one month later
(3) excessive, abnormal reaction
(4) indicates integration, too early for this stage

26. The nurse is caring for clients in outpatient surgery. The mother of a four-year-old asks the nurse how to prepare her daughter for eye surgery. Which of the following statements by the nurse is BEST?

1. "Draw a picture of the eye to explain what will happen."
2. "Tell your daughter that the procedure will take one hour."
3. "Use dolls or puppets to explain how to get ready for surgery."
4. "Read an age-appropriate illustrated book about eye surgery to your daughter."

Strategy: Think about growth and development.
(1) appropriate for school-aged child
(2) preschooler can't relate to the concept of one hour
(3) correct–use puppet or doll to show where procedure is performed; explain procedure in simple
terms and what the child will see, hear, taste, smell, and feel
(4) appropriate for school-aged child

27. A 23-year-old woman at 32-weeks gestation is seen in the outpatient clinic. Which of the following findings, if assessed by the nurse, would indicate a possible complication?

1. The client's urine test is positive for glucose and acetone.
2. The client has 1+ pedal edema in both feet at the end of the day.
3. The client complains of an increase in vaginal discharge.
4. The client says she feels pressure against her diaphragm when the baby moves.

Strategy: Determine how each answer choice relates to pregnancy.
(1) correct–abnormal finding, could indicate gestational diabetes (GDM), hazard of placental insufficiency
(2) not unusual, caused by pressure of enlarging uterus on veins returning blood from lower extremities
(3) common near term with increased vascularity of vagina and perineum, only abnormal if bloody, foul-smelling, or abnormally colored
(4) not unusual, due to pressure of enlarging uterus

28. A nurse is caring for a 37-year-old woman with metastatic ovarian cancer admitted for nausea and vomiting. The physician orders total parenteral nutrition (TPN), a nutritional consult, and diet recall. Which of the following is the BEST indication that the patient's nutritional status has improved after 4 days?

1. The patient eats most of the food served to her.
2. The patient has gained 1 pound since admission.
3. The patient's albumin level is 4.0mg/dL.
4. The patient's hemoglobin is 8.5g/dL.

Strategy: Determine how each answer choice relates to nutritional status.
(1) appetite is not the best indicator
(2) weight gain may be fluid retention (ascites)
(3) correct–albumin levels are best indicators of long-term nutritional status
(4) low levels are caused by chemotherapy or cancer, not a good indicator because it takes a long time to increase levels

29. The nurse is caring for clients on a medical/surgical unit and determines that several situations need to be addressed. Which of the following situations should the nurse attend to FIRST?

1. An angry daughter is threatening to sue the hospital because her confused mother fell out of bed during the previous shift.
2. The nursing assistant is 30 minutes overdue from a dinner break in the cafeteria for the third time this week.
3. The physician calls the unit to ask the nurse to obtain a client's latest serum electrolyte results from the lab.
4. The husband of a client reports to the nurse that his wife's nose began bleeding after she returned from radiation therapy.

Strategy: Determine the least stable situation
(1) important issue that needs to be addressed after tending to the client who is bleeding
(2) patients take priority over personnel issues
(3) can be delegated to another staff member
(4) correct–should assess client to determine amount and cause of bleeding

30. A woman is admitted to the labor and delivery unit in a sickle cell crisis. Which of the following nursing actions is the HIGHEST priority?
1. Administer oxygen.
2. Turn her to the right side.
3. Provide adequate hydration.
4. Start antibiotics.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) not a priority
(2) not a priority
(3) correct–adequate hydration is a priority for any client with sickle cell crisis
(4) not a priority

31. A client with a peptic ulcer had a partial gastrectomy and vagotomy (Billroth I). In planning the discharge teaching, the client should be cautioned by the nurse about which of the following?

1. Sit up for at least 30 minutes after eating.
2. Avoid fluids between meals.
3. Increase the intake of high-carbohydrate foods.
4. Avoid eating large meals that are high in simple sugars and liquids.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) client should recline for 30 minutes after eating
(2) fluids should be given between meals
(3) intake of carbohydrates should be reduced along with highly spiced foods
(4) correct–basic guidelines to teach a postgastrectomy client are measures to prevent dumping syndrome, which include: lying down for 30 minutes after meals, drinking fluids between meals, and reducing intake of carbohydrates

32. The nurse is assigned to work with the parents of a retarded child. Which of the following should the nurse include in the care plan for the parents?

1. Interpret the grieving process for the parents.
2. Discuss the reality of institutional placement.
3. Assist the parents in making decisions and long-term plans for the child.
4. Perform a family assessment to assist in the planning of intervention.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes.
(1) inappropriate before the assessment; action can be taken only when the circumstances are known
(2) inappropriate before the assessment; action can be taken only when the circumstances are known
(3) inappropriate before the assessment; action can be taken only when the circumstances are known
(4) correct–assessment, this will help the nurse to know where the family is in regard to grieving, coping, etc.

33. The nurse should explain to a client that tolbutamide (Orinase) is effective for diabetics who

1. can no longer produce any insulin.
2. produce minimal amounts of insulin.
3. are unable to administer their injections.
4. have a sustained decreased blood glucose.

Strategy: Think about each answer choice.
(1) type I insulin-dependent diabetic is unable to produce insulin
(2) correct–oral hypoglycemic agents are administered to type II (non-insulin-dependent) clients who are able to produce minimal amounts of insulin
(3) type I diabetics who cannot administer their injections need alternate plans to be made for them to receive the injection from a family member
(4) Orinase would be administered for an increase in blood glucose

34. A woman at 38-weeks gestation comes to the emergency room with complaints of vaginal bleeding. Which of the following statements, if made by the client, would suggest to the nurse placenta previa as the cause of the bleeding?

1. "I feel fine, but the bleeding scares me."
2. "I've been more nauseated during the past few weeks."
3. "The bleeding started after I carried four bags of groceries."
4. "I've been having severe abdominal cramps."

Strategy: All answers are assessments. Think about what each phrase is describing and how it relates to a placenta previa.
(1) correct–placenta previa is characterized by painless vaginal bleeding
(2) nausea not a symptom of placenta previa
(3) bleeding is not necessarily related to activity
(4) pain not characteristic of placenta previa

35. The nurse is caring for an 80-year-old client with Parkinson's disease. Which of the following nursing goals is MOST realistic and appropriate in planning care for this client?

1. Return the client to usual activities of daily living.
2. Maintain optimal function within the client's limitations.
3. Prepare the client for a peaceful and dignified death.
4. Arrest progression of the disease process in the client.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) unrealistic
(2) correct–irreversible disease that leads to permanent physical limitations
(3) unnecessary, disease usually is not terminal
(4) unrealistic, disease is progressive, cannot be arrested

36. When using restraints for an agitated/aggressive patient, which of the following statements should NOT influence the nurse's actions during this intervention?

1. The restraints/seclusion policies set forth by the institution.
2. The patient's competence.
3. The patient's voluntary/involuntary status.
4. The patient's nursing care plan.

Strategy: Think about each answer choice.
(1) nurse should follow the policies of the institution
(2) must get written permission from the patient for restraints; if patient has been judged incompetent, permission is obtained from the legal guardian
(3) correct–the need for restraints is based on patient's behavioral status and condition, not the patient's voluntary/involuntary status
(4) must first try less restrictive means to control patient before using restraints

37. A 12-year-old boy injured his right knee yesterday during a soccer game. He is brought to the outpatient clinic by his mother. His right knee is painful, swollen, and bruised. During the interview, the nurse learns that the boy has hemophilia A. Which of the following medications would be BEST for this patient?

1. Oxycodone terephthalate (Percodan).
2. Ibuprofen (Motrin).
3. Enteric-coated aspirin.
4. Codeine phosphate (Paveral).

Strategy: Think about the action of each medication.
(1) contains aspirin, contraindicated for persons with bleeding disorders
(2) increases bleeding time by decreasing platelet aggregation, contraindicated for persons with
bleeding disorders
(3) increases bleeding time by decreasing platelet aggregation, contraindicated for persons with bleeding disorders
(4) correct–analgesic used for moderate to severe pain

38. The parents of a one-month-old boy bring their son to the clinic for evaluation of a possible right dislocated hip. If a diagnosis of unilateral dislocation of the right hip is made, which of the following symptoms will the nurse observe?

1. Limited adduction of the right leg.
2. Uneven gluteal fold and thigh creases.
3. Increase in length of the right limb.
4. Internal rotation of the right leg.

Strategy: Think about each answer choice.
(1) will see limited abduction
(2) correct–folds and creases will be longer and deeper on affected side
(3) will be decrease in limb length
(4) may or may not see internal rotation

39. The nurse is administering terbutaline (Brethine) to a client in labor. Prior to administration of the medication, the nurse assesses the client's pulse to be 144. The nurse's priority action should be to

1. withhold the medication.
2. decrease the dose by half.
3. administer the medication.
4. wait 15 minutes, then recheck the rate.

Strategy: Answers are a mix of assessments and implementations. Is this a situation that requires validation? No. Determine the outcome of each answer choice.
(1) correct–maternal tachycardia is a side effect of Brethine; other maternal side effects include nervousness, tremors, headache, and possible pulmonary edema; fetal side effects include tachycardia and hypoglycemia; Brethine is usually preferred over ritodrine (Yutopar) because it
has minimal effects on blood pressure
(2) should never change a prescribed dosage of medication
(3) should not be given with a high pulse rate
(4) assessment, maternal tachycardia is a side effect of Brethine; medication should be withheld

40. The nurse is supervising the staff providing care for an 18-month-old hospitalized with hepatitis A. The nurse determines that the staff's care is appropriate if which of the following is observed?

1. The child is placed in a private room.
2. The staff removes a toy from the child's bed and takes it to the nurse's station.
3. The staff offers the child french fries and a vanilla milkshake for a midafternoon snack.
4. The staff uses standard precautions.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–contact precautions required for diapered or incontinent clients
(2) do not remove toys from room, possibly contaminated
(3) diet should be high in carbohydrates and protein and low in fat
(4) contact precautions required in addition to standard precautions

41. The nurse is preparing to administer an injection of haloperidol decanoate (Haldol D). Which of the following actions by the nurse is MOST appropriate?

1. Massage the injection site.
2. Give deep IM in a large muscle mass.
3. Use a 2 inch 25 gauge needle.
4. Administer the medication in divided doses.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should not be done because medication is very irritating to subcutaneous tissue
(2) correct–medication is very irritating to subcutaneous tissue
(3) should use a 2 inch 21 gauge needle
(4) should administer in single dose; patient should lie in recumbent position for one-half hour after administration of IM haloperidol decanoate

42. The nurse is monitoring a client's EKG strip and notes coupled premature ventricular contractions greater than 10 per minute. The nurse should expect to administer which of the following?

1. Atropine sulfate (Atropine) IV.
2. Isoproterenol (Isuprel) IV.
3. Verapamil (Calan) IV.
4. Lidocaine hydrochloride (Xylocaine) IV.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) antiarrhythmic, used for bradycardia
(2) antiarrhythmic, used for heart block, ventricular dysrhythmias
(3) antihypertensive, calcium-channel blocker
(4) correct–Lidocaine is the drug of choice for frequent premature ventricular contractions (PVC) occurring in excess of 6-10 per minute; for coupled PVCs or for a consecutive series of PVCs that may result in ventricular tachycardia

43. A client with newly diagnosed type I diabetes mellitus is being seen by the home health nurse. The physician orders include: 1,200-calorie ADA diet, 15 units of NPH insulin before breakfast, and check blood sugar qid. When the nurse visits the client at 5 PM, the nurse observes the man performing a blood sugar analysis. The result is 50 mg/dL. The nurse would expect the client to be

1. confused with cold, clammy skin and a pulse of 110.
2. lethargic with hot, dry skin and rapid, deep respirations.
3. alert and cooperative with a BP of 130/80 and respirations of 12.
4. short of breath, with distended neck veins and a bounding pulse of 96.

Strategy: Determine the cause of each answer choice.
(1) correct–symptoms of hypoglycemia, normal blood sugar 70-110 mg/dL
(2) symptoms of hyperglycemia, blood sugar above 110 mg/dL
(3) normal appearance and vital signs
(4) symptoms of fluid overload caused by CHF, rapid infusion of IV fluids

44. The nurse's INITIAL priority when managing a physically assaultive client is to

1. restrict the client to the room.
2. place the client under one-to-one supervision.
3. restore the client's self-control and prevent further loss of control.
4. clear the immediate area of other clients to prevent harm.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) time out or room restriction might be a useful strategy before the client becomes assaultive; once client is assaultive, s/he may continue this behavior in his/her room without any redirection and support
(2) may not stop assaultive behavior
(3) correct–most important priority in the nursing management of an assaultive client is to maintain milieu safety by restoring the client's self-control; a quick assessment of situation, psychological intervention, chemical intervention, and possibly physical control are important when managing the physically assaultive client
(4) is helpful, but may not be realistic if the situation escalates quickly

45. The nurse observes a LPN/LVN perform a wet-to-dry dressing change on a 2-inch abdominal incision. Which of the following behaviors, if performed by the LPN/LVN, would indicate an understanding of proper technique?

1. A clean cotton ball is used to cleanse from the top of the incision to the bottom of the incision using long strokes.
2. The incision is packed with sterile gauze, and then sterile saline is poured over the dressing.
3. The nurse packs wet gauze into the incision without overlapping it onto the skin.
4. The old dressing is saturated with sterile saline before it is removed.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should clean from the center of wound to the outside using sterile equipment
(2) dressings should be soaked before application
(3) correct–if wet dressing touches skin it could cause skin breakdown
(4) should be removed dry so wound debris and necrotic tissue are removed with old dressing

46. The nurse assesses the development of a three-month-old boy in the well-baby clinic. Which of the following behaviors, if observed by the nurse, would be UNEXPECTED?

1. The boy holds his head erect when sitting on the examination table.
2. The boy tries to grasp a toy just out of reach.
3. The boy turns his head to try to locate a sound.
4. The boy smiles spontaneously when he sees his mother.

Strategy: Picture the infant.
(1) expected at 3 months
(2) correct–unexpected until 6 months of age
(3) expected at 3 months of age
(4) expected at 3 months of age

47. An older man is seen in the outpatient clinic for treatment of an acute attack of gout. Which of the following nursing interventions would be MOST beneficial in decreasing the client's pain during ambulation?

1. Perform passive range-of-motion exercises before walking.
2. Encourage partial weight bearing while ambulating.
3. Immobilize the extremity between activities.
4. Restrict the amount of time and the distance the man walks.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) would aggravate pain
(2) correct–would relieve weight, pressure, and stress on affected leg, may use walker
(3) would increase stiffness
(4) immobility would aggravate pain and inflammation

48. Which of the following observations best indicates to the nurse that a paraplegic client can adequately carry out activities of daily living at home after discharge?

1. The client can shave himself and brush his teeth.
2. The client can transfer himself into and out of his wheelchair.
3. The client can maneuver his wheelchair without difficulty.
4. The client can prepare his own well-balanced meals.

Strategy: Answers are implementation. Determine the outcome of each answer choice. Is it desired?
(1) paraplegic has full use of his upper body, so this activity presents no problem
(2) correct–essential if client is to perform ADLs
(3) done with the arms, and presents no real problem
(4) is a necessary requisite for living alone and performing ADLs, but is not directly hindered by paraplegia

49. During a first aid class, the nurse instructs clients on the emergency care of second-degree burns. The nurse knows that which of the following interventions for second-degree burns of the chest and arms will BEST prevent infection?

1. Wash the burn with an antiseptic soap and water.
2. Remove clothing and wrap the victim in a clean sheet.
3. Leave the blisters intact and apply an ointment.
4. Take no action until the victim arrives in a burn unit.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) soaps and ointments should not be applied to second-degree burns in an emergency situation
(2) correct–after fire is out, remove clothing and cover victim with a clean sheet
(3) soaps and ointments should not be applied to second-degree burns in an emergency situation
(4) does not prevent infection

50. A 2-month-old boy with a temperature of 102°F (39°C) is brought to the emergency department by his mother. The mother tells the nurse that her son had a DPT injection one week ago, and asks if this fever is related to the immunization. The nurse's response should be based on the knowledge that

1. if a fever does occur in a child after a DPT, it usually occurs within the first 2 hours.
2. an elevated temperature is very rarely seen in a child after a DPT immunization.
3. if there is a fever after a DPT, it is usually low-grade and appears within the first 48 hours.
4. the child's high fever is a direct response to the DPT immunization and should be treated.

Strategy: Think about each answer choice.
(1) inaccurate, low-grade fever is expected within 24-48 hours
(2) inaccurate, low-grade fever is expected within 24-48 hours
(3) correct–low-grade fever and irritability frequent response to immunization
(4) symptoms should be reported to physician, antipyretic usually prescribed

51. A client has been taking perphenazine (Trilafon) by mouth for two days and now displays the following: head turned to the side, neck arched at an angle, stiffness and muscle spasms in neck. The nurse would expect to give which of the following as a PRN medication?

1. Promazine (Sparine).
2. Biperiden (Akineton).
3. Thiothixene (Navane).
4. Haloperidol (Haldol).

Strategy: Think about each answer choice.
(1) antipsychotic medication, would not relieve the side effects
(2) correct–is an antiparkinsonian agent, used to counteract extrapyramidal side effects the client is experiencing
(3) antipsychotic medication, would not relieve the side effects
(4) antipsychotic medication, would not relieve the side effects

52. The home care nurse is instructing a client recently diagnosed with tuberculosis. It is MOST important for the nurse to include which of the following as a part of the teaching plan?

1. During the first two weeks of treatment, the client should cover his mouth and nose when he coughs or sneezes.
2. It is necessary for the client to wear a mask at all times to prevent transmission of the disease.
3. The family should support the client to help reduce feeling of low self-esteem and isolation.
4. The client will be required to take prescribed medication for a duration of 6–9 months.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) on respiratory precautions for 2–4 weeks after beginning treatment; can send home with family because they are already exposed
(2) not required
(3) important, but not as important as taking medication
(4) correct–necessary to take medication for 6–9 months

53. Which of the following assessment findings would indicate to the nurse the need for more sedation in a client who is withdrawing from alcohol dependence?

1. Steadily increasing vital signs.
2. Mild tremors and irritability.
3. Decreased respirations and disorientation.
4. Stomach distress and inability to sleep.

Strategy: Determine the cause of each answer choice and how it relates to alcohol withdrawal.
(1) correct–indication that the client is approaching delirium tremens, which can be avoided with additional sedation
(2) describes normal mild withdrawal symptoms
(3) would contraindicate giving more sedation
(4) describes expected symptoms of alcohol withdrawal, which will subside as the alcohol is excreted from the body

54. The nurse in the outpatient clinic teaches the mother of a 10-year-old boy with asthma how to prevent future asthmatic attacks. The nurse would be MOST concerned if the mother made which of the following statements?

1. "My son plays the tuba in the grade school band."
2. "My son loves to help his dad rake leaves."
3. "My son participates in after-school activities three days a week."
4. "My son walks one mile to school every day with his friends."

Strategy: Think about what the words mean.
(1) involves forced expiration, would not cause problems with asthma
(2) correct–main cause of asthma is inhaled allergens (animal dander, mold, pollen, dust), would expose child to pollen and dust from leaves
(3) school activities should be encouraged to help development
(4) walking is good exercise, running could be a problem if he has exercise-induced asthma

55. The nurse is caring for a postcholecystectomy client who had the T-tube removed this AM. Two hours after removal of the T-tube, the nurse notes that the 4x4 dressing covering the stab site is saturated with dark, greenish-yellow drainage. It is MOST appropriate for the nurse to take which of the following actions?

1. Remove the dressing and replace it with a more absorbent dressing.
2. Collect a culture and sensitivity specimen of the drainage.
3. Observe the wound for dehiscence.
4. Reinforce the dressing with an 8x10 dressing.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? No. Determine the outcome of each implementation.
(1) correct–expected that a stab wound will continue to drain until the wound seals; nurse should keep wound clean and dry
(2) drainage described is bile, which is expected; no indication of infection
(3) doesn't usually occur
(4) reinforcing dressing might cause infection; change dressing to keep site clean and dry

56. The nurse knows which of the following would be MOST likely to help the family of an emotionally disturbed client manage behaviors at home after discharge from inpatient treatment?

1. Refer the family to Alliance for the Mentally Ill meetings for educational programs and support groups.
2. Provide the family with pamphlets that describe the desired action and side effects of medications the client is taking.
3. Tell the family that it is not their fault that the client behaves inappropriately.
4. Involve the family in the assessment of the client when s/he is first admitted to the hospital.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–this group provides ongoing support and educational information; people who attend have common needs and goals focused on managing the clients' behavior at home
(2) would be helpful, but will not have the ongoing impact of the support group
(3) would be helpful, but will not have the ongoing impact of the support group
(4) would be helpful, but will not have the ongoing impact of the support group

57. An 8-year-old client is returned to the recovery room after a bronchoscopy. The nurse should position the client

1. in semi-Fowler's position.
2. prone, with the head turned to the side.
3. with the head of the bed elevated 45° and the neck extended.
4. supine, with the head in the midline position.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–check vital signs every 15 minutes until stable, assess for respiratory difficulty (stridor
and dyspnea resulting from laryngeal edema or laryngospasm)
(2) would limit respiratory excursion and assessment of breathing
(3) extension of neck could obstruct airway because tongue falls in back of mouth
(4) not best position after procedure

58. Which of the following is a correctly stated nursing diagnosis for a client with abruptio placentae?

1. Infection related to obstetrical trauma.
2. Potential for fetal injury related to abruptio placentae.
3. Potential alteration in tissue perfusion related to depletion of fibrinogen.
4. Fluid volume deficit related to bleeding.

Strategy: Think about each answer choice.
(1) inaccurate for the situation
(2) incorrectly stated
(3) incorrectly stated
(4) correct–abruptio placenta is premature separation of a normally implanted placenta leading to hemorrhage; fluid volume deficit is a major nursing concern with these clients

59. An elderly client is returned to her room after an open reduction and internal fixation of the left femoral head after a fracture. It is MOST important for the nursing care plan to include that the client

1. eat a high-protein, low-residue diet.
2. lie on her unoperated side.
3. exercise her arms and legs.
4. cough and deep breathe.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) diet should be high-residue to prevent constipation due to inactivity
(2) may be positioned on affected side after incision heals
(3) foot flexion exercises should be done every hour to prevent complications
(4) correct–prevents respiratory complications due to immobility following surgery

60. The nursing team includes two RNs, one LPN/LVN, and one nursing assistant. The nurse should consider the assignments appropriate if the nursing assistant is assigned to care for

1. a client with Alzheimer's requiring assistance with feeding.
2. a client with osteoporosis complaining of burning on urination.
3. a client with scleroderma receiving a tube feeding.
4. a client with cancer who has Cheyne-Stokes respirations.

Strategy: Assign to nursing assistants clients with standard, unchanging procedures.
(1) correct–standard, unchanging procedure
(2) requires assessment, should assign to an RN
(3) stable patient with expected outcome, should assign to an LPN/LVN
(4) unstable patient, requires assessment and nursing judgment, should assign to an RN

61. A 23-year-old man is admitted with a subdural hematoma and cerebral edema after a motorcycle accident. Which of the following symptoms should the nurse expect to see INITIALLY?

1. Unequal and dilated pupils.
2. Decerebrate posturing.
3. Grand mal seizures.
4. Decreased level of consciousness.

Strategy: All answers are assessments. Determine how each relates to increased intercranial pressure.
(1) indicates brainstem damage
(2) late sign of brainstem damage
(3) late sign of increased intracranial pressure
(4) correct–may be confused and stuporous

62. The nurse performs an assessment of an 8-year-old girl diagnosed with scoliosis. Which of the following observations are expected with scoliosis?

1. The girl's thoracic area is asymmetrical.
2. The girl walks with a waddling gait.
3. The girl's lower legs are edematous.
4. The girl has a protruding sternum.

Strategy: Determine the significance of each answer choice and how it relates to scoliosis.
(1) correct–thoracic area becomes noticeably distorted
(2) will see with hip dislocation
(3) seen with circulatory or inflammatory processes
(4) seen with pigeon breast or pectus carinatum

63. A client in the ICU is given procainamide HCl (Pronestyl) slowly IV push. The nurse should withhold the next dose if which of the following was observed?

1. Presence of premature ventricular contractions.
2. Occurrence of severe hypotension.
3. Recurring paroxysmal atrial tachycardia.
4. A sedimentation rate of 10.

Strategy: Determine the cause of each answer choice and how it relates to Pronestyl.
(1) procainamide is given to treat premature ventricular contractions or atrial tachycardia
(2) correct–severe hypotension or bradycardia are signs of an adverse reaction to this medication
(3) procainamide is given to treat premature ventricular contractions or atrial tachycardia
(4) lab value is within normal limits

64. A client with AIDS is seen in the emergency room with complaints of mouth pain, difficulty swallowing, and a white discharge in the back of his throat. The nurse would expect the physician to order

1. metronidazole (Flagyl) 7.5 mg/kg q6h.
2. ketoconazole (Nizoral) 200 mg daily.
3. trimethoprim-sulfamethoxazole (Bactrim) 800 mg PO q12h.
4. rifampin (Rifadin) PO 10 mg/kg daily.

Strategy: The topic of the question is unstated.
(1) antiinfective, used in treatment of intestinal amebiasis, trichomoniasis, inflammatory bowel disease
(2) correct–drug of choice for treatment of candidiasis
(3) treatment for PCP, symptoms of dyspnea, tachypnea, persistent dry cough, fever, fatigue
(4) treatment for tuberculosis, symptoms of fever, chills, night sweats, weight loss, anorexia

65. A young woman is transferred to a psychiatric crisis unit with a diagnosis of a dissociative disorder. The nurse knows which of the following comments by the client is MOST indicative of this disorder?

1. "I keep having recurring nightmares."
2. "I have a headache and my stomach has bothered me for a week."
3. "I always check the door locks three times before I leave home."
4. "I don't know who I am and I don't know where I live."

Strategy: Think about each answer choice.
(1) posttraumatic stress disorder (PTSD) is characterized by anxiety and stress symptoms that occur after an intense traumatic event; characteristic symptoms are hypervigilance, insomnia, and recurring nightmares
(2) somatoform disorder (or hypochondria) is concerned with physical and emotional health, accompanied by various bodily complaints for which there is no physical basis
(3) reflects the compulsive checking behavior of the anxiety associated with obsessive-compulsive disorder
(4) correct–dissociative disorders characterized by either a sudden or a gradual disruption in the integrative functions of identity, memory, or consciousness; disruption may be transient or may become a well-established pattern; development of these disorders is often associated with exposure to a traumatic event

66. An older woman comes to the outpatient clinic because she has not been feeling well for several days. During the admission interview, the nurse learns that the client has a history of congestive heart failure (CHF), is on a low-sodium diet, and has been taking chlorothiazide (Diuril) 500 mg PO daily for 6 months. Diagnostic tests indicate: sodium 127mEq/L, potassium 3.8mEq/L, glucose 110mg/dL, and normal chest x-ray. The signs and symptoms the nurse would expect the client to exhibit include

1. sticky mucous membranes, decreased urinary output, and firm, rubbery tissues.
2. cool moist skin, fine hand tremors, and mental confusion.
3. headache, apprehension, and lethargy.
4. shortness of breath, chest pain, and anxiety.

Strategy: Determine the significance of each answer choice.
(1) symptoms of hypernatremia, along with restlessness, weakness, coma, tachycardia, flushed skin, oliguria, fever
(2) symptoms of hypoglycemia, normal blood sugar 70-110 mg/dL
(3) correct–symptoms of hyponatremia along with muscle twitching, convulsions, diarrhea, fingerprinting of skin
(4) symptoms of CHF, chest x-ray clear, no other information provided

67. The nurse is caring for a patient following an appendectomy. The patient takes a deep breath, coughs, and then winces in pain. Which of the following statements, if made by the nurse to the patient, is BEST?

1. "Take three deep breaths, hold your incision, and then cough."
2. "That was good. Do that again and soon it won't hurt as much."
3. "It won't hurt as much if you hold your incision when you cough."
4. "Take another deep breath, hold it, and then cough deeply."

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–most effective way of deep breathing and coughing, dilates airway and expands lung surface area
(2) should splint incision before coughing to reduce discomfort and increase efficiency
(3) partial answer, should take three deep breaths before coughing
(4) implies coughing routine is adequate, incision needs to be splinted

68. The nurse in a psychiatric emergency room is caring for a client who is a victim of interpersonal violence. The INITIAL priority of the nurse is to

1. encourage the client to verbalize feelings.
2. assess for physical trauma.
3. provide privacy for the client during the interview.
4. help the client identify and mobilize resources and support systems.

Strategy: Think "Maslow."
(1) psychosocial, priority is physical injury
(2) correct–physical, victim may have physical trauma and concealed injuries; assessment is of utmost importance so that the client's physiologic integrity is maintained
(3) psychosocial, done concurrently as the nurse is assessing for physical injury
(4) psychosocial, priority is physical injury

69. A client returns to his room following a myelogram. The nursing care plan should include which of the following?

1. Encourage oral fluid intake.
2. Maintain the prone position for 12 hours.
3. Encourage the client to ambulate after the procedure.
4. Evaluate the client's distal pulses on the affected side.

Strategy: Answers are a mix of assessments and implementations. Is the assessment appropriate? No. Determine the outcome of the implementations.
(1) correct–implementation, fluids should be encouraged to facilitate dye excretion and to maintain normal spinal fluid
(2) implementation, clients are not placed in the prone position
(3) implementation, bedrest is maintained for several hours after the test
(4) assessment, an extremity was not used for injection of the dye

70. The nurse in the well-baby clinic observes a group of children. The nurse notes that one child is able to sit unsupported, play "peek-a-boo" with the nurse and is starting to say "mama" and "dada." The nurse would expect these behaviors in a child that is

1. 5 months of age.
2. 6 months of age.
3. 9 months of age.
4. 1 year of age.

Strategy: Picture each infant.
(1) unable to sit unsupported until 8 months
(2) unable to sit unsupported until 8 months
(3) correct–can pull self up and assume a sitting position at 8 months, can say few words
(4) would be able to say 3–5 words in addition to dada and mama

71. The nurse in the outpatient clinic teaches a client with a sprained right ankle to walk with a cane. What behavior, if demonstrated by the client, would indicate that teaching was effective?

1. The client advances the cane 18 inches in front of her foot with each step.
2. The client holds the cane in her left hand.
3. The client advances her right leg, then her left leg, and then the cane.
4. The client holds the cane with her elbow flexed 60°.

Strategy: "Teaching was effective" indicates a correct behavior.
(1) should advance cane 6–10 inches with body weight on both legs
(2) correct–should hold cane on strong side, widens base of support, reduces stress on affected side
(3) should advance cane, weaker leg, stronger leg
(4) should flex no more than 30°

72. The nurse is performing triage on a group of clients in the emergency department. Which of the following clients should the nurse see FIRST?

1. A 12-year-old oozing blood from a laceration of the left thumb due to cut on a rusty metal can.
2. A 19-year-old with a fever of 103.8°F (39.8°C) who is able to identify her sister but not the place
and time.
3. A 49-year-old with a compound fracture of the right leg who is complaining of severe pain.
4. A 65-year-old with a flushed face, dry mucous membranes, and a blood sugar of 470 mg/dL.

Strategy: Identify the least stable client.
(1) no indication of hemorrhage, will require a tetanus shot
(2) correct–disoriented, requires immediate assessment to determine underlying cause
(3) splint, cover wound with sterile dressing, check temperature, color, sensation, give narcotic
(4) hyperglycemic, give IV fluid, regular insulin

73. If a client develops cor pulmonale (right-sided heart failure), the nurse would expect to observe

1. increasing respiratory difficulty seen with exertion.
2. cough productive of a large amount of thick, yellow mucus.
3. peripheral edema and anorexia.
4. twitching of extremities.

Strategy: Determine how each answer choice relates to cor pulmonale.
(1) common assessment finding of the patient with chronic lung disease
(2) describes a complication of pneumonia
(3) correct–right-sided heart failure is manifested by congestion of the venous system, resulting in peripheral edema; also, there is congestion of the gastric veins, resulting in anorexia and eventual development of ascites
(4) is not seen with this client

74. A 43-year-old man is receiving gemfibrozil (Lopid) 600 mg PO bid. It would be MOST important for the nurse to monitor which of the following?

1. Serum creatine.
2. Erythrocyte sedimentation rate (ESR).
3. AST (aspartate aminotransferase) (SGOT).
4. Arterial blood gasses (ABG).

Strategy: Recall what each lab function is measuring and determine how it relates to gemfibrozil (Lopid).
(1) indicates renal function, normal 0.6–1.2 mg/dL
(2) indicates inflammation, normal 0–20 mm/h
(3) correct–indicates liver function, normal 8–20 U/L, lipid-lowering agent used with patients with high serum triglyceride levels, side effects include abdominal pain, cholelithiasis, take 30 minutes before breakfast and supper
(4) indicates acid/base balance

75. The physician orders ranitidine hydrochloride (Zantac) 150 mg PO qd for a client. The nurse should advise the client the BEST time to take this medication is

1. before breakfast.
2. with dinner.
3. with food.
4. at hs.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) absorption is not affected by food
(2) absorption is not affected by food
(3) absorption is not affected by food
(4) correct–best results when taking once a day

76. After a client has a positive Chlamydia trachomatis culture, she and her husband return for counseling. It would be MOST important for the nurse to ask which of the following questions?

1. “Do you have contacts to identify?”
2. “What is your understanding regarding how chlamydia is transmitted?”
3. “Do you have questions about the culture and its validity?”
4. “Do you have allergies to the medications?”

Strategy: "MOST important" indicates that this is a priority question.
(1) may be part of follow-up
(2) correct–means of transmission of chlamydia may or may not have been made clear to both
partners; nurse should assess this first; is a sexually transmitted disease
(3) most cultures used today have few false positives
(4) would be done later in the nursing assessment

77. A 59-year-old woman with bipolar disorder is receiving haloperidol (Haldol) 2 mg PO tid. She tells the nurse, "Milk is coming out of my breasts." Which of the following responses by the nurse is BEST?

1. "You are seeing things that aren't real."
2. "Why don't we go make some fudge."
3. "You are experiencing a side effect of Haldol."
4. "I'll contact your physician to change your medication."

Strategy: The topic of the question is unstated.
(1) hallucinations usually not seen with patients with bipolar disorder, seen with psychotic disorders
(2) assumption that patient just wants attention
(3) correct–side effects include galactorrhea (excessive or spontaneous flow of milk), lactation, gynecomastia (excessive growth of male mammary glands)
(4) indicates a side effect, not effectiveness of medication

78. A client returns from surgery after having a cholecystectomy, and there is an order for antiembolism stockings. Which of the following would be appropriate teaching regarding wearing the support stockings?

1. The client will need to wear the stockings when her legs cramp.
2. The stockings should be worn the entire time the client is in the hospital.
3. The stockings should be put on in the evening prior to going to bed.
4. After the client gets out of bed and walks around, she should put on the stockings.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) antiembolism stockings should be worn to prevent any discomfort, and to increase the blood
flow
(2) correct–stockings should be worn the entire time client is in the hospital; should be removed for baths and replaced after the skin is dry, and before the client gets out of bed
(3) stockings should be worn during the day and when client is nonambulatory
(4) stockings should be applied before getting out of bed

79. A client is scheduled for a left lower lobectomy. The physician has ordered diazepam (Valium) 2 mg IM for anxiety. The nurse would determine that the medication is appropriate if the client displays which of the following symptoms?

1. Agitation and decreased level of consciousness.
2. Lethargy and decreased respiratory rate.
3. Restlessness and increased heart rate.
4. Hostility and increased blood pressure.

Strategy: Determine if the answer choice relates to Valium.
(1) more indicative of preoperative complications, and should be reported before medications are given
(2) more indicative of preoperative complications, and should be reported before medications are given
(3) correct–observation most indicative for antianxiety drugs is restlessness and increase in heart rate due to circulating catecholamines (fight or flight)
(4) hostility may be best treated by ventilating feelings

80. A client with multiple sclerosis (MS) at 39-weeks gestation is admitted to the labor and delivery unit in active labor. The client's vital signs are: BP 127/72; pulse 72 bpm; cervix is 4 cm dilated; FHT 124 bpm; moderate contractions are 4 minutes apart. The nurse should anticipate the need for which of the following interventions?

1. Prepare to administer IV Pitocin to the client.
2. A reduction in the amount of pain medication administered.
3. Check the client's blood pressure every 5 minutes.
4. Prepare an isolette for the infant.

Strategy: Answers are a mix of assessments and implementations. Does the assessment make sense? No. Determine the outcome of each intervention.

(1) uterine contractions not affected by MS
(2) correct–less pain medication is required due to overall decrease in pain perception due to MS
(3) no reason to assess this frequently
(4) baby's outcome not affected by MS

81. The clinic nurse is performing diet teaching with a 67-year-old client with acute gout. The nurse should teach the client to limit his intake of

1. red meat and shellfish.
2. cottage cheese and ice cream.
3. fruit juices and milk.
4. fresh fruits and uncooked vegetables.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–should be on low-purine diet, should avoid red and organ meats, shellfish, oily fish with bones
(2) calcium-rich foods are not limited with gout
(3) no restriction with gout
(4) high-roughage foods are not limited with gout

82. When assisting with a bone marrow aspiration, the nurse should

1. drop additional sterile supplies onto a sterile tray.
2. have all sterile packs unwrapped for the procedure in case they are needed.
3. reach over the tray and remove contaminated supplies.
4. place the bottle of sterile liquid on the sterile field so it does not splash.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) correct–sterile articles should be dropped at a reasonable distance from the edge of the sterile area
(2) sterile packs should be opened only as needed
(3) never reach an unsterile arm over a sterile field
(4) outside of a bottle containing sterile liquid is not considered to be sterile

83. A 69-year-old client is undergoing his second exchange of intermittent peritoneal dialysis (IPD). Which of the following would require an intervention by the nurse?

1. The client complains of pain during the inflow of the dialysate.
2. The client complains of constipation.
3. The dialysate outflow is cloudy.
4. There is blood-tinged fluid around the intra-abdominal catheter.

Strategy: "Require an intervention" indicates you are looking for a complication.
(1) common complaint, moderate pain is frequently experienced as fluid is instilled during first few exchanges
(2) common complaint due to inactivity, decreased nutrition, use of medications; high-fiber diet and stool softeners help to prevent
(3) correct–indicates peritonitis, also will see nausea and vomiting, anorexia, abdominal pain, tenderness, rigidity
(4) caused by subcutaneous bleeding, common during first few exchanges

84. The nurse is observing care given to a client experiencing severe to panic levels of anxiety. The nurse would intervene in which of the following situations?

1. The staff maintains a calm manner when interacting with the client.
2. The staff attends to client's physical needs as necessary.
3. The staff helps the client identify thoughts or feelings that occurred prior to the onset of the anxiety.
4. The staff assesses the client's need for medication or seclusion if other interventions have failed to reduce anxiety.

Strategy: "Nurse would intervene" indicates that you are looking for an inappropriate response.
(1) appropriate nursing action for this level of anxiety
(2) appropriate nursing action for this level of anxiety
(3) correct–in this level of anxiety, client is unable to process thoughts and feelings for problem solving
(4) appropriate nursing action for this level of anxiety

85. A four-month-old child is admitted with a tentative diagnosis of meningitis. To confirm the diagnosis, a lumbar puncture (LP) is ordered. While assisting the physician with the procedure, it is MOST important for the nurse to

1. appropriately restrain the child.
2. instruct the parents about the procedure.
3. provide support to the child.
4. elevate the head of the bed.

Strategy: Think "Maslow."
(1) correct–primary objective is to prevent trauma to child during the procedure; child must be restrained
(2) not as high a priority as preventing injury to the child
(3) should be done before and/or after the procedure
(4) elevating the head of the bed for a four-month-old will not expose the spinal column

86. A 48-year-old woman is seen in the outpatient clinic for complaints of irregular menses. The client's history indicates an onset of menses at age 14, para 2 gravida 2, and regular periods every 28 to 30 days. The client is divorced and works full time as a bank teller. The nurse knows the MOST probable cause of the client's symptom is

1. emotional trauma and stress.
2. the onset of menopause.
3. the presence of uterine fibroids.
4. a possible tubal pregnancy.

Strategy: "MOST probable" indicates discrimination is required to answer the question.
(1) not enough information given in questions to assume that symptoms are caused by stress
(2) correct–ovarian function gradually decreases and then stops, usually 45-50 years old
(3) benign tumors arising from muscle tissue of uterus, menorrhagia (excessive bleeding) most common symptom along with backache, constipation, dysmenorrhea
(4) usually see history of missed period or spotting with abdominal pain

87. The nurse is caring for a six-year-old boy several hours after the application of a hip spica cast. The patient turns on the call light and complains of pain in his left foot. Which of the following actions should the nurse take FIRST?

1. Elevate the left leg on two pillows.
2. Palpate the cast for warmth and wetness.
3. Administer pain medication as ordered.
4. Check the blanching sign on both feet.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes.
(1) implementation, done to prevent swelling and venous congestion, not helpful to reduce pain
due to circulatory impairment
(2) assessment, not helpful to reduce pain due to circulatory impairment, should not palpate wet
cast, would result in depressions causing pressure
(3) implementation, pain important diagnostic symptom, should not be suppressed or masked
(4) correct–assessment, pain main symptom of circulatory impairment from cast, pressing nail of great toe indicates circulatory function, compare speed with which color returns with result on the opposite side, sluggish return indicates circulatory impairment, too rapid return indicates venous congestion

88. The nurse is caring for clients in the skilled nursing facility. Which of the following clients require the nurse's IMMEDIATE attention?

1. A client admitted for a cerebral vascular accident (CVA) whose prescription for warfarin (Coumadin) expired two days ago.
2. A client in pain who was receiving morphine in an acute care institution and was transferred with a prescription for acetaminophen with codeine.
3. A client who has dysuria and foul-smelling, cloudy, dark amber urine.
4. An immunosuppressed client who has not received an influenza immunization.

Strategy: Determine the least stable client
(1) correct–duration of Coumadin 2–5 days, client at risk for a repeat CVA
(2) anticoagulant takes priority, client still receiving pain medication
(3) painful urination, may indicate infection
(4) anticoagulant takes priority

89. An extremely agitated client is receiving haloperidol (Haldol) IM every 30 minutes while in the psychiatric emergency room. The MOST important nursing intervention is to

1. monitor vital signs, especially blood pressure, every 30 minutes.
2. remain at the client's side to provide reassurance.
3. tell the client the name of the medication and its effects.
4. monitor the anticholinergic effects of the medication.

Strategy: Answers are a mix of assessments and implementations. Is this a situation that requires assessment? Yes. Is there an appropriate assessment? Yes.
(1) correct–assessment, monitoring vital signs is of utmost importance to ensure client safety and physiological integrity; rapid neuroleptization is a pharmacological intervention used to rapidly diminish severe symptoms that accompany acute psychosis; alpha-adrenergic blockade of peripheral vascular system lowers BP and causes postural hypotension
(2) implementation, should be done, but is not highest priority
(3) implementation, should be done, but is not highest priority
(4) assessment, circulatory system takes priority

90. The newborn infant of an HIV-positive mother is admitted to the nursery. Which of the following would the nurse include in the plan of care?

1. Standard precautions.
2. Testing for HIV.
3. Transfer to an acute care nursery facility.
4. Request AZT from the pharmacy.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–provides immediate protective care for the staff members
(2) might be employed, safety is the priority
(3) might be employed, is not a priority
(4) this medication is not used in infancy

91. A client has received an IV antibiotic every eight hours for four days. It is mixed in 100 cc D5W. Which of the following would cause the nurse to be concerned about postinfusion phlebitis?

1. Tenderness at the IV site.
2. Increased swelling at the insertion site.
3. Reddened area or red streaks at the site.
4. Leaking of fluid around the IV catheter.

Strategy: Determine the significance of each assessment and how it relates to phlebitis.
(1) tenderness at the IV site is common
(2) increased swelling at the insertion site may indicate infiltration
(3) correct–characterized by inflammation and reddened areas around site and up length of vein
(4) not indicative of phlebitis

92. The nurse counsels a 70-year-old woman who comes to the outpatient clinic for a routine examination. The history indicates the client takes a laxative tablet twice a day and a laxative suppository once a day. The nurse should suspect the client

1. has an anal fixation resulting from recent loss of her husband.
2. is depressed due to alterations in intestinal absorption and excretion.
3. is experiencing excessive concern with body function due to physical changes.
4. has regressed due to a fear of losing the ability to have bowel movements.

Strategy: Think about each answer choice.
(1) makes judgment without information
(2) constipation common finding in elderly, no information about depression
(3) correct–physical changes occur in late adulthood causing changes in body image, constipation frequent problem of elderly, but reaction by this client is excessive
(4) no information provided about regression

93. The nurse is performing discharge teaching for a client with Addison's disease. It is MOST important for the nurse to instruct the client about

1. signs and symptoms of infection.
2. fluid and electrolyte balance.
3. seizure precautions.
4. steroid replacement.

Strategy: Determine the outcome of each answer choice. Is it desired?
(1) not most important
(2) not most important
(3) not most important
(4) correct–steroid replacement is the most important information the client needs to know

94. A client has a history of oliguria, hypertension, and peripheral edema. Current lab values are: BUN –25, K+ –4.0 mEq/L. Which nutrient should be restricted in the client's diet?

1. Protein.
2. Fats.
3. Carbohydrates.
4. Magnesium.

Strategy: Determine which system is involved and then determine which nutrients need to be restricted.
(1) correct–decreased production of urea nitrogen can be achieved by restricting protein;
metabolic wastes cannot be excreted by the kidneys
(2) decrease the nonprotein nitrogen production, these foods are encouraged
(3) decrease the nonprotein nitrogen production, these foods are encouraged
(4) should not be restricted

95. After a client develops left-sided hemiparesis from a cerebral vascular accident (CVA), there is a decrease in muscle tone. Which of the following nursing diagnoses would be a priority to include in his care plan?

1. Alteration in mobility related to paralysis.
2. Alteration in skin integrity related to decrease in tissue oxygenation.
3. Alteration in skin integrity related to immobility.
4. Alteration in communication related to decrease in thought processes.

Strategy: Think about each answer choice.
(1) not a priority
(2) correct–leading cause of skin breakdown is a decrease in tissue perfusion
(3) not a priority
(4) would be more relevant to right-sided hemiparesis

96. The nurse is caring for clients in the pediatric clinic. A mother reports that her infant's smile is "crooked." The nurse should assess which of the following cranial nerves?

1. III.
2. V.
3. VII.
4. XI.

Strategy: Think about each answer choice.
(1) oculomotor, provides innervation for extraocular movement
(2) trigeminal, provides sensation to face muscles
(3) correct–facial, provides motor activity to the facial muscles
(4) spinal accessory, provides innervation to the trapezius and sternocleidomastoid muscles

97. An adolescent client is ordered to take tetracycline HCL (Achromycin) 250 mg PO bid. Which of the following instructions should be given to this client by the nurse?

1. "Take the medication on a full stomach, or with a glass of milk."
2. "Wear sunscreen and a hat when outdoors."
3. "Continue taking the medication until you feel better."
4. "Avoid the use of soaps or detergents for two weeks."

Strategy: Think about each answer choice.
(1) should be taken on an empty stomach
(2) correct–photosensitivity occurs with the use of this medication
(3) should be taken as directed
(4) unnecessary

98. A client who is positive for human immunodeficiency virus (HIV) is to be discharged and will be taking zidovudine (AZT) at home. Which of the following actions by the nurse is BEST?

1. Review the importance of adhering to a four-hour schedule.
2. Advise the client to buy a timed pill dispenser.
3. Write the schedule of when the medicine should be taken.
4. Encourage self-medication prior to discharge.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) less helpful in the overall teaching-learning process
(2) less helpful in the overall teaching-learning process
(3) correct–planned and written schedule of administration is more effective for adherence to time frames
(4) less helpful in the overall teaching-learning process

99. The nurse recognizes which of the following as a positive response to fluoxetine HC (Prozac)?

1. The nurse notes hand tremors and leg twitching.
2. The client states that he is able to sleep for longer periods of time.
3. The client has an increased energy level and participates in unit activities.
4. The nurse observes that the client is hypervigilant and scans the environment.

Strategy: Think about each answer choice.
(1) can be side effect of the medication
(2) not an effect of Prozac, can actually inhibit sleep; is useful with clients who experience increased sleeping and psychomotor retardation and lethargy
(3) correct–fluoxetine HC (Prozac) is an "energizing" antidepressant; as client begins to demonstrate a positive response, s/he has an increased energy level, is able to participate more in milieu
(4) can be side effect of medication

100. The nurse is supervising the staff caring for four clients receiving blood transfusions. Which of the four clients should the nurse see FIRST?

1. A client complaining of a headache.
2. A client vomiting.
3. A client complaining of itching.
4. A client with neck vein distention.

Strategy: Determine the least stable client.
(1) febrile reaction, symptoms include fever, chills, nausea, headache; treatment is to stop blood and administer aspirin
(2) correct–hemolytic reaction, most dangerous type of transfusion reaction, symptoms include nausea, vomiting, pain in lower back, hematuria; treatment is to stop blood, obtain urine specimen, maintain blood volume and renal perfusion
(3) allergic reaction, symptoms include urticaria, pruritus, fever; treatment is to stop blood, give Benadryl, and administer oxygen
(4) circulatory overload, treatment is to stop blood, position in an upright position, administer oxygen

101. The nurse is planning care for a client on bedrest. To promote evening rest and sleep for this client, it is MOST important for the nurse to

1. provide privacy.
2. give back rubs at hs.
3. assist with a bath every day.
4. encourage daytime activities.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) excessive privacy can limit sensory input
(2) will help client to relax, but is not most important
(3) should encourage client to do as much of his care as he can to maintain independence
(4) correct–provides relief from tension, ensures client naps less during the day, helps client to relax

102. Which nursing interventions would be a priority in preventing complications after a cesarean birth?

1. Turn, cough, and deep breathe.
2. Limit fluid intake.
3. Supply a high-carbohydrate diet.
4. Evaluate skin integrity.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–represents preventive care for respiratory congestion resulting from anesthesia and shallow respirations due to the abdominal incision
(2) fluids should be encouraged
(3) will not prevent complications
(4) does not address a common complication

103. The nurse is caring for a client who has just returned to the postsurgical unit following abdominal surgery for cancer of the colon. It is MOST appropriate for the nurse to take which of the following actions?

1. Determine the stage of loss and grief.
2. Analyze the quality and quantity of pain.
3. Instruct the client to cough and deep breathe.
4. Ask the client to lift his head off the pillow.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Remember Maslow.
(1) physical needs take priority
(2) not most important
(3) implementation, should first assess
(4) correct–should assess whether there are any remaining effects of neuromuscular blocking agents; may block ability to breathe deeply

104. A nurse recognizes that an initial positive outcome of treatment for a victim of sexual abuse by one parent would be that the client

1. acknowledges willing participation in an incestuous relationship.
2. reestablishes a trusting relationship with his/her other parent.
3. verbalizes that s/he is not responsible for the sexual abuse.
4. describes feelings of anxiety when speaking about sexual abuse.

Strategy: Think about each answer choice.
(1) continues the myth of "badness" and that s/he deserved the abuse and actively consented to it
(2) outcome that would be positive but usually is not an initial result of treatment
(3) correct–victim needs assistance to challenge "belief of victims," which includes "I am bad and deserve the abuse"
(4) expected outcome

105. A 38-year-old woman is returned to her room after a subtotal thyroidectomy for treatment of hyperthyroidism. Which of the following, if found by the nurse at the patient's bedside, is nonessential?

1. Potassium chloride for IV administration.
2. Calcium gluconate for IV administration.
3. Tracheostomy set-up.
4. Suction equipment.

Strategy: Answers are all implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–hypokalemia is not expected after this surgery
(2) used to treat tetany resulting from possible damage to parathyroid glands
(3) essential equipment to provide for airway
(4) needed to maintain a patent airway

106. The nurse knows that the client with drug-induced Cushing's syndrome should FIRST be instructed about

1. compression fractures from increased calcium excretion.
2. decreased resistance to stress.
3. the schedule for gradual withdrawal of the drug.
4. changes in secondary sex characteristics.

Strategy: Think about each answer choice.
(1) problems associated with Cushing's syndrome, but are not the first priority
(2) problems associated with Cushing's syndrome, but are not the first priority
(3) correct–if steroids are withdrawn suddenly, the client may die of acute adrenal insufficiency
(4) not seen with this medication

107. Which of the following is a correct instruction by the nurse to the parent of a four-year-old client regarding collecting a specimen to be tested for pinworms?

1. Collect the specimen 30 minutes after the child falls asleep at night.
2. Save a portion of the child's first stool of the day and take it to the physician's office immediately.
3. Collect the specimen in the early morning with a piece of scotch tape touched to the child's anus.
4. Feed the child a high-fat meal, and then save the first stool following the meal.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) specimen should be collected early in the morning after the child awakens
(2) unnecessary, pinworms are not routinely found in the stool
(3) correct–pinworms crawl outside the anus early in the morning to lay their eggs
(4) inappropriate for this situation

108. A client is being discharged with sublingual nitroglycerin (Nitrostat). The client should be cautioned by the nurse to

1. take the medication five minutes after the pain has started.
2. stop taking the medication if a stinging sensation is absent.
3. take the medication on an empty stomach.
4. avoid abrupt changes in posture.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should be taken immediately when pain is felt
(2) presence or absence of a stinging sensation is not indicative of the effect of the drug
(3) should be taken when pain is experienced
(4) correct–nitroglycerin can cause hypotension; client should avoid changing positions quickly to decrease the chances of falling

109. The RN is making nursing assignments for the burn unit. Which of the following indicates the MOST appropriate assignment for a client who has a positive cytomegalovirus (CMV) titer?

1. A nurse with an upper respiratory infection.
2. A young nurse who is eight weeks pregnant.
3. A male nurse who is CMV-negative.
4. An older nurse with 30 years experience.

Strategy: Determine the nurse with the least risk.
(1) those with a cytomegalovirus-positive titer are often immunosuppressed clients who should be protected from other pathogens
(2) CMV is fetotoxic, should inform client of risks
(3) this nurse is at increased risk for developing the disease
(4) correct–most appropriate option due to decreased risk

110. A 13-year-old male with muscular dystrophy (MD) has just developed nocturia. The client wants to know about external catheters. The nurse should base the response on which of the following statements?

1. The catheter can be removed during the day.
2. External catheters are uncomfortable.
3. The catheter would drain into a bag at the bedside or on the wheelchair.
4. The external condom catheter is easy to apply.

Strategy: Think about each answer choice.
(1) correct–being free from any drain bags during the day would appeal to a 13-year-old
(2) is negative
(3) would be embarrassing to a 13-year-old
(4) it would be impossible for a teen with muscular weakness to put on an external catheter

111. A client is seen in the clinic for treatment of chronic back pain. The client mentions to the clinic nurse that at home he applies an ointment prepared from several different herbs that relieves his lower back pain. He asks the nurse, "Should I continue using it?" Which of the following responses by the nurse would be BEST?

1. "No. It might do you more harm than good."
2. "Yes. Continue using it but I don't see how it could help your condition."
3. "You may think it works, but I don't believe home remedies work."
4. "Pain can be relieved in several ways. Consult your physician regarding this home remedy."

Strategy: Remember therapeutic communication.
(1) closed statement
(2) closed statement, casts doubt on efficiency of alternative therapy
(3) focus should be on client, not on nurse's beliefs
(4) correct–pain affects people from different cultures in different ways

112. Which of the following techniques is correct for the nurse to use when changing a large abdominal dressing on an incision with a Penrose drain?

1. Remove the dressing layers one at a time.
2. Clean the wound with Betadine solution and hydrogen peroxide.
3. Clean the drain area first.
4. If the dressing adheres to the wound, pull gently and firmly.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–to avoid dislodging drain, remove the dressing layers one at a time
(2) do not clean a wound with both a Betadine solution and hydrogen peroxide
(3) cleansing of the wound is from the center outward to the edges and from the top to the bottom
(4) incorrect, may dislodge drain

113. Which of the following assessments would a nurse expect to make regarding the developmental stage of a 40-year-old male?

1. Cognitive skills are starting to decline.
2. A balance is found among work, family, and social life.
3. Bone mass begins to increase at this age.
4. The client starts to measure life accomplishments against goals.

Strategy: Think about each answer choice.
(1) does not occur
(2) occurs earlier in development
(3) at age 40, bone mass begins to decrease
(4) correct–is characteristic of midlife crisis

114. The nurse is teaching a 40-year-old man diagnosed with a lower motor neuron disorder to perform intermittent self-catheterization at home. The nurse should instruct the client to

1. use a new sterile catheter each time he performs a catheterization.
2. perform the Valsalva maneuver before doing the catheterization.
3. perform the catheterization procedure every 8 hours.
4. limit his fluid intake to reduce the number of times a catheterization is needed.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should use clean (not sterile) technique, used for clients with lower motor neuron disorders
resulting in flaccid bladder
(2) correct–client holds breath and bears down as if trying to defecate, or uses Crede maneuver
(places hands over bladder and pushes in and down), done to try to empty bladder before catheterization
(3) usually done every 2–3 hours initially, and then increased to every 4–6 hours
(4) should encourage fluids

115. The nurse is preparing client assignments for the day. The nurse should assign a LPN/LVN to which of the following clients?

1. A client who had a total hip replacement and requires assistance with ambulation.
2. A client with type I diabetes mellitus who has bilateral 4+ pitting edema of the feet.
3. A client with cholelithiasis scheduled for a cholecystectomy and receiving IV morphine.
4. A client 6 hours postoperative after cystoscopy to remove a mass in the bladder.

Strategy: The LPN/LVN is assigned to stable patients with expected outcomes.
(1) correct–stable patient with expected outcome
(2) requires the assessment skills of the RN
(3) requires assessment and teaching
(4) requires assessment skills of RN

116. A client is admitted to the outpatient unit in the Cancer Center for chemotherapy. The client is lethargic, weak, and pale. During chemotherapy, which of the following nursing interventions would be MOST important?

1. Establish emotional support.
2. Position for physical comfort.
3. Maintain droplet precautions.
4. Perform handwashing prior to care.

Strategy: Think "Maslow."
(1) appropriate, but not a priority
(2) appropriate, but not a priority
(3) unnecessary during chemotherapy
(4) correct–chemotherapy can lead to immunosuppression, which predisposes client to infection; handwashing is one of most effective means of decreasing infection transmission

117. The nurse is caring for clients on the medical/surgical unit. The nurse identifies that which of the following clients would be MOST at risk for developing herpes zoster?

1. A 19-year-old with a broken tibia in Buck's traction.
2. A 50-year-old with a diabetic foot ulcer.
3. A 62-year-old heart transplant with suspected rejection.
4. An 84-year-old with chronic obstructive pulmonary disease.

Strategy: Think about each answer choice.
(1) has an acute trauma, is not immunocompromised
(2) has a bacterial infection, is not immunocompromised
(3) correct–immunocompromised due to immune suppression therapy, clients with compromised immune system at risk for reactivation of the varicella zoster virus
(4) has chronic disease, is not immunocompromised

118. The nurse is caring for a young adult admitted to the hospital with a severe head injury. The nurse should position the patient

1. with his neck in a midline position and the head of the bed elevated 30°.
2. side-lying with his head extended and the bed flat.
3. in high Fowler's position with his head maintained in a neutral position.
4. in semi-Fowler's position with his head turned to the side.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–decreases intracranial pressure
(2) decreases venous blood return
(3) too elevated, would increase intracranial pressure
(4) head should be maintained in neutral position

119. A woman at the health clinic asks the nurse if she should get a flu shot. Which of the following factors, if learned by the nurse in the history, would NOT be a reason for this woman to receive the flu vaccine?

1. The client is 69 years old.
2. The client had bronchitis twice last year.
3. The client volunteers at a preschool.
4. The client lives with two large dogs.

Strategy: Think about each answer choice.
(1) recommended for people over 65
(2) recommended for people with chronic respiratory or cardiovascular disease
(3) recommended for people who come in contact with young children
(4) correct–not at risk for getting the flu from a dog

120. The nurse is caring for clients in the pediatric clinic. The mother of a child calls the nurse to say that after administering Dimetane-DC cough syrup to her child, her child becomes very excitable and restless. The MOST appropriate action for the nurse to take is to

1. report the child's behavior to the physician to alert the physician to the potential need for a change in medication.
2. instruct the mother to administer half the ordered amount in all future doses to limit this behavioral response.
3. instruct the mother to give the child a glass of warm milk to dilute any medication left in the stomach.
4. chart the child's response to the medication and alert the staff about the mother's phone call.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–while this type of response to antihistamines is not uncommon in young children, it is undesirable and must be reported to the physician so a change in drug therapy can be initiated
(2) is not within the realm of the nurse's scope of practice, physician must order dose changes
(3) inappropriate
(4) response must be charted and the child's intolerance to the drug documented and reported to other nurses; this is not enough, physician must be alerted so preventive action can be taken

121. A 23-year-old client in the AIDS clinic asks the nurse what he should do for the multiple small, painless, purplish-brown spots on his right leg and ankle. The nurse should instruct the client to

1. clean the spots carefully with soap and warm water twice a week and cover them with a sterile dressing.
2. clean the lesions twice a day with a diluted solution of povidone-iodine (Betadine) and leave them open to the air.
3. shower daily using a mild soap from a pump dispenser and pat the skin dry.
4 soak in a warm tub three times a day and rub the spots with a washcloth.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) if lesions are open and draining they must be cleaned and dressed daily to prevent secondary infection
(2) treatment for herpes simplex virus abscess, not Kaposi's sarcoma
(3) correct–important to keep the skin clean and prevent secondary skin infection
(4) increases risk of secondary skin infection

122. The nurse knows which of the following observations is indicative of chronic cocaine use?

1. Nasal septum disruption.
2. Lack of coordination.
3. Constricted pupils.
4. Craving for sweets and carbohydrates.

Strategy: Determine how each answer choice relates to cocaine.
(1) correct–chronic inhalation creates sores, burns, disruption of mucous membranes, and holes in
the nasal septum
(2) barbiturate abusers typically suffer from lack of coordination
(3) narcotic abusers demonstrate constricted pupils
(4) clients who abuse marijuana, hashish, and/or THC experience cravings for sweets and carbohydrates

123. Which of the following statements should the nurse make to a client who is going to self-administer continuous ambulatory peritoneal dialysis (CAPD) at home?

1. "Check your weight daily."
2. "Maintain clean technique at all times during the procedure."
3. "Milk the catheter to encourage extra fluid to be removed from the abdomen."
4. "Eat a well-balanced, low-protein diet."

Strategy: Answers are a mix of assessments and implementations. Is assessment required. Yes. Is the assessment appropriate? Yes.
(1) correct–assessment, daily weight necessary with peritoneum empty to assess fluid volume
status, guidelines for weight gain/loss set by physician
(2) implementation, strict aseptic technique required to prevent contamination, sterile = aseptic,
clean = antiseptic
(3) implementation, don't milk catheter, drainage by gravity only
(4) implementation, encouraged to eat a high-protein diet due to protein loss with CAPD

124. Which of the following nursing interventions is MOST important for a 45-year-old woman with rheumatoid arthritis?

1. Provide support to flexed joints with pillows and pads.
2. Position her on her abdomen several times a day.
3. Massage the inflamed joints with creams and oils.
4. Assist her with heat application and ROM exercises.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) would result in contractures due to the strength of flexor muscles
(2) should encourage range of motion in all joints, not just hip flexors
(3) massaging inflamed joints will add to inflammation and pain
(4) correct–reduces swelling, increases circulation, diminishes stiffness while preserving joint mobility

125. A nonstress test is scheduled for a client at 34-weeks gestation who developed hypertension, periorbital edema, and proteinuria. Which of the following nursing actions should be included in the care plan in order to BEST prepare the client for the diagnostic test?

1. Start an intravenous line for an oxytocin infusion.
2. Obtain a signed consent prior to the procedure.
3. Instruct client to push a button when she feels fetal movement.
4. Attach a spiral electrode to the fetal head.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) would be appropriate for an oxytocin (stress) test
(2) is incorrect because this is noninvasive
(3) correct–nonstress test is a noninvasive test to evaluate the response of the fetal heart rate to the stress of fetal movement; response will be reflected on the fetal monitor
(4) prepares for internal fetal monitoring

126. A client is in cardiogenic shock after a myocardial infarction (MI). Which of the following is a correctly stated nursing diagnosis for this client?

1. Activity intolerance: related to impaired oxygen transport.
2. Altered tissue perfusion related to decreased heart-pumping action.
3. Altered cardiac output related to cardiac ischemia.
4. Potential fluid volume deficit related to decreased intake.

Strategy: Think about each answer choice.
(1) a colon is not acceptable punctuation when stating a nursing diagnosis
(2) correct–correctly stated, appropriate nursing diagnosis
(3) altered cardiac output is not a commonly accepted nursing diagnosis
(4) not appropriate for this client

127. The client is exhibiting symptoms of myxedema. The nursing assessment should reveal

1. increased pulse rate.
2. decreased temperature.
3. fine tremors.
4. increased radioactive iodine uptake level.

Strategy: Determine how each answer choice relates to myxedema.
(1) pulse will decrease
(2) correct–with myxedema there is a slowing of all body functions
(3) associated with hyperthyroidism
(4) associated with hyperthyroidism

128. The physician orders sucralfate (Carafate) 1 g PO bid for a 56-year-old woman taking digoxin (Lanoxin) 0.25 mg qd. The woman asks the nurse if she can take both pills together with her breakfast so she doesn't forget to take them. The nurse should advise the woman to

1. take the Carafate and Lanoxin before breakfast.
2. take the Lanoxin 1 hour before breakfast and the Carafate 1 hour after breakfast.
3. take the Carafate 1 hour before breakfast and the Lanoxin 1 hour after breakfast.
4. take the Carafate and the Lanoxin after breakfast.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) Carafate forms a barrier on the GI mucosa, would decrease absorption of other medications,
separate by 2 hours
(2) Carafate best results on empty stomach
(3) correct–Carafate best results on empty stomach, medications should be separated by 2 hours for maximum absorption
(4) Carafate best results on empty stomach, medications should be separated by 2 hours for maximum absorption

129. In preadmission planning with a client who is to have a renal transplant, the client should be educated by the nurse regarding the need to

1. remind family and friends that there is restricted visiting for at least 72 hours postoperatively.
2. arrange all live plants received postoperatively in one section of the room.
3. continue intermittent peritoneal dialysis for three months following surgery.
4. limit consumption of sodium-free liquids for one year postoperatively.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) correct–transplant clients require protective isolation following surgery
(2) can't have live plants in their room at all
(3) no need for dialysis following transplant
(4) need to force fluids, not restrict them

130. When administering antipsychotic medications parenterally, the nurse should take which of the following actions?

1. Monitor the client's blood pressure while sitting and standing before and after each dose is given.
2. Caution the client not to drink or operate machinery that requires mental alertness for safety.
3. Have an emergency cart available in case of an adverse reaction.
4. Reassure the client that side effects are only temporary.

Strategy: Answers are a mix of assessments and implementations. Does the assessment make sense? Yes.

(1) correct–primary concern with postural hypotension caused by medication and preventing an injury from a fall; monitoring vital signs will provide data to address this concern
(2) not relevant with this classification of medications
(3) not relevant with this classification of medications
(4) not relevant with this classification of medications

131. A client is receiving total parenteral nutrition (TPN). To determine the client's tolerance of this treatment, the nurse should assess for which of the following?

1. A significant increase in pulse rate.
2. A decrease in diastolic blood pressure.
3. Temperature in excess of 98.6°F (37°C).
4. Urine output of at least 30 cc per hour.

Strategy: Determine how each answer choice relates to TPN.
(1) if the pulse rate increases, it might indicate fluid overload
(2) if the diastolic blood pressure decreases, it might indicate shock or lack of blood volume
(3) temperature should remain within normal limits
(4) correct–if the client is being properly hydrated with hypertonic IV such as TPN, urine output needs to be at least 30 cc/h; other nursing action includes assessment of blood glucose levels

132. The visiting nurse is teaching a client how to use esophageal speech following a total laryngectomy. Which of the following actions, if performed by the client, indicates that the teaching was effective?

1. The client swallows air, and then eructates it while forming words with his mouth.
2. The client places a battery-powered device against the side of his neck.
3. The client places a finger over the tracheostomy, forcing air up through the vocal cords.
4. The client covers the stoma in the tracheoesophageal fistula and moves his lips.

Strategy: "Teaching has been effective" indicates a correct response.
(1) correct–describes esophageal speech
(2) describes electric larynx
(3) method of speech for patient with a tracheostomy
(4) describes tracheoesophageal fistula (TEF)

133. The nurse is caring for a client who has just returned to his room after a scleral buckling procedure to repair a detached retina was completed. Which of the following is the MOST important nursing action?

1. Remove reading material to decrease eyestrain.
2. Ask the client if he is nauseous.
3. Assess color of drainage from the affected eye.
4. Maintain sterility during q3h saline eye irrigations.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Think about what the assessments mean.
(1) implementation, would be ineffective
(2) correct–assessment, is important to prevent nausea and vomiting, would increase intraocular pressure, could cause damage to area repaired
(3) assessment, refers to an eye infection, would be important after initial operative day
(4) implementation, eye irrigations are not commonly done following this procedure

134. A four-month-old infant is admitted to the pediatric intensive care unit with a temperature of 105°F (40.5 °C). The infant is irritable, and the nurse observes nuchal rigidity. Which assessment finding would indicate an increase in intracranial pressure?

1. Positive Babinski.
2. High-pitched cry.
3. Bulging posterior fontanelle.
4. Pinpoint pupils.

Strategy: Determine if each answer relates to increased ICP.
(1) normal for the first year of life
(2) correct–high-pitched cry is one of the first signs of an increase in the intracranial pressure in infants
(3) fontanelle should be closed by the third month
(4) with increased pressure, the pupil may respond to light slowly, rather than with the usual brisk response

135. A client comes to the health clinic and tells the nurse that he has been taking acetaminophen (Aspirin-Free Excedrin) daily for 5 months. The nurse would be MOST concerned by which of the following lab results?

1. AST (SGOT) 30 U/L, ALT (SGPT) 27 U/L.
2. Hgb 16.2 g/dL, Hct 46%.
3. WBC 7,000/mm3 .
4. BUN 9 mg/dL.

Strategy: Determine how each answer choice relates to acetaminophen.
(1) correct–can cause liver damage, normal AST (formerly SGOT) 8–20 U/L, normal ALT (formerly SGPT) 8–20 U/L
(2) normal Hgb male 13.5–17.5 g/dL, female 12–16 g/dL, normal Hct male 41–53%, female
36–46%
(3) normal WBC 5,000–10,000/mm3
(4) normal BUN 7–18 mg/dL

136. The nurse is teaching a well-baby class to a group of parents with toddlers. The nurse should encourage the parents to

1. have their children exercise daily.
2. use a playpen whenever possible.
3. provide a safe play area for their children.
4. teach their children noncompetitive activities.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) no specific exercise program is necessary, children of this age in good health are naturally active
(2) limits a child's interaction with the outside world, should be used judiciously
(3) correct–safety is fundamental issue with this age group; they are exploratory in their play
(4) unnecessary, children learn by observing and by participating

137. A two-year-old is admitted to the pediatric unit with numerous bruises, a fractured left humerus, and several lacerations with unexplained origin. The nurse would identify which of the following as a priority nursing action?

1. Report the findings to the Child Protection Agency.
2. Share this information only with other health care professionals.
3 Document this information in the chart.
4. Share the information with the Pediatric Social Worker.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–any suspicion of child abuse should be reported to the Child Protection Agency
(2) does not provide or plan for protection of the child
(3) does not provide or plan for protection of the child
(4) does not provide or plan for protection of the child

138. A 72-year-old patient is admitted to the hospital for treatment of a fractured femur. The patient's wife tells the nurse that he has become very hard of hearing. The nurse might expect the patient to exhibit which of the following characteristics?

1. The patient prefers to be left alone.
2. The patient appears suspicious of strangers.
3. The patient communicates best in writing.
4. The patient's speech is difficult to understand.

Strategy: All answers are assessments. Determine how each assessment relates to this situation.
(1) unrelated to hearing deficit
(2) correct–suspiciousness results from interference with communication
(3) writing may be difficult for patient, depends on intellectual capacity
(4) diminished hearing late in life does not cause speech difficulties

139. The nurse is caring for a client with type I diabetes mellitus (IDDM). The client is receiving nasal oxygen at 4L/min. The student nurse reports that the client has pulled out his nasogastric tube and is picking at this bed covers. The client's BP is 150/90 and pulse is 90. Which of the following actions by the nurse is MOST appropriate?

1. Obtain a pulse oximetry reading.
2. Apply soft wrist restraints.
3. Reorient the client to person and place.
4. Determine the client's blood glucose level.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Is there an appropriate assessment? Yes.
(1) correct–assessment, symptoms indicate reduced oxygen levels
(2) implementation, must assess first to determine problem; all other interventions must be tried before using restraints
(3) implementation, must determine the cause of the behavior before implementing
(4) assessment, symptoms indicate decreased oxygen levels

140. To maintain client safety, the nurse should have which of the following equipment readily available when inserting an Ewald tube?

1. Suction equipment.
2. Blood pressure cuff.
3. Levine tube.
4. Emesis basin.

Strategy: Think about each answer choice.
(1) correct–Ewald tube is a large orogastric tube designed for rapid lavage; insertion often causes gagging and vomiting, suction equipment must be immediately available to reduce the risk of aspiration
(2) not a high priority
(3) not a high priority
(4) not a high priority

141. In planning anticipatory guidance for parents of a beginning school-aged child, it is MOST important for the nurse to include which of the following?

1. Teach the child to read and write.
2. Teach the child sex education at home.
3. Give the child responsibility around the house.
4. Expect stormy behavior.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) may require some assistance from the parents, but children this age learn at their own rate
(2) unnecessary at this early age
(3) correct–giving children responsibilities allows them to develop feelings of competence and selfesteem through their industry
(4) does not occur until about age 11

142. The nurse is caring for clients in the antepartal clinic. A client at 34-weeks gestation comes to the clinic for treatment of a sprained ankle. The nurse should question which of the following orders?

1. ASA (aspirin) 650 mg PO q4h PRN for pain.
2. Return to the clinic in two weeks.
3. Ice to sprain for 20 minutes qh for 24h.
4. Teach client 3-gait crutch walking.

Strategy: Determine the outcome of each answer choice. Is it desired?
(1) correct–aspirin can cause fetal hemorrhage, do not use during pregnancy
(2) routine follow-up
(3) treat sprain with rest and elevation of affected part; intermittent ice compresses for 24 hours
(4) appropriate gait if client unable to bear weight

143. Which of the following nursing actions would be important for safe administration of oxytocin?

1. Assess respirations and urine output.
2. Administer oxytocin parenterally as the primary IV.
3. Have calcium gluconate available as an antidote.
4. Palpate the uterus frequently.

Strategy: Answers are a mix of assessments and implementations. Is there an appropriate assessment? Yes.

(1) assessment, pertinent to the care of a client receiving magnesium sulfate for preeclampsia
(2) implementation, oxytocin is always given via an infusion pump and is never allowed to be the primary IV
(3) implementation, pertinent to the care of a client receiving magnesium sulfate for preeclampsia
(4) correct–assessment, oxytocin stimulates the uterus to contract, which necessitates frequent assessment of the uterus; prolonged tetanic contraction can lead to a ruptured uterus

144. An adult client has regular insulin ordered before breakfast. The nurse notes that the client's blood glucose level is 68 mg/dL, and the client is nauseated. Which of the following actions should the nurse take?

1. Immediately give the client orange juice to drink.
2. Administer the insulin on time.
3. Withhold the insulin and notify the physician.
4. Return the breakfast tray to the kitchen.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?

(1) may cause vomiting
(2) correct–take insulin or oral agent as ordered, check blood glucose or urine ketones every 3-4
hours, sip 8-12 oz liquid per hour, substitute easily digested soft foods, liquids if solids not tolerated
(3) blood glucose increases during illness even though client can't eat, administer insulin
(4) does not address the client's problem

145. The nurse is caring for client in the Emergency Department of an acute care facility. Four clients have been admitted in the last 10 minutes. Which of the following admissions should the nurse see FIRST?

1. A client complaining of chest pain that is unrelieved by nitroglycerine.
2. A client with third-degree burns to the face.
3. A client with a fractured hip.
4. A client complaining of epigastric pain.

Strategy: Think ABCs.
(1) not the highest priority; airway most important
(2) correct–face, neck, chest, or abdominal burns result in severe edema, causing airway restriction
(3) airway is most important
(4) requires further assessment, airway is a priority

146. The nurse is preparing to perform peritoneal dialysis on a 65-year-old patient. The patient states she had pain the last time the procedure was done. It would be MOST appropriate for the nurse to take which of the following actions?

1. Administer a warm drink to the patient.
2. Administer a warm bath to the patient.
3. Warm the bag of dialysate solution with a heating pad.
4. Warm the bag of dialysate solution in a microwave oven.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) does not affect pain with fluid infusion
(2) does not affect pain with fluid infusion
(3) correct–temperature can be regulated, warming reduces pain caused by cold solution
(4) contraindicated because of unpredictable warming patterns

147. Which of the following symptoms are MOST likely to be observed by the nurse when a client is withdrawing from heroin?

1. Severe cravings, depression, fatigue, hypersomnia.
2. Depression, disturbed sleep, restlessness, disorientation.
3. Nausea and vomiting, tachycardia, coarse tremors, seizures.
4. Runny nose, yawning, fever, muscle and joint pain, diarrhea.

Strategy: Think about the cause of each symptom and how it relates to narcotic withdrawal.
(1) describes cocaine withdrawal
(2) describes amphetamine withdrawal
(3) describes barbiturate withdrawal
(4) correct–narcotic withdrawal is very much like the symptoms of the flu

148. The nurse is caring for a 26-year-old woman immediately after delivery of an 8 lb 4 oz baby girl. The patient's history indicates she was diagnosed with type I diabetes mellitus (IDDM) at age 12. The nurse would expect which of the following changes to occur in the patient?

1. The blood sugar will fall due to a sudden decrease in insulin requirements.
2. The blood sugar will rise due to a rapid decrease in circulating insulin.
3. The blood sugar will gradually rise due to a decreased level of metabolic stress.
4. The blood sugar will gradually fall due to a decrease in food intake.

Strategy: Think about each answer choice.
(1) correct–hormonal interference in glucose metabolism during pregnancy causes insulin requirements to increase then decrease after delivery
(2) blood sugar will fall after delivery
(3) blood sugar level will fall after delivery
(4) fall in blood sugar not primarily caused by decrease in food intake

149. In caring for a client with a nursing diagnosis of rape trauma syndrome, acute phase, the nurse should consider the MOST important initial goal to be that

1. within three to five months, the client will state that the memory of the event is less vivid and distressing.
2. the client will indicate a willingness to keep a follow-up appointment with a rape crisis counselor.
3. the client will be able to describe the results of the physical examination that was completed in the emergency room.
4. the client will begin to express her reactions and feelings about the assault before leaving the emergency room.

Strategy: Think about each answer choice.
(1) valid goal that needs to be addressed, but after the initial goal has been met
(2) valid goal that needs to be addressed, but after the initial goal has been met
(3) valid goal that needs to be addressed, but after the initial goal has been met
(4) correct–is nurse's initial priority to encourage client to begin dealing with what happened by verbalizing her feelings and gaining some acceptance and perspective

150. The nurse is leading an in-service education class on legal issues. Which of the following acts constitutes battery?

1. The nurse restrains an agitated, confused patient in the Emergency Room with a physician's order.
2. The nurse chases a patient who tries to run away while outside for a walk.
3. The nurse holds the arms of a manic patient who struck her while calling for assistance.
4. The nurse administers an injection to a schizophrenic patient who refuses to take the medication by mouth because he believes it is poison.

Strategy: Determine the outcome of each answer choice.
(1) restraining a client to prevent injury to self or others is appropriate
(2) appropriate behavior
(3) restraining a client to prevent injury to self or others is appropriate
(4) correct–battery is harmful or offensive touching of another's person; unless court ordered, clients have the right to refuse medication, even if client is psychotic.