

The client who underwent bilateral adrenalectomy is to receive lifetime supply of steroid replacement, which of the following assessment indicate deficient replacement?

1/1

- a. Gastritis
- b. Hyperglycemia
- c. Hypoglycemia
- d. Weight gain
- e. All of the above

2. A client is tested positive for cretinism, to prevent mental retardation, the nurse anticipate that the doctor will order for

0/1

- a. Levothyroxine
- b. Prednisone
- c. Carbimazole
- d. Iodine
- e. Epinephrine

3. Captopril is prescribed to a client with hypertension, the nurse knowsthat the action of this drug is to

0/1

- a. Cause vasodilation
- b. Blocks action of angiotensin II
- c. Increase heart rate
- d. Stimulates adrenergic receptors in the CNS

4. Anticholinesterase drug is used to patients with Myasthenia Gravis, to assess for the effectiveness of the drug, the nurse should assess for

1/1

- a. Normal respiratory rate in ANTICHOLinesterase in the NMJ
- b. Muscle strength
- c. Improve swallowing
- d. Decreased ptosis

5. Adrenergic agonists –(stimulate the sympa) produces the following, except

0/1

a. Vasoconstrict

b. Bradycardia

c. Bronchodilation

d. No exception

6. A client with hepatic encephalopathy was given Neomycin and Lactulose, the nurse anticipate that these drugs are exerting its therapeutic effect if

0/1

a. The client improve his level of consciousness -

b. The client will have soft stools

c. The client increased excretion of ammonia putrefaction- bacteria act of fecal material= ammonia

d. The client will decrease bacteria in the colon

7. A client was given insulin, to determine the occurrence of the primary adverse effect of insulin, the nurse should monitor for

0/1

a. Increased urine output

b. Pallor (diaphoresis, tachycardia, palpitation , cold, clammy skin,

c. Hyperventilation

d. All of the above

all antipsychotic drugs has anticholinergic effect

8. Anticholinergic effects are seen as adverse effects of antipsychotic drugs, such include the following except

0/1

block cholinergic-Block PNS – block the acetylcholin

a. Drying of the mouth

b. Urinary retention -

c. Constipation

d. Abdominal spasm

9. Parasympathomimetic effects will cause

1/1

a. Miosis -pupillary constriction-

b. Constipation

c. Hypertension

d. All of the above

10. Biphosphonates (Alendronate (Dosamax) are drugs used for treatment of Osteoporosis, the action of this drug is to a. Decrease osteoclast a

0/1

3 bone cell

1. psteo

a. Decrease osteoclast activity – cause bone restriction-

b. Inhibit osteoblast activity

c. Increased calcium absorption from the GIT

d. All of the above

11. A client receiving a lipid lowering agent is being assessed for possible hepatotoxic effect which is initially manifested as

1/1

a. Elevated AST and ALT (liver function tests)

b. Oliguria -nephrotoxicity

c. Abdominal pain -

d. All of the above

12. Which are routes of drug excretion?1. GI tract; feces2. Genitourinary (GU) tract; urine3. Lymphatic system4. Circulatory system; blood/plasma5. Respiratory system; exhalation

1/1

a. 1,2,3

b. 1,2,4

c. 1,2,5

d. 1,2,3,4,5

0 of 1 points

The GI system is a primary route for drug excretion. The GU and the respiratory systems do function in the excretion of drugs. The lymphatic and circulatory systems are involved with drug distribution, not drug excretion.

14. Which route(s) enable(s) drug absorption more rapidly than the subcutaneous route? 1. IV route 2. IM route 3. Inhalation/sublingual 4. Intradermal route 5. Enteral route

0/1

a. 1,2,3

b. 1,2,4

c. 1,2,5

d. 1,2,3,4,5

0 of 1 points

IV route of administration enables drug absorption more rapidly than the subcut route. IM route of administration enables drug absorption more rapidly because of greater blood flow per unit weight of muscle. Inhalation/sublingual route of administration enables drug absorption more rapidly than the subcut route. Intradermally administered drugs are absorbed more slowly because of the limited available blood supply in the dermis. Enteraly administered drugs are absorbed more slowly because of the biotransformation process.

15. The nurse recognizes that which factor(s) would contribute to digoxin toxicity in a 92-year-old patient? 1. Taking the medication with meals 2. Prolonged half-life of the drug digoxin 3. Impaired renal function 4. Diminished mental capacity

0/1

a. 1,2

b. 2,3

c. 3,4

d. 1,2,3,4

0 of 1 points

Impaired renal and hepatic function in older adults impairs metabolism and excretion of drugs, thus prolonging the half life of a medication. Food would decrease the absorption of the drug. Diminished mental capacity does not contribute to drug toxicity unless it is due to administration errors.

16. Which statement(s) about variables that influence drug action is/are true? 1. An older adult will require increased dosage of a drug to achieve the same therapeutic effect as that seen in a younger person. 2. Body weight can affect the therapeutic

response of a medication. 3. Chronic smokers may metabolize drugs more rapidly than nonsmokers. 4. A patient's attitude and expectations affect the response to medication. 5. Reduced circulation causes drugs to absorb more rapidly.

0/1

a. 1,2,3

b. 2,3,4

c. 3,4,5

d. 1,2,3,4,5

36 of 116 points

Body weight can affect response to medications; typically, obese patients require an increase in dosage and underweight patients a decrease in dosage. Chronic smoking enhances metabolism of drugs. Attitudes and expectations play a major role in an individual's response to drugs. Older adults require decreased dosages of drugs to achieve a therapeutic effect. Decreased circulation causes drugs to absorb more slowly.

17. Teratogenic drugs, 1. Thalidomide 2. chloramphenicol 3. Tetracycline 4. Amoxicillin 5. Paracetamol

1/1

a. 1,2

b. 1,2,3

c. 1,2,3,4

d. 1,2,3,4,5

18. The safety of the drug is assured in maintaining

0/1

a. Recommended dose

b. Therapeutic level

c. Loading dose

d. Stock dose

e. All of the above

19. What is the most reliable method to calculate a pediatric patient's medication dosage?

0/1

a. Age

b. Height

c. Weight

d. Placement on a growth scale

20. The nursing assessment identifies that the client is nauseated and cannot take acetaminophen (Tylenol) orally. Which is true regarding the substitution of this medication to suppository form?

0/1

a. It is standard practice when the patient is unable to take the ordered medication.

b. It is acceptable if the patient agrees to the altered route form.

c. It is preferable to having the patient miss a dose of the medication.

d. It is contraindicated without an order from the physician.

21. Which example best demonstrates safe drug administration by the nurse?

1/1

a. Administering an oral medication with the patient sitting upright – prevent aspiration

b. Asking children to say their name before administering the medication

c. Leaving the medications on the bedside stand after verifying patient identification

d. Returning the unused portion of a medication to a stock supply bottle

22. The nurse is preparing to administer Lanoxin to a patient on the telemetry unit. In addition to understanding the patient's diagnosis, the nurse must also know which characteristic(s) of the medication? 1. Chemical composition 2. Adverse effects 3. Expected actions 4. Contraindications for use 5. Usual dosing

1/1

a. 1,2,3,4

b. 2,3,4,5

c. 3,4,5

d. 1,2,3,4,5

23. A nurse calculates the pediatric patient's medication dosage using Clarks rule and uses what formula?

1/1

- a. Infants age in months/150 months times the average adult dose
- b. Childs age in years/child's age in years plus 12 times the average
- c. Weight of child in pounds/150 pounds times the average adult dose
- d. Surface area in square meters/1.73 times the average adult dose

24. The nurse receives a new medication order for a patient to administer 600 mg of medication per day in equally divideddoses everyy 6 hours. How many mg of the drug should thenurse administerr for each dose?

0/1

- a. 150 mg (600/4)
- b. 75 mg
- c. 100 mg
- d. 50 mg

25. A physician orders 500 mL of IV solution be administered over 8hours. If the IV infusion set delivers 15 drops per mL, how manydrops per minute should the nurse administer to the patient?

1/1

- a. 15 drops/min $\frac{500 \times 15}{8 \text{ hrs} \times 60 \text{ min/hr}}$
- b. 20 drops/min
- c. 32 drops/min
- d. 64 drops/min

26. The nurse is teaching a diabetic patient to self-administerHumulin insulin, supplied in a vial labeled 100 units/mL. The provider has ordered 32 units of Humulin insulin to be taken each morning. How many mL of insulin would the patient prepare for onedose?

1/1

- a. 0.032 MI
- b. 0.32 MI (32 units/100 ml)
- c. 3.2 MI

d. 0.64 mL

27. The physician writes an order for oxazepam for a 6-year-old child. The nurse verifies that there is no established dosage for children 6 to 12 years of age for oxazepam. The nurse knows that the usual adult dose is 10 mg tid. What would the nurse calculate the appropriate dose to be?

0/1

a. 0.03 mg tid Pediatric dose- age in years plus 12 x average adult dose = Young's rule
b. 0.3 mg tid
c. 1.8 mg tid

d. 3.3 mg tid

28. The nurse begins administering 500 mL of 5% dextrose and water solution at 01:00 to run over 4 hours. At 02:00, the nurse administers 80 mg gentamicin in 50 cc normal saline to infuse over 30 minutes. How many mL of fluid will the nurse administer to the patient between 02:00 and 03:00?

0/1

a. 175 mL 500 mL/4 hrs
b. 150 mL

c. 125 mL
d. 100 mL

29. The nurse is preparing medication for a 30-month-old child with otitis media in the right ear. The child weighs 33 pounds. The physician has ordered Keflex, 50 mg/kg/d in equally divided doses every 8 hours. The medication concentration is 250 mg/5 mL. How many milliliters should the nurse give the toddler for each dose?

0/1

A. 5 mL
B. 6 mL

C. 10 mL
D. 12 mL

30. An adolescent is admitted to the intensive care unit with diabetic ketoacidosis. The nurse prepares a continuous insulin infusion of 100 units (U) regular insulin in 500

milligram normal saline. When documenting this medication, how many units of regular insulin will this patient receive per milligram of IV solution?

1/1

- a. 0.175 U/milligram
- b. 0.2 U/milligram $100\text{u}/500\text{ mg} = 0.2\text{u}/\text{mg}$
- c. 0.25 U/milligram
- d. 0.5 U/milligram

31. A patient with Ulcerative colitis and have had 10 episodes of bloody diarrhea is awake, alert, and oriented and has vital sign measurements of: blood pressure 130/90 mm Hg, pulse 118 beats/minute, respirations 18/minute, and temperature 98.6F(37C). Which finding should the nurse consider as a possible sign of early shock?

1/1

- a. Respirations 18/min
- b. Heart rate 118 beats/min
- c. Temperature 98.6F (37C)
- d. Blood pressure 130/90 mm Hg

32. A patient involved in a motor vehicle accident has pale mucous membranes, diaphoresis, confusion, blood pressure 88/48 mm Hg, irregular heart rhythm, and metabolic acidosis. Which findings should the nurse recognize as the likely cause of acidosis?

0/1

- a. Hyperventilation
- b. Aerobic metabolism
- c. Inadequate ventilation
- d. Anaerobic metabolism

33. A patient with progressive shock is diaphoretic and confused. The most recent blood pressure measurement was 82/40 mm Hg and a urinary catheter output was 10 mL for 1 hour. Intravenous (IV) fluids are infusing at 150 mL/hr. Which action should the nurse take related to the urine output?

0/1

- a. Encourage oral fluids.

b. Irrigate urinary catheter.

c. Increase IV fluid infusion rate.

d. Check urinary catheter for kinking.

34. A patient who is hemorrhaging has pale mucous membranes, blood pressure 92/52 mm Hg, pulse 160 beats/minute, and respirations 30/minute. The patient is receiving IV fluids at 150mL/hour, has a blood transfusion infusing, and is being provided oxygen via a mask. What should the nurse recognize as the most likely cause of the patient's respiratory rate?

1/1

a. Electrolyte imbalances

b. Inadequate tissue perfusion

c. Rapid rate of fluid replacement

d. Reaction to the blood transfusion

35. Despite aggressive treatment, the condition of a patient in shock continues to worsen. Surgical intervention stops the bleeding, and the shock stabilizes. Which finding should the nurse act upon immediately?

0/1

a. The blood pH is 7.36.

b. Bowel sounds are hypoactive.

c. Urinary output is 15 mL/hour.

d. Pupils are equally reactive to light.

36. After an episode of shock, a patient's laboratory results reveal elevated serum levels of ammonia and bilirubin and decreased plasma proteins and clotting factors. Which organ should the nurse recognize as being damaged from the shock?

1/1

a. Heart

b. Liver

c. Kidneys

d. Intestines

37. The nurse provides comfort measures to maintain normal body temperature and reduce pain and anxiety for a patient who is experiencing septic shock due to gangrenous leg ulcer. What is the effect of the nurse performing these actions?

0/1

- a. Increases fluid volume
- b. Decreases fluid volume
- c. Increases oxygen demand

d. Decreases oxygen demand

38. A patient is receiving a dopamine infusion for cardiogenic shock. What should the nurse expect to assess in the patient because of this medication?

0/1

- a. Pain relief
- b. Decreased heart rate
- c. Increased blood pressure
- d. Increased respiratory rate

39. A patient is admitted with suspected septic shock. Which action should the nurse take first?

0/1

- a. Obtain patient temperature.

b. Insert an IV access device.

- c. Determine if the patient has any medication allergies.
- d. Reassure the patient that everything possible will be done.

40. A patient hemorrhaging from an incision has a blood pressure of 70/0 mm Hg. What type of fluid replacement should the nurse anticipate will be ordered initially?

1/1

- a. 0.9 % normal saline
- b. Fresh frozen plasma
- c. Packed red blood cells
- d. Lactated Ringers with 50 mL albumin

41. A patient is experiencing respiratory distress and mild shock. In which position should the nurse place the patient?

1/1

- a. Prone
- b. Head elevated
- c. Trendelenburg position -modified Trendelenburg for shock-
- d. Flat with elevated foot of bed

42. A patient with a history of a myocardial infarction has chest pain. The patient's skin color is grayish, blood pressure is 88/70 mm Hg, pulse is 116 beats/minute and irregular, and respirations are 30/minute. Which action should the nurse take?

1/1

- a. Place the patient supine.
- b. Notify the charge physician.
- c. Check the urine specific gravity.
- d. Infuse 0.9% normal saline wide open.

43. The spouse of a patient in neurogenic shock asks what is happening to the patient. How should the nurse respond to the spouse?

1/1

- a. This is because of an allergic reaction.
- b. There is a drop in circulating blood volume.
- c. The heart has failed to pump blood throughout the body.
- d. The blood vessels have dilated and lowered the blood pressure.

44. As part of ongoing data collection and care of a patient in shock, the nurse notes a slowing heart rate, systolic blood pressure less than 60 mm Hg, a decreasing temperature, decreasing respiration rate, and scant urine output. These signs and symptoms should indicate to the nurse that the patient is in which stage of shock?

1/1

- a. Compensatory
- b. Progressive
- c. Irreversible
- d. none of the above

45. After collecting data, the nurse suspects that a patient is experiencing cardiogenic shock. Which finding supports this nurse's suspicion?

0/1

- a. Oliguria
- b. Tachypnea
- c. Bronchospasm – anaphylactic shock
- d. Pulmonary edema

46. The nurse is receiving report on patients assigned for the next shift. Which patient should the nurse observe first?

0/1

- a. A patient who has a pressure ulcer and is due for a dressing change
- b. A patient with diabetes who has a blood sugar of 85 and is eating lunch
- c. A patient with cellulitis who is receiving the first dose of IV antibiotics and who is reporting a feeling of tightness in the throat
- d. A patient with sickle cell anemia who is receiving a monthly transfusion of a unit of packed red blood cells who is reporting left knee pain

47. A patient is admitted for care because of heatstroke. Why should the nurse include interventions to prevent the onset of shock?

0/1

- a. The heat causes excessive dilation of veins and arteries.
- b. Inability to tolerate oral fluids could lead to more water lost.
- c. Parasympathetic stimulation causes blood to pool in the extremities.
- d. Excessive water loss through sweating can lead to hypovolemic shock.

48. Which is an early sign of shock?

1/1

- a. Hypotension
- b. Narrowing of pulse pressure
- c. Bradycardia
- d. All of the above

49. Characteristics of compensatory shock except

0/1

- a. Tachycardia
- b. Decreasing urine output
- c. Hypotension
- d. No exception

50. Neurogenic shock will show the following manifestations except

0/1

- a. Hypotension
- b. bradycardia
- c. Loss of Reflexes
- d. Sudden jerky movement

51. A patient is diagnosed with anemia and asks the nurse what nutrients are important for RBC formation. The nurse bases an answer on the understanding that which nutrients are essential for production of healthy red cells?

0/1

- a. Iron, folic acid, and vitamin B12
- b. Vitamin C, vitamin D, and selenium
- c. Vitamin A, calcium, and phosphorus
- d. Aluminum, vitamin E, and beta carotene

52. A patient with iron-deficiency anemia has been taking oral iron supplements. Which test should the nurse review to determine the effectiveness of this intervention?

0/1

- a. Hemoglobin
- b. flushing of face
- c. increase activity
- d. All of the above

53. The nurse is assisting in the development of a care plan for a patient with anemia. Which nursing diagnosis is most common in a patient with anemia?

0/1

- a. Activity Intolerance related to tissue hypoxia
- b. Ineffective Airway Clearance related to dyspnea
- c. Chronic Pain related to bone marrow dysfunction
- d. Risk for Infection related to reduction in circulating WBCs

54. The nurse is preparing to give an injection of iron (Imferon) to a patient with anemia. What is the rationale for using the Z-track method for injection?

0/1

- a. Prevent pain at the site
- b. Prevent tissue damage at the site
- c. Promote absorption of the medication
- d. Prevent discoloration of tissue at the site

55. A patient with thrombocytopenia is having pain. If each of the following medications is ordered, which should the nurse choose to administer?

0/1

- a. Morphine SQ
- b. Meperidine (Demerol) IM
- c. Oxycodone with aspirin (Percodan) PO
- d. Acetaminophen with codeine (Tylenol No. 3) PO

56. The nurse is caring for a patient with thrombocytopenia. Which activity should be avoided?

0/1

- a. Ambulation
- b. Intramuscular injections
- c. Visits from family members
- d. Eating fresh fruits and vegetables

57. A patient with aplastic anemia is to receive an injection of erythropoietin (Epogen). The patient asks what the injection is intended to do. Which should the nurse respond to the patient?

0/1

- a. It will increase production of RBC and other cells.
- b. It works like a blood transfusion to give you extra red blood cells.
- c. It will stimulate your body to produce more of its own red blood cells.
- d. It will increase your energy while your body is recovering from the anemia.

58. A patient is admitted in sickle cell crisis with symptoms of dyspnea and leg pain. The patient's significant other asks, I don't really understand why he is hurting so badly. Which response by the nurse is best?

0/1

- a. The pain is due to a disturbance in cellular metabolism.
- b. The bone marrow is expanding with the sickled cells and that causes pain.
- c. Clumping of abnormal red blood cells blocks the flow of blood through the capillaries.
- d. Bleeding in the joints occurs because red blood cells are being rapidly destroyed by the bone marrow.

59. The nurse is caring for a patient in sickle cell crisis. What is the rationale for providing warm compresses and blankets for this patient?

0/1

- a. Sickle cell crisis causes shivering and discomfort.
- b. Heat helps prevent the cells from becoming sickled.
- c. Heat speeds production of new healthy RBCs.
- d. Heat prevents vasoconstriction and impaired circulation.

60. A patient is admitted to the hospital with hypertension and vertigo related to polycythemia vera (PV). For which treatment should the nurse prepare the patient?

0/1

- a. Myelogram
- b. Splenectomy
- c. Therapeutic phlebotomy
- d. Injection of colony-stimulating factors

61. The nurse is caring for a patient with PV (Polycythemia Vera). Which laboratory study should the nurse monitor to help evaluate the effectiveness of treatment for this patient?

0/1

- a. Hematocrit > 60
- b. Total protein
- c. Blood urea nitrogen (BUN)
- d. WBC differential – distribution of WBC-

62. The nurse is planning discharge teaching for a patient with polycythemia. Which nursing intervention should the nurse consider to help prevent complications in this patient?

0/1

- a. Monitor intake and output.
- b. Avoid use of injections for pain.
- c. Maintain bedrest during treatment.

d. Encourage 3 L of water intake daily.

63. The nurse is caring for a patient with a clotting disorder. Which blood product should the nurse anticipate being prescribed?

0/1

- a. Albumin
- b. Normal saline
- c. Fresh frozen plasma
- d. Packed WBCs

64. The nurse is reviewing the care plan for a patient with disseminated intravascular coagulation. Which nursing intervention is most likely to cause an acute complication in this patient?

0/1

- a. Placing the patient on strict bedrest
- b. Providing a diet that is high in fat and sodium
- c. Administering intramuscular meperidine (Demerol) for pain

d.Allowing a family member with a respiratory infection to visit

65. A nurse is assisting with data collection on a newly admitted patient with a history of hemophilia (most common for men). Which assessment finding indicates that the patient has experienced some severe episodes of bleeding in the past?

0/1

Hemarthrosis- bleeding in the joints

a.Joint deformities

b.Distended abdomen

c.Ecchymoses on the extremities -hematoma in the present -

d.Elevated WBC count

66. The nurse is determining the effectiveness of treatment prescribed for a patient with anemia. Which question should the nurse use to make this evaluation?

0/1

a.Is your appetite improving?

b.Are you sleeping all night?

c.Are you requiring many analgesics?

d.Are you keeping up with your work schedule?

67. A patient is being prepared for splenectomy. What is the purpose of the order for a vitamin K injection? X., 9, 7,2

1/1

a.It corrects a dietary deficiency.

b.It helps correct underlying anemia.

c.It corrects clotting factor deficiencies.

d.It replaces vitamin K lost during night sweats.

68. The nurse suspects a patient has polycythemia. Which hematocrit value is causing the nurse to have this concern?

0/1

a.38%

b.45%

c.47%

d.53%

69. The nurse is providing education to an individual with sickle cell anemia. Which activities should the nurse instruct the patient to avoid? 1.Scuba diving2.Contact sports3.Sexual activity4.Long-distance driving5.Skiing in the mountains6.Standing for long periods

0/1

- a. 1,2
- b. 1,3

- c. 1,4
- d. 1,5**
- e. 1,6

70. Nursing care for a patient who has polycythemia vera would focus in preventing:

1/1

- a. dysrhythmias
- b. hypotension
- c. thrombosis

- d. decubitus ulcers

71. Which of the following is not expected in Polycythemia vera?

0/1

- a. Flushing of face
- b. Erythromelalgia – burning sensation in the extremities
- c. Elevated platelets

- d. Elevated erythropoietin**
- e. None of the above

72. A patient who has Disseminated Intravascular coagulation (DIC) is administered heparin sodium. Which of the following responses, if identified with the patient would indicate that heparin is effective:

0/1

- a. breath sound clear to auscultation
- b. stool negative to occult blood**
- c. pupils equal and reactive to light

- d. oral mucosa pink and moist

73. To which of the following nursing diagnosis would the nurse give priority in the care of a patient whose blood test reveals RBC count of 3.0 M/mm³:

0/1

- a. risk for activity intolerance
- b. risk for fluid volume deficit
- c. risk for impaired skin integrity
- d. risk for infection

74. Which of the following observations of a patient who has pernicious anemia would indicate that the goal of the care has been achieved:

0/1

- a. the patient's skin has no petechiae
- b. the patient has no paresthesia
- c. the patient has no dependent edema
- d. the patient has good appetite

75. A client was diagnosed with Polycythemia. Hematocrit is 60%. This condition is common among

1/1

- a. Children
- b. Women
- c. 60 years old and above
- d. Reproductive years

76. Which of the following is an assessment finding in a client with Erythrocytosis?

0/1

- a. Flushing, headache, claudication, epistaxis
- b. Headache, hypertension, chest pain
- c. Stasis, hypercoagulability, endothelial injury, fever
- d. Hypotension, thrombus formation, dizziness

77. Phlebotomy is ordered for a client with Polycythemia, the nurse knows that such procedure will

0/1

- a. Remove excess plasma in the blood
- b. Increases viscosity of the blood
- c. Deplete iron stores
- d. All of the above

78. A client who underwent Bariatric surgery is at most risk for developing which type of anemia?

0/1

- a. Iron deficiency anemia
- b. Pernicious anemia
- c. Folic acid deficiency
- d. Hemolytic anemia

79. A 28 year old female client is experiencing heavy menstrual flow with dysmenorrhea for more than 7 days. She feels listless and tires all the time. The nurse knows that the cause of the client's symptoms is

0/1

- a. The pain does not allow her to rest so she feels tired all the time
- b. The problem has decreased her hemoglobin levels
- c. The symptoms are not related to heavy menstrual flow
- d. The symptoms must have been there before heavy menstrual flow occurred

80. Which of the following interventions will prevent sickle cell crisis?

0/1

- a. Restrict fluid and sodium
- b. Encourage flu vaccines
- c. Administer prophylactic antibiotic
- d. Administer analgesic as ordered

81. A mother who is Rh- has delivered a baby who is Rh+. This blood type depends on the presence of what antigen in the RBC membrane?

0/1

- a. Antigen A
- b. Antigen B
- c. Antigen A and B
- d. Antigen C

82. Which of the following mother whose husband is Rh+ should receive Rhogam - immunoglobulin?

0/1

- a. An Rh- mother who delivers an Rh – baby
- b. An Rh+ mother who delivers an Rh – baby
- c. An Rh – pregnant who had ectopic pregnancy
- d. All of the above

83. Blood type A+ means

1/1

- a. RBC has antigen A and antigen D
- b. Plasma has antibody B
- c. Both
- d. Neither

84. Blood type O- means

1/1

- a. RBC has no antigen A
- b. RBC has no antigen B
- c. RBC has no antigen D
- d. All of the above

85. The nurse receives during endorsement a baby who had ABO incompatibility. The nurse expects the baby was delivered with

0/1

- a. Neural tube defects
- b. Jaundice
- c. Microcytic RBC
- d. Overweight

86. Which of the following evaluation outcome tells the nurse that the interventions to a client with COPD are ineffective?

0/1

- a. The client has RR 12 cpm
- b. The client has clear breath sound
- c. The client exhibits intolerance to activity
- d. The client is maintained on low flow oxygen

87. A client with COPD has a history of smoking 2 packs of cigarettes for 15 years. Compute for the pack years the patient had smoked

0/1

- a. 30 pack years
- b. 15 pack years
- c. 40 pack years
- d. 600 pack years

88. Which of the following conditions in a client with Emphysema needs further assessment?

0/1

- a. Pulse oximeter reading is 93%
- b. The client's arterial blood gas is 75
- c. The client has dyspnea in walking to the kitchen
- d. The client has fever

89. A client with chronic bronchitis comes to the emergency room in acute exacerbation. The nurse knows that the one prominent clinical manifestation of this condition

0/1

- a. Dyspnea
- b. Cough
- c. Fever
- d. Rusty sputum

90. The nurse diagnosed a client with COPD with impaired gas exchange. Which of the following outcome is appropriate for the diagnosis?

1/1

- a. The client drinks 2 – 3 liters of fluid per day
- b. The client demonstrates the correct way to purse – lip breathing
- c. The client is able to ambulate to the bathroom without dyspnea
- d. The client is able to identify early symptoms of exacerbation

91. The nurse is assessing a client recently diagnosed with chronicbronchitis. Which of the following findings is not expected?

0/1

- a. Clubbing of the client's fingers.
- b. Frequent respiratory infections.
- c. Productive cough
- d. Hacking cough

92. The nurse is assessing a client with acute attack of bronchialasthma. Which of the following symptoms would the nurse expect to find?

1/1

- a. Fever
- b. Rales
- c. Wheezing
- d. Barrel chest

93. The nurse knows that an attack of asthma is becoming severe which of the following occurs?

1/1

- a. Louder wheezing
- b. Severe intercostal retraction
- c. Respiratory rate of 25
- d. Diminished breath sounds

94. A client with mild intermittent asthma will receive

0/1

- a. Inhaled steroids
- b. Oral steroids
- c. Bronchodilator & steroids inhaler
- d. Leukotriene agonists

95. Which of the following statements is correct about mast cell stabilizers? -preventive

0/1 mast cells= histamine > stabilize mast cells> prevent histamine release> prevent asthma attack

- a. "I should take two (2) puffs when I begin to have an asthma attack."
- b. "I must taper off the medications and not stop taking them abruptly."
- c. "These drugs will be most effective if taken at bedtime."

d. "These drugs are not good at the time of an attack."

96. The nurse is checking the spirometry results of a client with acute exacerbation of bronchial asthma. Which of the following is an unexpected finding in this client?

1/1

- a. Increased residual volume
- b. Decreased expiratory reserve volume
- c. Increased tidal volume
- d. Increased functional residual capacity

97. Which of the following assessment finding would indicate a possible bronchial asthma?

0/1

- a. Low O2 saturation
- b. Swelling caused by histamine release
- c. Wheezing on inspiration

d. Wheezing on expiration

- e. All of the above

98. The nurse knows that bronchodilators act by

1/1

- a. Relaxing the smooth muscles of the bronchioles
- b. Loosens phlegm
- c. Decreasing edema of the bronchi -steroids
- d. Prevent histamine release

99. Which of the following is the most common clinical manifestations of pulmonary embolism?

0/1

- a. Positive Homan's sign -DVT/VTE- venous thromboembolism
- b. Crushing chest pain and diaphoresis - MI
- c. Bilateral crackles and cough -Pneumonia
- d. Sudden onset of chest pain and dyspnea -

100. When assessing a client with chest trauma. Which of the following indicates a possible pneumothorax? – air on a pleural space -it will collapse lungs

0/1

- a. Adventitious sound and dyspnea
- b. Tracheal deviation and absent breath sounds -tension pneumothorax
- c. Frothy bloody sputum and consolidation. -pneumonia
- d. Flat sound on percussion, absent breath sound and dyspnea -pleural effusion/hydrothorax
neumothorax- hyper resonant

101. Flail chest develop in a client after trauma, will show which of the following assessment finding?

1/1

- a. Paradoxical breathing
- b. A symmetrical chest expansion
- c. Pain on expiration
- d. All of the above

102. Management of flail chest include the following except

0/1

- a. Narcotics as ordered
- b. Mechanical ventilation
- c. Support lung function
- d. No exception

103. The nurse is monitoring a client who has a right sided chest tube inserted two hours ago. Which of the following should be implemented if the nurse notices that the water seal chamber has no fluctuation?

1/1

- a. Assess for leakage
- b. Increase the amount of wall suction.
- c. Check the tubing for kinks or clots.
- d. Monitor the client's pulse oximeter reading.

104. A client who has left-sided chest tube refuses to do deep breathing exercises due to pain. Which of the following should be done by the nurse?

0/1

- Option 1a. Administer pain medication prior to deep breathing exercises.
- b. Encourage the client to take shallow breaths to help with the pain.

- c. Explain that deep breaths do not have to be taken at this time.
- d. Tell the client that if he doesn't take deep breaths, he could die

105. The nurse is discussing pneumothorax to a group of nursing. Which statement is correct about tension pneumothorax?

0/1

- a. A tension pneumothorax develops when an air-filled bleb on the surface of the lung ruptures.
- b. When a tension pneumothorax occurs, the air moves freely between the pleural space and the atmosphere.
- c. The injury allows air into the pleural space but prevents it from escaping from the pleural space.
- d. A tension pneumothorax results from a puncture of the pleura during a central line placement.

106. The nurse receives an order that the chest tubes will be removed in 30 minutes. Which of the following should be done first?

1/1

- a. Prepare the needed equipment
- b. Administer analgesic as ordered
- c. Inform the X ray department
- d. Position the client

107. Which expected outcome should be given priority in the nursing care plan for a patient with adult respiratory distress syndrome:

0/1

- a. systolic BP blood pressure greater than 90 mmHg
- b. oxygen saturation greater than 95%
- c. respiration rate less than 20/min
- d. heart rate less than 100/min

108. The nurse is caring for a patient who has just had an endotracheal tube inserted. Which of the following actions would the nurse take first:

1/1

- a. inflate the cuff with appropriate volume
- b. auscultate for bilateral breath sound
- c. tape the tube securely in place
- d. suction the pulmonary secretion

109. The client diagnosed with ARDS is transferred to the intensive care department and placed on a ventilator. Which intervention should the nurse implement first?

1/1

- a. Confirm that the ventilator settings are correct.
- b. Verify that the ventilator alarms are functioning properly.
- c. Assess the respiratory status and pulse oximeter reading.
- d. Monitor the client's arterial blood gas results.

110. Which of the following assessment data would make the nurse suspect of developing ARDS?

0/1

- a. Low arterial oxygen when administering high concentration of oxygen
- b. The client is in severe respiratory distress
- c. Breath sounds are clear but pulse oximeter reading is low
- d. The client has distended neck veins and cough

111. A client with ARDS is hooked to a mechanical ventilator, which assessment finding would the nurse suspect that the client develops complication secondary to ventilator?

1/1

Mechanical ventilator= positive pressure to the lungs= barotoma> lung collapse

- a. Urine output is 100 ml in 2 hours
- b. The cardiac monitor is showing sinus tachycardia
- c. Diminished breath sound on one lung
- d. Pulse oximeter greater than 95%

112. The STAT ABG in a client with ARDS were as follows pH 7.38 (7/35-7/45), PaO₂ 92 (80-100), PaCO₂ 38 (35-45), HCO₃ 24 (22-26). What is the priority action by the nurse?

0/1

- a. Continue to monitor the client without taking any action
- b. Encourage the client to take deep breaths and cough.
- c. Administer one (1) amp of sodium bicarbonate IVP.
- d. Notify the respiratory therapist of the ABG results.

113. A client is diagnosed to have ARDS. The nurse knows that ARDS is

0/1

- a. Caused by an acute lung injury
- b. Causing sudden pulmonary edema
- c. Manifesting poor lung compliance
- d. All of the above

114. Which statement by the nurse with sleep apnea is incorrect?

0/1

- a. "If I lose weight and stop smoking cigarettes I may not need treatment for sleep apnea."
- b. "The continuous positive airway pressure (CPAP) holds my airway open with pressure."
- c. "The CPAP will help me stay awake during the day while I am at work."
- d. "It is all right to have a couple of beers at night because I have this CPAP machine"

115. The nurse is preparing a plan to a client post pleurodesis. Which of the following is a collaborative intervention for this patient?

1/1

- a. Monitor the amount of the drainage
- b. Perform complete respiratory assessment every 2 hours
- c. Administer Morphine sulfate IV
- d. Monitor vital signs

116. Pleurodesis is done to

0/1

- a. Decrease rate of fluid accumulation
- b. Separate pleural membranes
- c. Prevent another thoracentesis
- d. All of the above

117. The nurse is assessing a client with chronic bronchitis for recurrent pneumonia. The client is at risk for developing bronchiectasis. The nurse anticipate that the doctor will order for which of the following?

0/1

- a. Intravenous antibiotic for 7 to 10 days
- b. Provide low calorie and low sodium diet
- c. Start TPN
- d. Encourage the client to turn, cough and deep breathe frequently

118. Which of the following assessment data indicates that the client is having Pleural effusion on the right side?

0/1

- a. Crackles and diminished breath sound on the right side
- b. Vesicular breath sounds on the left and resonant on percussion
- c. Absent breath sound and flat on percussion on the right side
- d. Pain on the left side on deep inspiration and difficulty of breathing

119. The client is undergoing spirometry to assess pulmonary function. The student nurse asks the staff nurse, what does it mean when they say that the dead space volume is increased, the staff nurse is correct by saying

1/1

- a. Increased dead space volume means the air that is left in the lung after forceful expiration is increased -residual volume
- b. Increased dead space volume means there is increased volume of air that does not participate in gas exchange
- c. Increased dead space volume means that there is increased amount of air that is normally inhaled or exhaled. Tidal volume
- d. Increased dead space volume means there is increased volume of air that the lungs can hold -total lung capacity

120. Functional residual capacity is increased as well in the patient. The student nurse learns that this is

0/1

- a. Volume of air that is left in the lungs after normal expiration - inspiratory reserve volume
- b. Volume of air that can still be inhaled after normal inspiration
- c. Volume of air that cannot be expelled -residual volume
- d. Volume of air that actually participate in gas exchange – functional volume

121. Vital capacity is decreased in elderly. This is the

0/1

- a. Total volume of air that goes in and out of the lungs in normal respiration - tidal volume
- b. Total volume of air maximally inhaled and exhaled
- c. Total volume of air the lungs can hold -total lung capacity
- d. Total volume of air left in the lungs after forceful expiration =residual volume

122. The student nurse is learning about the possible risk factors for the development of emphysema which include

1/1

- a. Smoking, family history, allergy,
- b. Chronic asthma, family history, allergy, stress
- c. Male patient, asthma, hypertension, and smoking
- d. Family history, chronic asthma, smoking

123. A client with pneumothorax is being assessed. The nurse anticipates that percussion of the unaffected lung is

0/1

- a. Resonant
- b. Hyperresonant

- c. Flat
- d. Dull

124. For a client with thick, tenacious secretions, which of the following is the most appropriate nursing diagnosis?

0/1

- a. Ineffective airway clearance
- b. Ineffective breathing pattern
- c. Impaired gas exchange
- d. Increase oral fluid intake

125. A client is admitted to the hospital due to overdose of barbiturates. Which of the following assessments would the nurse not encounter?

0/1

- a. Respiratory depression
- b. Bradypnea

- c. Respiratory alkalosis
- d. Decreasing O2 saturation

126. The nurse is making a home visit to a 70-year-old with emphysema. Which assessment findings assessment is expected, by the nurse

0/1

- a. Increase AP diameter of the chest
- b. Rales in both lower lung fields
- c. Deep breathing
- d. Decresed antero posterior diameter of the chest

127. Which of the following is a complication of pulmonary embolism?

0/1

- a. Pulmonary hypertension
- b. Left sided heart failure
- c. Heart attack

d. Pneumonia

128. The most common life-threatening cause of heatstroke is non-exertional prolonged exposure to environmental temperature greater than

0/1

a. 38 degrees Celsius

b. 39 degrees Celsius

c. 40 degrees Celsius

d. 41 degrees Celsius

129. Increased mortality is seen in patients with heat index greater than

0/1

a. Greater than 35 degrees Celsius

b. Greater than 37 degrees Celsius

c. Greater than 39 degrees Celsius

d. Greater than 40 degrees Celsius

130. Clinical manifestations of heat stroke include the following

0/1

a. Confusion, tachycardia, headache and hypertension

b. Dry skin, tachycardia, tachypnea and hypotension

c. Bizarre behaviour, anhidrosis, bradycardia

d. All of the above

131. Which of the following methods maybe used to decrease corebody temperature of a client with heat stroke?

0/1

a. Cool sheets and towels or continuous sponging with cool water

b. Apply ice to the neck, groin , chest,and axilla while applying tepid water

c. Cooling blanket or immersion of patient in a cold water bath

d. All of the above

132. Which of the following is a complication of heat stroke?

1/1

- a. Acute renal failure
- b. Seizure
- c. Myocardial injury
- d. All of the above

Situation

1 of 4 points

SITUATION: Ellen, 65 year old is admitted due to anginal pain

133. The nurse knows that the possible cause of angina pectoris is

0/1

- a. Dysrhythmias triggered by stress
- b. Coronary vasospasm -prinzmetal
- c. Minute emboli through the narrowed lumen of the coronary vessels
- d. Spasms of the vessel walls owing to excessive secretion of epinephrine

134. Ellen has nitroglycerine at her bedside to take PRN. The nurse knows that nitroglycerine acts in all of the following ways except

0/1

- a. Causing venous pooling throughout the body
- b. Dilate coronary arteries affected
- c. Dilating coronary arteries to increase oxygen supply
- d. Lowering systemic blood pressure

135. Ellen's angina has become prolonged and has changed and becoming unrelieved by rest. Variant angina is being considered. The nurse knows that priority intervention when another attack happen is

1/1

- a. Place the patient in a semi fowler's position
- b. Administer the prescribed nitroglycerine dose
- c. Administer morphine as ordered
- d. Oxygen administration

136. After administering the prescribed NTG, her BP drops to 80/60, what is the initial action by the nurse

0/1

- a. Administer O2
- b. Refer to the physician

c. Place the lower extremities on 2 pillows

- d. Get the Ecart

Situation

2 of 4 points

SITUATION: A 40 year old male has hypertension and diabetes. He smokes two packs of cigarettes a day. His current concern is calf pain during minimal exercise which decreases with rest.

137. The nurse assesses the patient's symptoms as being associated with peripheral arterial occlusive disease. The nursing diagnosis is probably:

0/1

a. Alteration in tissue perfusion related to compromised circulation

- b. Dysfunctional use of extremities related to muscle spasms

- c. Impaired mobility related to stress associated with pain
- d. Impairment in muscle use associated with pain

138. The nurse knows that the hallmark symptom of peripheral arterial occlusion disease is

1/1

- a. Intermittent claudication pain when waling

- b. Phlebothrombosis
- c. Post phlebitis syndrome
- d. Thrombophlebitis

139. The most important health teaching for this client is

0/1

- a. Elevate legs after work
- b. Stop smoking
- c. Pain reliever as ordered

- d. Avoid trauma

140. Management in this client includes the following, except

1/1

a. Elevate the legs

- b. Analgesic for pain
- c. Avoid trauma
- d. No exception

Situation

2 of 4 points

Situation: A 23 year old nursing student complains of palpitation, chest pain and easy fatigability. After a thorough workup, she is diagnosed to have Mitral valve prolapse. -palpitation

141. This client should avoid which of the following?

1/1

- A. high volumes of fluid intake
- B. aerobic exercise programs
- C. caffeine-containing products
- D. foods rich in protein

142. Upon assessment, which finding is expected of this client condition?

0/1

- a. Murmur
- b. Systemic click over the apex
- c. Mitral click on the 4th ICS left parasternal area
- d. Atrial gallop

143. The most definitive diagnostic test for patients with mitral valve prolapse is

1/1

- a. ECG
- b. 2D echocardiography
- c. Chest X ray
- d. Brain natriuretic peptide

144. Complications of mitral valve prolapse may include

0/1

- a. Mitral regurgitation
- b. Dysrhythmias

c. Both

- d. Neither

Situation

0 of 7 points

Situation: A client with Congestive heart failure

145. The client is admitted to the ICU diagnosed with congestive heart failure (CHF). Which signs/symptoms would the nurse expect to find when assessing this client?

0/1

- a. Heart rate 110, tachypnea and bilateral edema
- b. Crackles all over lung fields that clear with cough.

- c. The client sleeping with head of bed elevated at 45 degrees
- d. Radial pulse rate of 90 and capillary refill time more than 3 seconds

146. The nurse is developing a discharge-teaching plan for the client diagnosed with congestive heart failure and will take digoxin at home. Which intervention should be priority?

0/1

- a. Notify health-care provider of a weight gain of more than one (1) pound in a week.
- b. Teach client how to count the radial pulse when taking digoxin.
- c. Instruct client to remove the saltshaker from the dinner table.

- d. Encourage client to monitor ECG

147. The nurse enters the room of the client diagnosed with congestive heart failure. The client is lying in bed gasping for breath is cool and clammy, and has cyanosis in the mouth. Which intervention would the nurse implement first?

0/1

- a. Relieve patient's anxiety.
- b. Check medications taken.

- c. Take the client's vital signs.
- d. Elevate the head of bed high Fowler's

148. After rendering nursing interventions to a client with congestive heart failure. Which assessment indicates ineffectiveness of the nursing plan?

0/1

- a. The client's peripheral pitting edema has gone from 3+ to 1+.
- b. The client's BP is 110/80 from 150/100.
- c. The client is able to walk around the room without dyspnea.
- d. The client is using accessory muscles for breathing.

149. The nurse is assessing the client diagnosed with congestive heart failure. Which laboratory data would indicate that the client is in severe congestive heart failure?

0/1

- a. Pulmonary edema on Chest x ray and cardiomegaly.
- b. An elevated creatine kinase (CK-MB).
- c. Cardiac catheterization
- d. Decreased albumin in the blood

150. The client diagnosed with congestive heart failure is maintained on Furosemide (Lasix) 40 mg once a day, Digoxin 0.125 mg half tablet daily and Captopril 25 mg OD. Why is it important to monitor serum potassium level?

- a. May cause leg cramps
- b. Furosemide induced hypokalemia can increase digoxin toxicity.
- c. Hyperkalemia is dangerous to the heart
- d. None of the above

0/1

151. The nurse is caring for a client with congestive heart failure class II. It is most important for the nurse to

0/1

- a. Plan all activities throughout the day
- b. Put the client on complete bed rest

- c. Monitor VS every 15 minutes
- d. Place oxygen on bedside

Situation

3 of 8 points

Situation: A client with Acute Coronary Syndrome

152. Which cardiac enzyme would the nurse expect to elevate first in a client diagnosed with a myocardial infarction?

0/1

- a. Creatine phosphokinase (CPK).
- b. Troponin
- c. Myoglobin
- d. CK MB isoenzyme

153. Which of the following is characteristic of MI pain?

1/1

- a. Mid-epigastric pain and pyrosis.
- b. Constant and severe lasting more than 30 minutes
- c. Radiating to the left arm and face.
- d. Excruciating with feeling of impending doom and facial grimace

154. A client diagnosed with unstable angina experienced chest pain while preparing to go home. Which action should the nurse implement first?

0/1

- a. Administer sublingual nitroglycerin.
- b. Obtain a STAT electrocardiogram.
- c. Have the client sit down immediately.
- d. Assess the client's vital signs.

155. Two hours after Percutaneous Transluminal Coronary angioplasty, which of the following assessment data is most important?

1/1

- a. The client is not complaining of pain.
- b. The pressure dressing to the right femoral area is intact.
- c. The client is complaining of numbness in the right foot.
- d. The client's right pedal pulse is 3+ and bounding.

156. The nurse is caring for a client post-acute MI who develops an audible S3. Which of the following should be done by the nurse first?

0/1

- a. Monitor vital signs.
- b. Elevate the head of the client's bed.
- c. Document this as a normal and expected finding.
- d. Administer morphine intravenously.

157. The doctor orders a calcium channel blocker to a client with myocardial infarction. The nurse withholds medication because

0/1

- a. The client's apical pulse is 62.
- b. The client's calcium level is decreased.
- c. The client's ECG is normal.

d. The client's blood pressure is 90/62.

158. When the client asks the nurse about the cause of chest pain in coronary artery disease, the nurse's best response is

0/1

- a. "Chest pain is caused by decreased oxygen to the heart muscle."
- b. "There is ischemia to the myocardium as a result of hypoxemia".
- c. "The heart muscle is unable to pump effectively to perfuse the body."
- d. "Chest pain occurs when the lungs cannot adequately oxygenate the blood".

159. A client with angina pectoris is taking a beta-blocker (lolol family). Which of the following would indicate the client is experiencing an adverse effect?

1/1

- a. The client has a BP of 110/70.
- b. The client has heart rate of 56.

- c. The client is complaining of a headache.
- d. The client's potassium level is 5.0 mEq/L.

Situation

2 of 5 points

Situation: A client with Valvular Heart Disease

160. A client is being seen in the clinic to R/O mitral valve stenosis. Which of the following assessment data indicate an early complication

0/1

- a. The client complains of shortness of breath when walking
- b. The client has jugular vein distention and bipedal edema.
- c. The client complains of chest pain after eating a large meal.
- d. Murmur is heard over the apical area.

161. Which of the following assessment is indicative of tricuspid regurgitation

0/1

- a. Murmur in the 4th ICS left parasternal
- b. Murmur in the apical area
- c. Murmur in the 2nd ICS right parasternal area
- d. Murmur in the 4th ICS right parasternal area

162. The definitive management for severe valvular defects?

0/1

- a. Valvular replacement
- b. Valvuloplasty
- c. Angioplasty
- d. Bypass surgery

163. Valvular heart disease maybe caused by

1/1

- a. Rheumatic disease
- b. Congenital
- c. Infection
- d. All of the above

164. Valvular defects may lead to

1/1

- a. Coronary cardiogenic shock
- b. Non coronary cardiogenic shock**
- c. Obstructive shock
- d. All of the above

Situation

1 of 7 points

Situation: A client with Pericarditi

165. Which of the following is the most prominent clinical manifestation of pericarditis?

0/1

- a. Pulsus paradoxus. – fall of systolic blood pressure >10 mmhg during the inspiratory phase
- b. Complaints of fatigue and arthralgias.
- c. Petechiae and splinter hemorrhages.
- d. Increased chest pain with inspiration.** And friction rub

166. The client is diagnosed with acute pericarditis. Which sign/symptom warrants immediate attention by the nurse?

0/1

- a. Muffled third heart sounds
- b. Flat jugular veins.
- c. Bounding peripheral pulses.
- d. Altered consciousness.**

167. The client is admitted due to pericarditis and in pain. It is most important for the nurse to do which of the following in the emergency room.

0/1

- a. Place the client in an orthopneic position.**
- b. Monitor for friction rub
- c. Monitor vital signs
- d. Assess for signs of cardiac tamponade

168. The client with pericarditis is prescribed a nonsteroidal anti-inflammatory drug (NSAID). Which teaching instruction should the nurse discuss with the client?

0/1

- a. Explain the importance of tapering off the medication.
- b. Discuss that the medication will make the client drowsy.
- c. Instruct the client to take the medication with food.
- d. Tell the client to take the medication when the pain level is around "8."

169. Which of the following signs would indicate that the client with pericarditis is experiencing cardiac tamponade?

0/1

- a. Hypotension, flat neck veins, muffled heart sounds
- b. Hypotension, bounding pulses
- c. Distant heart sounds, friction rub

d. Decreasing BP, muffled heart sounds

170. The client diagnosed with pericarditis is experiencing cardiac tamponade. Which collaborative intervention should the nurse anticipate for this client?

1/1

- a. Refer to the physician
- b. Request STAT cardiac enzymes.
- c. Perform a 12-lead electrocardiogram.
- d. Prepare pericardiocentesis.

171. The client has just had a pericardiocentesis. Which interventions should the nurse implement?

0/1

- a. Monitor vital signs every 15 minutes for the first hour.
- b. Assess the client's heart and lung sounds.
- c. Record the amount of fluid removed as output.

d. All of the above

Situation

12 of 69 points

Situation: A client with infective endocarditis

172. The client with infective endocarditis is admitted to the medical department. Which of the following order should be implemented first?

1/1

- a. Administer intravenous antibiotic.
- b. Obtain blood cultures.**
- c. Schedule an echocardiogram.
- d. Encourage bed rest with bathroom privileges.

173. The following are important risk factors for development of infective endocarditis, except

0/1

- a. Immunocompromised patient
- b. Invasive procedure
- c. Existing valvular disease
- d. No exception**

174. Embolization can complicate infective endocarditis due to

0/1

- a. Dislodgment of microthrombi**
- b. Septicemia
- c. Stasis of blood
- d. All of the above

175. Which of the following procedures/ treatment will not require prophylactic antibiotic?

0/1

- a. Dental extraction
- b. Normal Spontaneous Delivery
- c. Cardiac catheterization
- d. None of the above**

176. Which of the following is a priority independent nursing intervention is the most important to a patient with bacterial endocarditis with mitral regurgitation?

1/1

- a. Manage fever with antipyretic drug
- b. Assess for changes in murmur
- c. Assess for microthrombi
- d. Assess for signs of ecchymoses
- e. All of the above

177. The 66-year-old male client has his blood pressure (BP) of 168/98. Which action should the nurse implement first?

0/1

- a. Tell the client that this is normal for his age.
- b. Instruct the client to see his doctor as soon as possible.
- c. Discuss the importance of eating a low-salt, low-fat, low-cholesterol diet.
- d. Tell the client to monitor BP monthly.

178. Which of the following client should be handled by an experienced nurse?

0/1

- a. The client diagnosed with congestive heart failure who is being discharged in the morning.
- b. The client who is having frequent diarrhea and vomiting.
- c. The client with a heart rate of 115, a respiratory rate of 25, and a blood pressure of 94/63.
- d. The client who is complaining of chest pain with inspiration and a nonproductive cough.

179. The nurse is administering a beta-blocker to the client diagnosed with essential hypertension. Which intervention should the nurse implement?

0/1

- a. Notify the doctor if the potassium level is 3.8 mEq.
- b. Do not administer if the medication if heart rate is 30.
- c. Do not administer the medication if the client's radial pulse is less than 100.
- d. Monitor the client's blood pressure while he or she is lying, standing, and sitting.

180. After receiving the morning endorsement, which client should the nurse assess first?

0/1

- a. The client diagnosed with coronary artery disease who has a BP of 170/100.
- b. The client diagnosed with deep vein thrombosis who is complaining of chest pain.
- c. The client diagnosed with pneumonia and a temperature of 40°C.
- d. The client diagnosed with ulcerative colitis who has non bloody diarrhea.

181. The client diagnosed with essential hypertension asks the nurse, "I don't know why the doctor is worried about my blood pressure. I feel okay." Which statement by the nurse would be the most appropriate response?

0/1

- a. "Damage can be occurring to your heart and kidneys even if you feel okay."
- b. "Unless you have a headache your blood pressure is probably within normal limits."
- c. "When is the last time you saw your doctor? Does he know you are feeling great?"
- d. "Your blood pressure reflects how well your heart is working."

182. The client comes to the emergency room complaining of claudication and leg pain. The nurse knows that this problem is due to

0/1

- a. Peripheral vascular disease (PVD).
- b. Arterial insufficiency.
- c. Deep vein thrombosis (DVT).
- d. Varicose veins

183. A client with arterial ulcer would have which of the following priority nursing diagnosis?

0/1

- a. Impaired skin integrity.
- b. Activity intolerance.
- c. Ineffective health maintenance.
- d. Risk for peripheral neuropathy.

184. The nurse is assessing the client diagnosed chronic arterial ulcer. Which of the following is characteristic assessment of chronic arterial insufficiency?

0/1

a. Hairless skin on the legs.

b. Brittle, flaky toe nails.

c. Petechiae on the soles of feet.

d. Nonpitting ankle edema.

185. The most common sign of abdominal aortic aneurysm is

1/1

a. Chest pain

b. Abdominal bruit.

c. Abdominal pain.

d. Difficulty of breathing.

186. The client is admitted for surgical repair of an 8-cm abdominal aortic aneurysm. Which sign/symptom would make the nurse suspect the client has an expanding Abdominal Aortic Aneurysm?

0/1

a. Complaints of low back pain.

b. Weakened radial pulses.

c. Decreased urine output.

d. Increased abdominal girth.

187. The client asks the nurse, "what caused my varicose veins?"

0/1

a. "You have incompetent valves in your legs."

b. "Your legs have decreased oxygen to the muscle."

c. "There is an obstruction in the saphenous vein."

d. "Your blood is thick and can't circulate properly."

188. Which of the following statements made by the client diagnosed with chronic venous insufficiency is correct?

0/1

- a. "I shouldn't cross my legs for more than 15 minutes."
- b. "I need to elevate the foot of my bed while sleeping."
- c. "I should take a baby aspirin every day with food."
- d. "I should increase my fluid intake to 3000 mL a day."

189. Which of the following assessment is expected in a client with chronic venous insufficiency?

0/1

- a. Absent pedal pulses
- b. Cool skin temperature.
- c. Intermittent claudication.
- d. Pigmented skin

190. Which of the following nursing action would be most important when caring for a patient who has begun treatment with Verapamil: -calcium channel blocker

0/1

- a. auscultating heart sound
- b. assessing capillary refill
- c. palpating pedal pulse
- d. monitoring blood pressure

191. Which of the following question is most important for the nurse to ask when taking history from a patient who presents with symptoms of peripheral arterial occlusive disease:

0/1

- a. do your legs hurt while walking
- b. do you notice swelling in your legs at night
- c. do you have calf pain when you flex your foot
- d. do your feet feel warm after exercise

192. Which of the following instruction should the nurse give to patient who has a history of venous leg ulcers in order to prevent recurrence;

0/1

- a. sit with your legs dependent whenever possible
- b. use warm compress in your legs in the evening
- c. examine your legs for areas of redness everyday
- d. keep your legs flexed when standing for long periods

193. A patient is admitted to the hospital for bilateral vein ligation and stripping of the legs. The patient asks the nurse what will happen to the blood flow in the legs after the surgery. The nurse will explain that the surgery will have which of these effects on the circulation in the lower extremities:

0/1

- a. the blood vessel leading to the vein will collapse spontaneously
- b. the blood flow will be diverted around the decrease portion of the vein
- c. the blood flow will be reestablished after the vein has been anatomically realigned

d. the venous blood flow will be established through the collateral circulation

194. A patient who is connected to cardiac monitor develops a heart rate of 40 beats per minute. Which of the following action should the nurse take first:

1/1

- a. establish intravenous access
- b. call the physician
- c. check the patient's blood pressure
- d. position the patient flat in bed

195. The most prominent symptom of Buerger's disease is

0/1

- a. Numbness and tingling sensation
- b. Pain in the upper extremities
- c. Pain in the lower extremities
- d. All of the above

196. A newly diagnosed client with hypertension insists that there is nothing wrong with him because he feels alright. Which of the following nursing diagnosis is appropriate for this client at this time?

0/1

- a. Ineffective coping related to condition
- b. Anxiety related to fear of the unknown
- c. Knowledge deficit related to the disease
- d. Powerlessness related to anticipated lifestyle changes

197. Which of the following clients is susceptible to develop right-sided heart failure?

0/1

- a. COPD
- b. Patients with pulmonary embolism
- c. Patients with Tricuspid stenosis
- d. All of the above

198. A client with hypertrophic cardiomyopathy was admitted due to heart failure, which of the following Doctor's orders would the nurse question?

0/1 -

- a. Chest X ray
- b. 2 D echocardiography
- c. Furosemide
- d. Digoxin

199. The most appropriate nursing diagnosis for a client with dysrhythmias is

0/1

- a. Ineffective peripheral tissue perfusion
- b. Decrease cardiac output
- c. Impaired gas exchange
- d. Risk for cardiogenic shock

200. The briefest explanation of therapeutic communication in the elderly is that it:

0/1

a.has a specific intent or purpose.

b.is the only form of professional communication.

c.should never be used in a social setting.

d.requires no special skills, just a willingness to listen.

201. The nurse is careful in the use of medical jargon while talking with an older adult patient because the use of medical jargon might become a(n):

0/1

a.opportunity to instruct the patient.

b.effective abbreviated communication shortcut.

c.indicator of formal communication.

d.communication barrier.

202. The nurse uses superficial social conversation to initiate communication because this type of exchange:

1/1

a.lets the patient know that he or she is considered to be a person, not just a patient.

b.encourages sharing of intimate details.

c.establishes the nurses role as a health care provider.

d.blocks more meaningful therapeutic communication.

203. The nurse communicating with an older adult who has a hearing impairment will improve reception by speaking:

0/1

a.in a higher tone, standing directly in front of the patient.

b.more loudly from several feet away.

c.normally with exaggerated hand gestures.

d.in a low tone, bending close to the patient.

204. Seeing a patient with his head in his arms resting on the over-the-bed table, the nurse steps into the room and asks if the patient feels ill. The patient, without raising his head, says, Im fine. he nurse should:

0/1

a sit down next to the bed and say, You dont act fine.

b.pat him on the shoulder and continue on rounds.
c.say, from the doorway, If you need anything, just call me.

d.assist the patient to sit up and say, Now, thats much better, isnt it?

205. The nurse cautions the older man who has diminished depthperception that he will have difficulty:

0/1

a.judging the height of steps

b.reading small print on food labels.
c.reading street signs.
d.seeing in dim light.

206. The home health nurse helps the family improve the safety of the environment for the 85-year-old male patient with Parkinson disease who is at risk for falls related to:

0/1

a.postural hypotension.
b.cognitive changes.
c.altered vision.

d.altered gait -shuffling gait in Parkinson

207. The nurse reminds the older adult who is taking drugs for hypertension that to prevent falls from orthostatic hypotension, the patient should:

0/1

a.ambulate with a walker.
b.avoid hot baths.
c.avoid climbing stairs.

d.**lie on the side of the bed for a moment before ambulating.**

208. The nurse is aware that some older adults deny that they have fallen because they fear that they will:

0/1

a.fall again.

b.be hospitalized for treatment.

c.be seen as frail and dependent.
d.be considered clumsy.

209. After the 82-year-old female patient fell in her home, the homehealth nurse interviewed her about the incident because the information will:

0/1

a.be reflected in the home health nurses documentation.
b.help the patient gain insight into the cause of the fall.
c.be used to guarantee no further falls.

d.be collected for research purposes.

210. The nurse is aware that a fall prevention exercise program for the residents in a long-term care facility is focused on:

0/1

a.improving balance.
b.use of assistive devices.
c.improving circulation.
d.increase in the knowledge base about falls.

211. The nurse keeps the environment warmer for older adults because they are more sensitive to cold because of the age-related changes in their:

0/1

a.metabolism rate.
b.subcutaneous tissue.
c.musculoskeletal system.
d.peripheral vascular system.

212. The nurse cautions the Nursing Assistant to use care when transferring or handling older adults because their vascular fragility will cause:

0/1

a.altered blood pressure.
b.pressure ulcers.
c.pruritus.
d.senile purpura.

213. The nurse assesses a stage I pressure ulcer on an older adult's coccyx by the appearance of a:

1/1

- a. clear blister.
- b. nonblanchable area of erythema.
- c. scaly abraded area.
- d. painful reddened area.

214. The nurse leads a group of postmenopausal older women on a daily 15-minute walking tour through the long-term care facility to:

0/1

- a. improve bone strength.
- b. orient them to their surroundings.
- c. improve their socialization.
- d. increase their appetite.

215. When the perplexed 70-year-old woman asks, How in the world can my bones be brittle when I eat all the right foods? the nurse's most informative reply is:

1/1

- a. Calcium loss is expected in the older adult.
- b. Calcium is continuously withdrawn from bone for nerve and muscle function.
- c. Smoking and alcohol consumption speed calcium loss from the bones.
- d. Walking and standing increase calcium loss from the bone.

216. When the 70-year-old woman complains, I weigh exactly the same as I did when I wore a size 10 and now I can barely squeeze into a size 16, the nurse explains:

0/1

- a. Metabolism in the older adult creates increased adipose tissue.
- b. Postmenopausal women gain adipose tissue related to loss of calcium.
- c. Decrease in muscle mass is replaced with adipose tissue.
- d. Kyphosis causes a redistribution of weight.

217. When the 70-year-old postmenopausal woman asks whether her hormone replacement therapy (HRT) will prevent bone loss, the nurses most helpful response is:

1/1

- a.No. HRT is not helpful after the age of 60.
- b.Yes. HRT will prevent bone loss but can cause a stroke, heart attack, or breast cancer.
- c.No. HRT is reliant on some natural estrogen production from the ovaries.
- d.Yes. HRT is a widely accepted therapy for prevention of bone loss.

218. An 80-year-old woman who has osteoarthritis complains of how ugly her hands have become since she has developed Heberden nodes, which are:

0/1

- a. yellow longitudinal lines in the nails.
- b. thickened discolored fingernails.
- c. darkened areas under the fingernail.

d. bony enlargements of distal joints of the fingers.

219. The nurse modifies the nursing care plan for a 62-year-old woman in an extended-care facility who is suffering a flare in her rheumatoid arthritis to include interventions to:

0/1

- a. increase fluid intake.
- b. schedule several rest periods to balance activity.
- c. reduce salt in the diet.

d. assist with rigorous finger extension exercises.

220. Atrial rhythm can be determined by examining what interval on the ECG strip?

0/1

a. PP interval

- b. QT interval
- c. RR interval

d. TP interval

221. First degree AV block is characterized by:

1/1

- a. A variable heart rate usually slower than 60 bpm
- b. An irregular rhythm
- c. Delayed conduction producing a prolonged PR interval
- d. P waves hidden with the QRS

222. The client's ECG reading shows a P-wave before each QRS complex and the rate is 70. P – R interval is 0.16 sec and consistent in all waves. Which action should the nurse implement?

1/1-1st degree AV block- normal PR- 0/12- 0/20 SE

- a. Document this as normal sinus rhythm.
- b. Call a code
- c. Prepare to administer digoxin per orem.
- d. Assess the client's cardiac enzymes.

223. Which client problem has priority for the client with a cardiac dysrhythmia?

0/1

- a. Alteration in comfort.
- b. Decreased blood pressure
- c. Impaired gas exchange.
- d. Activity intolerance

224. After administering Propranolol to a client with Atrial fibrillation. The nurse evaluates the effectiveness of propranolol by monitoring the

0/1

- a. Blood pressure
- b. Heart rate
- c. ECG
- d. Respiratory rate

225. ECG shows ventricular rate greater than 300 per minute, extremely irregular without specific pattern, QRS is irregular, undulating waves without recognizable QRS complex. Interpretation of this reading is:

0/1

- a. Atrial fibrillation > 300
- b. Atrial flutter
- c. Ventricular fibrillation
- d. Ventricular flutter

226. This is the most common type of dysrhythmia. Majority of patients are asymptomatic. Atrial rate is very fast and the P wave is not recognizable. The nurse knows this as

0/1

- a. Atrial fibrillation
- b. Atrial flutter
- c. Ventricular tachycardia
- d. Ventricular fibrillation

227. T wave represents

0/1

- a. Atrial repolarization
- b. Atrial depolarization
- c. Ventricular depolarization
- d. Ventricular repolarization

228. The normal duration of QRS is

0/1

- a. 0.10 second
- b. 0.12 to 0.20 second
- c. 0.24 second
- d. 0.36 to 0.44 second

229. To gather information about impulse conduction from the atria to the ventricle, study the

0/1

- a. P wave
- b. PR interval
- c. ST segment

d. T wave

230. Atrial and ventricular rates can be determined by counting the small boxes between

0/1

- a. The end of P and the beginning of another
- b. Two consecutive P or R waves
- c. The middle of two consecutive T waves

d. The beginning of P and the end of T wave

231. A patient with symptomatic sinus bradycardia at a rate of 40 beats per minute typically experiences

0/1

a. High blood pressure

b. Hypotension and dyspnea

- c. Facial flushing and ataxia
- d. Calf pain and cough

232. A monitor shows an irregular rhythm and a rate that increases and decreases in consistent cycles. The rhythm most likely represents

0/1

- a. Sinus arrest
- b. Sinus bradycardia

- c. Normal sinus rhythm
- d. Sinus arrhythmia

233. Nebivolol may be used to treat

0/1

- a. Sinus bradycardia

b. Sinus tachycardia

c. Sinus arrhythmia

d. Sinus arrest

234. In the ECG strip, you identify that rhythm is regular, the atrial rate is 310 beats per minute, ventricular rate is 80 beats per minute, the p wave consists of saw – toothed waves, the PR interval is unmeasurable, the QRS complex is 0.08 second, the T wave is unidentifiable, the QT is unmeasurable. You would identify the strip as

1/1

a. Atrial tachycardia

b. Atrial fibrillation

c. Atrial flutter

d. None of the above

235. In controlled atrial fibrillation. The ventricular response rate is

0/1

a. Less than 60 beats per minute

b. Less than or equal to 100 beats per minute

c. Greater than 100 beats per minute

d. Greater than 120 beats per minute

236. The ECG strip show irregular ventricular rhythm, ventricular rate is 130 beats per minute, the P wave is absent, the PR interval and the QT interval are not measurable, QRS complex is wide and bizarre with varying duration and the T wave is opposite the QRS complex. You would interpret the rhythm as

0/1

a. Ventricular fibrillation

b. Ventricular tachycardia

c. Idioventricular rhythm

d. Torsades de pointes

237. In type I second degree block, the PR interval

0/1

a. Varies according to the ventricular response

b. Progressively lengthens until QRS complex is dropped

- c. Remains constant despite an irregular ventricular rhythm
- d. Is unmeasurable

238. The client is in complete heart block. Which intervention should the nurse implement first?

0/1

- a. Prepare to insert a pacemaker.
- b. Administer atropine as ordered.
- c. Obtain a STAT electrocardiogram (ECG).
- d. Monitor vital signs

239. Which of the following is the ECG finding in hypokalemia?

0/1

- a. Presence of U wave
- b. Peak T wave
- c. Prolonged QT
- d. Shortening of the QT

240. Which of the following ECF finding is characteristic of Hypocalcemia.

1/1

- a. Shortening of QT
- b. Prolonged QT
- c. Presence of U wave
- d. Tall T wave

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