MSN

1. Which individual is at greatest risk for developing hypertension?

A. 45 year-old African American lawyer
B. 60 year-old Asian American shop owner
C. 40 year-old Caucasian nurse
D. 55 year-old Hispanic teacher

2. A child who ingested 15 maximum strength acetaminophen tablets 45 minutes ago is seen in the emergency department. Which of these orders should the nurse do first?

A. Gastric lavage PRN
B. Acetylcysteine (mucomyst) for age per pharmacy
C. Start an IV Dextrose 5% with 0.33% normal saline to keep vein open
D. Activated charcoal per pharmacy

3. Which complication of cardiac catheterization should the nurse monitor for in the initial 24 hours after the procedure?

A. angina at rest
B. thrombus formation
C. dizziness
D. falling blood pressure

4. A client is admitted to the emergency room with renal calculi and is complaining of moderate to severe flank pain and nausea. The client's temperature is 100.8 degrees Fahrenheit. The priority nursing goal for this client is

A. Maintain fluid and electrolyte balance
B. Control nausea
C. Manage pain
D. Prevent urinary tract infection

5. What would the nurse expect to see while assessing the growth of children during their school age years?

A. Decreasing amounts of body fat and muscle mass
B. Little change in body appearance from year to year
C. Progressive height increase of 4 inches each year
D. Yearly weight gain of about 5.5 pounds per year

6. At a community health fair the blood pressure of a 62 year-old client is 160/96. The client states "My blood pressure is usually much lower." The nurse should tell the client to

A. go get a blood pressure check within the next 48 to 72 hours
B. check blood pressure again in 2 months
C. see the health care provider immediately
D. visit the health care provider within 1 week for a BP check

7. The hospital has sounded the call for a disaster drill on the evening shift. Which of these clients would the nurse put first on the list to be discharged in order to make a room available for a new admission?

A. A middle aged client with a history of being ventilator dependent for over 7 years and admitted with bacterial pneumonia five days ago
B. A young adult with diabetes mellitus Type 2 for over 10 years and admitted with antibiotic induced diarrhea 24 hours ago
C. An elderly client with a history of hypertension, hypercholesterolemia and lupus, and was admitted with Stevens-Johnson syndrome that morning
D. An adolescent with a positive HIV test and admitted for acute cellulitis of the lower leg 48 hours ago

8. A client has been newly diagnosed with hypothyroidism and will take levothyroxine (Synthroid) 50 mcg/day by mouth. As part of the teaching plan, the nurse emphasizes that this medication:

A. Should be taken in the morning
B. May decrease the client's energy level
C. Must be stored in a dark container
D. Will decrease the client's heart rate

9. A 3 year-old child comes to the pediatric clinic after the sudden onset of findings that include irritability, thick muffled voice, croaking on inspiration, hot to touch, sit leaning forward, tongue protruding, drooling and suprasternal retractions. What should the nurse do first?

A. Prepare the child for x-ray of upper airways
B. Examine the child's throat
C. Collect a sputum specimen
D. Notify the healthcare provider of the child's status

10. In children suspected to have a diagnosis of diabetes, which one of the following complaints would be most likely to prompt parents to take their school age child for evaluation?

A. Polyphagia
B. Dehydration
C. Bedwetting
D. Weight loss

11. A client comes to the clinic for treatment of recurrent pelvic inflammatory disease. The nurse recognizes that this condition most frequently follows which type of infection?

A. Trichomoniasis
B. Chlamydia
C. Staphylococcus
D. Streptococcus

12. An RN who usually works in a spinal rehabilitation unit is floated to the emergency department. Which of these clients should the charge nurse assign to this RN?

A. A middle-aged client who says "I took too many diet pills" and "my heart feels like it is racing out of my chest."
B. A young adult who says "I hear songs from heaven. I need money for beer. I quit drinking 2 days ago for my family. Why are my arms and legs jerking?"
C. An adolescent who has been on pain medications terminal cancer with an initial assessment finding pupils and a relaxed respiratory rate of 10
D. An elderly client who reports having taken a "large crack hit" 10 minutes prior to walking into the emergency room

13. When teaching a client with coronary artery disease about nutrition, the nurse should emphasize

A. Eating 3 balanced meals a day
B. Adding complex carbohydrates
C. Avoiding very heavy meals
D. Limiting sodium to 7 gms per day

14. Which of these findings indicate that a pump to deliver a basal rate of 10 ml per hour plus PRN for pain break through for morphine drip is not working?

A. The client complains of discomfort at the IV insertion site
B. The client states "I just can't get relief from my pain."
C. The level of drug is 100 ml at 8 AM and is 80 ml at noon
D. The level of the drug is 100 ml at 8 AM and is 50 ml at noon

15. The nurse is speaking at a community meeting about personal responsibility for health promotion. A participant asks about chiropractic treatment for illnesses. What should be the focus of the nurse's response?

A. Electrical energy fields
B. Spinal column manipulation
C. Mind-body balance
D. Exercise of joints

16. The nurse is performing a neurological assessment on a client post right CVA. Which finding, if observed by the nurse, would warrant immediate attention?

A. Decrease in level of consciousness
B. Loss of bladder control

C. Altered sensation to stimuli
D. Emotional ability

17. A child who has recently been diagnosed with cystic fibrosis is in a pediatric clinic where a nurse is performing an assessment. Which later finding of this disease would the nurse not expect to see at this time?

A. Positive sweat test
B. Bulky greasy stools
C. Moist, productive cough
D. Meconium ileus

18. The home health nurse visits a male client to provide wound care and finds the client lethargic and confused. His wife states he fell down the stairs 2 hours ago. The nurse should

A. Place a call to the client's health care provider for instructions
B. Send him to the emergency room for evaluation
C. Reassure the client's wife that the symptoms are transient
D. Instruct the client's wife to call the doctor if his symptoms become worse

19. Which of the following should the nurse implement to prepare a client for a KUB (Kidney, Ureter, Bladder) radiograph test?

A. Client must be NPO before the examination
B. Enema to be administered prior to the examination
C. Medicate client with Lasix 20 mg IV 30 minutes prior to the examination
D. No special orders are necessary for this examination

20. The nurse is giving discharge teaching to a client 7 days post myocardial infarction. He asks the nurse why he must wait 6 weeks before having sexual intercourse. What is the best response by the nurse to this question?

A. "You need to regain your strength before attempting such exertion."
B. "When you can climb 2 flights of stairs without problems, it is generally safe."
C. "Have a glass of wine to relax you, then you can try to have sex."
D. "If you can maintain an active walking program, you will have less risk."

21. A triage nurse has these 4 clients arrive in the emergency department within 15 minutes. Which client should the triage nurse send back to be seen first?

A. A 2 month old infant with a history of rolling off the bed and has bulging fontanels with crying
B. A teenager who got a singed beard while camping
C. An elderly client with complaints of frequent liquid brown colored stools
D. A middle aged client with intermittent pain behind the right scapula

22. While planning care for a toddler, the nurse teaches the parents about the expected developmental changes for this age. Which statement by the mother shows that she understands the child's developmental needs?

A. "I want to protect my child from any falls."
B. "I will set limits on exploring the house."
C. "I understand the need to use those new skills."
D. "I intend to keep control over our child."

23. The nurse is preparing to administer an enteral feeding to a client via a nasogastric feeding tube. The most important action of the nurse is

A. Verify correct placement of the tube
B. Check that the feeding solution matches the dietary order
C. Aspirate abdominal contents to determine the amount of last feeding remaining in stomach
D. D. Ensure that feeding solution is at room temperature

24. The nurse is caring for a client with a serum potassium level of 3.5 mEq/L. The client is placed on a cardiac monitor and receives 40 mEq KCL in 1000 ml of 5% dextrose in water IV. Which of the following EKG patterns indicates to the nurse that the infusions should be discontinued?

A. Narrowed QRS complex
B. Shortened "PR" interval
C. Tall peaked T waves
D. Prominent "U" waves

25. A nurse prepares to care for a 4 year-old newly admitted for rhabdomyosarcoma. The nurse should alert the staff to pay more attention to the function of which area of the body?

A. All striated muscles
B. The cerebellum
C. The kidneys
D. The leg bones

26. The nurse anticipates that for a family who practices Chinese medicine the priority goal would be to

A. Achieve harmony
B. Maintain a balance of energy
C. Respect life
D. Restore yin and yang

27. During an assessment of a client with cardiomyopathy, the nurse finds that the systolic blood pressure has decreased from 145 to 110 mm Hg and the heart rate has risen from 72 to 96 beats per minute and the client complains of periodic dizzy spells. The nurse instructs the client to

A. Increase fluids that are high in protein
B. Restrict fluids
C. Force fluids and reassess blood pressure
D. D. Limit fluids to non-caffeine beverages

28. A client has a Swan-Ganz catheter in place. The nurse understands that this is intended to measure

A. Right heart function
B. Left heart function
C. Renal tubule function
D. Carotid artery function

29. A nurse enters a client's room to discover that the client has no pulse or respirations. After calling for help, the first action the nurse should take is

A. Start a peripheral IV
B. Initiate closed-chest massage
C. Establish an airway
D. Obtain the crash cart

30. A client is receiving digoxin (Lanoxin) 0.25 mg. Daily. The health care provider has written a new order to give metoprolol (Lopressor) 25 mg. B.I.D. In assessing the client prior to administering the medications, which of the following should the nurse report immediately to the health care provider?

A. Blood pressure 94/60
B. Heart rate 76
C. Urine output 50 ml/hour
D. Respiratory rate 16

31. While assessing a 1 month-old infant, which finding should the nurse report immediately?

A. Abdominal respirations
B. Irregular breathing rate
C. Inspiratory grunt
D. Increased heart rate with crying

32. The nurse practicing in a maternity setting recognizes that the post mature fetus is at risk due to

A. Excessive fetal weight
B. Low blood sugar levels
C. Depletion of subcutaneous fat
D. Progressive placental insufficiency

33. The nurse is caring for a client who had a total hip replacement 4 days ago. Which assessment requires the nurse's immediate attention?

A. I have bad muscle spasms in my lower leg of the affected extremity.
B. "I just can't 'catch my breath' over the past few minutes and I think I am in grave danger."

C. “I have to use the bedpan to pass my water at least every 1 to 2 hours.”
D. “It seems that the pain medication is not working as well today.”

34. A client has been taking furosemide (Lasix) for the past week. The nurse recognizes which finding may indicate the client is experiencing a negative side effect from the medication?

A. Weight gain of 5 pounds
B. Edema of the ankles
C. Gastric irritability
D. Decreased appetite

35. A client who is pregnant comes to the clinic for a first visit. The nurse gathers data about her obstetric history, which includes 3 year-old twins at home and amiscarriage 10 years ago at 12 weeks gestation. How would the nurse accurately document this information?

A. Gravida 4 para 2
B. Gravida 2 para 1
C. Gravida 3 para 1
D. Gravida 3 para 2

36. The nurse is caring for a client with a venous stasis ulcer. Which nursing intervention would be most effective in promoting healing?

A. Apply dressing using sterile technique
B. Improve the client’s nutrition status
C. Initiate limb compression therapy
D. Begin proteolytic debridement

37. A nurse is to administer meperidine hydrochloride (Demerol) 100 mg, atropine sulfate (Atropisol) 0.4 mg, and promethizine hydrochloride (Phenergan) 50 mg IM to a pre-operative client. Which action should the nurse take first?

A. Raise the side rails on the bed
B. Place the call bell within reach
C. Instruct the client to remain in bed
D. Have the client empty bladder

38. Which of these statements best describes the characteristic of an effective reward-feedback system?

A. Specific feedback is given as close to the event as possible
B. Staff are given feedback in equal amounts over time
C. Positive statements are to precede a negative statement
D. Performance goals should be higher than what is attainable

39. A client with multiple sclerosis plans to begin an exercise program. In addition to discussing the benefits of regular exercise, the nurse should caution the client to avoid activities which

A. Increase the heart rate
B. Lead to dehydration
C. Are considered aerobic
D. May be competitive

40. During the evaluation of the quality of home care for a client with Alzheimer's disease, the priority for the nurse is to reinforce which statement by a family member?

A. At least 2 full meals a day is eaten.
B. We go to a group discussion every week at our community center.
C. We have safety bars installed in the bathroom and have 24 hour alarms on the doors.
D. The medication is not a problem to have it taken 3 times a day.

Answers and Rationale

1. Answer: A: 45 year-old African American lawyer

The incidence of hypertension is greater among African Americans than other groups in the US. The incidence among the Hispanic population is rising.

2. Answer: A: Gastric lavage PRN

Removing as much of the drug as possible is the first step in treatment for this drug overdose. This is best done by gastric lavage. The next drug to give would be activated charcoal, then mucomyst and lastly the IV fluids.

3. Answer: B: thrombus formation

Thrombus formation in the coronary arteries is a potential problem in the initial 24 hours after a cardiac catheterization. A falling BP occurs along with hemorrhage of the insertion site which is associated with the first 12 hours after the procedure.

4. Answer: C: Manage pain

The immediate goal of therapy is to alleviate the client's pain.

5. Answer: D: Yearly weight gain of about 5.5 pounds per year

School age children gain about 5.5 pounds each year and increase about 2 inches in height.

6. Answer: A: go get a blood pressure check within the next 48 to 72 hours

The blood pressure reading is moderately high with the need to have it rechecked in a few days. The client states it is 'usually much lower.' Thus a concern exists for complications such as stroke. However immediate check by the provider of care is not warranted. Waiting 2 months or a week for follow-up is too long.

7. Answer: A: A middle aged client with a history of being ventilator dependent for over 7 years and admitted with bacterial pneumonia five days ago

The best candidate for discharge is one who has had a chronic condition and is most familiar with their care. This client in option A is most likely stable and could continue medication therapy at home.

8. Answer: A: Should be taken in the morning

Thyroid supplement should be taken in the morning to minimize the side effects of insomnia

9. Answer: D: Notify the health care provider of the child's status

These findings suggest a medical emergency and may be due to epiglottitis. Any child with an acute onset of an inflammatory response in the mouth and throat should receive immediate attention in a facility equipped to perform intubation or a tracheostomy in the event of further or complete obstruction.

10. Answer: C: Bedwetting

In children, fatigue and bed wetting are the chief complaints that prompt parents to take their child for evaluation. Bed wetting in a school age child is readily detected by the parents.

11. Answer: B: Chlamydia

Chlamydial infections are one of the most frequent causes of salpingitis or pelvic inflammatory disease.

12. Answer: C: An adolescent who has been on pain medications for terminal cancer with an initial assessment finding of pinpoint pupils and a relaxed respiratory rate of 10

Nurses who are floated to other units should be assigned to a client who has minimal anticipated immediate complications of their problem. The client in option C exhibits opioid toxicity with the pinpoint pupils and has the least risk of complications to occur in the near future.

13. Answer: C: Avoiding very heavy meals

Eating large, heavy meals can pull blood away from the heart for digestion and is dangerous for the client with coronary artery disease.

14. Answer: C: The level of drug is 100 ml at 8 AM and is 80 ml at noon

The minimal dose of 10 ml per hour which would be 40 ml given in a 4 hour period. Only 60 ml should be left at noon. The pump is not functioning when more than expected medicine is left in the container.

15. Answer: B: Spinal column manipulation

The theory underlying chiropractic is that interference with transmission of mental impulses between the brain and body organs produces diseases. Such interference is caused by misalignment of the vertebrae. Manipulation reduces the subluxation.

16. Answer: A: Decrease in level of consciousness

A further decrease in the level of consciousness would be indicative of a further progression of the CVA.

17. Answer: C: Moist, productive cough Option c is a later sign.

Noisy respirations and a dry non-productive cough are commonly the first of the respiratory signs to appear in a newly diagnosed client with cystic fibrosis (CF). The other options are the earliest findings. CF is an inherited (genetic) condition affecting the cells that produce mucus, sweat, saliva and digestive juices. Normally, these secretions are thin and slippery, but in CF, a defective gene causes the secretions to become thick and sticky. Instead of acting as a lubricant, the secretions plug up tubes, ducts and passageways, especially in the pancreas and lungs. Respiratory failure is the most dangerous consequence of CF.

18. Answer: B: Send him to the emergency room for evaluation

This client requires immediate evaluation. A delay in treatment could result in further deterioration and harm. Home care nurses must prioritize interventions based on assessment findings that are in the client's best interest.

19. Answer: D: No special orders are necessary for this examination

No special preparation is necessary for this examination.

20. Answer: B: "When you can climb 2 flights of stairs without problems, it is generally safe."

There is a risk of cardiac rupture at the point of the myocardial infarction for about 6 weeks. Scar tissue should form about that time. Waiting until the client can tolerate climbing stairs is the usual advice given by health care providers.

21. Answer: B: A teenager who got signed beard while camping

This client is in the greatest danger with a potential of respiratory distress. Any client with singed facial hair has been exposed to heat or fire in close range that could have caused serious damage to the interior of the lungs. Note that the interior linings of the lungs have no nerve fibers so the client will not be aware of swelling.

22. Answer: C: "I understand the need to use those new skills."

Erikson describes the stage of the toddler as being the time when there is normally an increase in autonomy. The child needs to use motor skills to explore the environment.

23. Answer: A: Verify correct placement of the tube

Proper placement of the tube prevents aspiration.

24. Answer: C: Tall peaked T waves

A tall peaked T wave is a sign of hyperkalemia. The health care provider should be notified regarding discontinuing the medication.

25. Answer: A: All striated muscles

Rhabdomyosarcoma is the most common children's soft tissue sarcoma. It originates in striated (skeletal) muscles and can be found anywhere in the body. The clue is in the middle of the word and is "myo" which typically means muscle.

26. Answer: D: Restore yin and yang

For followers of Chinese medicine, health is maintained through balance between the forces of yin and yang.

27. Answer: C: Force fluids and reassess blood pressure

Postural hypotension, a decrease in systolic blood pressure of more than 15 mm Hg and an increase in heart rate of more than 15 percent usually accompanied by dizziness indicates volume depletion, inadequate vasoconstrictor mechanisms, and autonomic insufficiency.

28. Answer: B: Left heart function

The Swan-Ganz catheter is placed in the pulmonary artery to obtain information about the left side of the heart. The pressure readings are inferred from pressure measurements obtained on the right side of the circulation. Right-sided heart function is assessed through the evaluation of the central venous pressures (CVP).

29. Answer:B. Initiate closed-chest massage

As per new guidelines, the American Heart Association recommends beginning CPR with chest compression (rather than checking for the airway first). Start CPR with 30 chest compressions before checking the airway and giving rescue breaths. Starting with chest compressions first applies to adults, children and infants needing CPR, but not newborns. CPR can keep oxygenated blood flowing to the brain and other vital organs until more definitive medical treatment can restore a normal heart rhythm.

30. Answer: A: Blood pressure 94/60 : Both medications decrease the heart rate. Metoprolol affects blood pressure. Therefore, the heart rate and blood pressure must be within normal range (HR 60-100; systolic BP over 100) in order to safely administer both medications.

31. Answer: C: Inspiratory grunt

Inspiratory grunting is abnormal and may be a sign of respiratory distress in this infant.

32. Answer: D: Progressive placental insufficiency

The placenta functions less efficiently as pregnancy continues beyond 42 weeks. Immediate and long term effects may be related to hypoxia.

33. Answer: B: "I just can't"catch my breath" over the past few minutes and I think I am in grave danger."

The nurse would be concerned about all of these comments. However the most life threatening is option B. Clients who have had hip or knee surgery are at greatest risk for development of postoperative pulmonary embolism. Sudden dyspnea and tachycardia are classic findings of pulmonary embolism. Muscle spasms do not require immediate attention. Option C may indicate a urinary tract infection. And option D requires further investigation and is not life threatening.

34. Answer: D: Decreased appetite

Lasix causes a loss of potassium if a supplement is not taken. Signs and symptoms of hypokalemia include anorexia, fatigue, nausea, decreased GI motility, muscle weakness, dysrhythmias.

35. Answer: C: Gravida 3 para 1: Gravida is the number of pregnancies and Parity is the number of pregnancies that reach viability (not the number of fetuses). Thus, for this woman, she is now pregnant, had 2 prior pregnancies, and 1 viable birth (twins).

36. Answer: B: Improve the client's nutritional status

The goal of clinical management in a client with venous stasis ulcers is to promote healing. This only can be accomplished with proper nutrition. The other answers are correct, but without proper nutrition, the other interventions would be of little help.

37. Answer: D: Have the client empty bladder

The first step in the process is to have the client void prior to administering the pre-operative medication. The other actions follow this initial step in this sequence: 4 3 1 2

38. Answer: A: Specific feedback is given as close to the event as possible

Feedback is most useful when given immediately. Positive behavior is strengthened through immediate feedback, and it is easier to modify problem behaviors if the standards are clearly understood.

39. Answer: B: Lead to dehydration: The client must take in adequate fluids before and during exercise periods.

40. Answer: C: We have safety bars installed in the bathroom and have 24 hour alarms on the doors. Ensuring safety of the client with increasing memory loss is a priority of home care. Note all options are correct statements. However, safety is most important to reinforce.

1. A nurse is reviewing a patient's medication during shift change. Which of the following medication would be contraindicated if the patient were pregnant? Note: More than one answer may be correct.

1. Coumadin
2. Finasteride
3. Celebrex
4. Catapres
5. Habitrol
6. Clofazimine

2. A nurse is reviewing a patient's PMH. The history indicates photosensitive reactions to medications. Which of the following drugs has not been associated with photosensitive reactions? Note: More than one answer may be correct.

1. Cipro
2. Sulfonamide
3. Noroxin
4. Bactrim
5. Accutane
6. Nitro-dur

3. A patient tells you that her urine is starting to look discolored. If you believe this change is due to medication, which of the following patient's medication does not cause urine discoloration?

1. Sulfasalazine
2. Levodopa
3. Phenolphthalein
4. Aspirin

4. You are responsible for reviewing the nursing unit's refrigerator. If you found the following drug in the refrigerator it should be removed from the refrigerator's contents?

1. Corgard
2. Humulin (injection)
3. Urokinase
4. Epogen (injection)

5. A 34 year old female has recently been diagnosed with an autoimmune disease. She has also recently discovered that she is pregnant. Which of the following is the only immunoglobulin that will provide protection to the fetus in the womb?

1. IgA
2. IgD
3. IgE
4. IgG

6. A second year nursing student has just suffered a needlestick while working with a patient that is positive for AIDS. Which of the following is the most important action that nursing student should take?

1. Immediately see a social worker
2. Start prophylactic AZT treatment
3. Start prophylactic Pentamidine treatment
4. Seek counseling

7. A thirty five year old male has been an insulin-dependent diabetic for five years and now is unable to urinate. Which of the following would you most likely suspect?

1. Atherosclerosis
2. Diabetic nephropathy
3. Autonomic neuropathy
4. Somatic neuropathy

8. You are taking the history of a 14 year old girl who has a (BMI) of 18. The girl reports inability to eat, induced vomiting and severe constipation. Which of the following would you most likely suspect?

1. Multiple sclerosis
2. Anorexia nervosa
3. Bulimia
4. Systemic sclerosis

9. A 24 year old female is admitted to the ER for confusion. This patient has a history of a myeloma diagnosis, constipation, intense abdominal pain, and polyuria. Which of the following would you most likely suspect?

1. Diverticulosis
2. Hypercalcaemia
3. Hypocalcaemia
4. Irritable bowel syndrome

10. Rhogam is most often used to treat____ mothers that have a ____ infant.

1. RH positive, RH positive
2. RH positive, RH negative
3. RH negative, RH positive
4. RH negative, RH negative

11. A new mother has some questions about (PKU). Which of the following statements made by a nurse is not correct regarding PKU?

1. A Guthrie test can check the necessary lab values.
2. The urine has a high concentration of phenylpyruvic acid
3. Mental deficits are often present with PKU.
4. The effects of PKU are reversible.

12. A patient has taken an overdose of aspirin. Which of the following should a nurse most closely monitor for during acute management of this patient?

1. Onset of pulmonary edema
2. Metabolic alkalosis
3. Respiratory alkalosis
4. Parkinson's disease type symptoms

13. A fifty-year-old blind and deaf patient has been admitted to your floor. As the charge nurse your primary responsibility for this patient is?

1. Let others know about the patient's deficits.
2. Communicate with your supervisor your patient safety concerns.
3. Continuously update the patient on the social environment.
4. Provide a secure environment for the patient.

14. A patient is getting discharged from a SNF facility. The patient has a history of severe COPD and PVD. The patient is primarily concerned about their ability to breath easily. Which of the following would be the best instruction for this patient?

1. Deep breathing techniques to increase O2 levels.
2. Cough regularly and deeply to clear airway passages.
3. Cough following bronchodilator utilization
4. Decrease CO2 levels by increased oxygen take output during meals.

15. A nurse is caring for an infant that has recently been diagnosed with a congenital heart defect. Which of the following clinical signs would most likely be present?

1. Slow pulse rate
2. Weight gain
3. Decreased systolic pressure
4. Irregular WBC lab values

16. A mother has recently been informed that her child has Down's syndrome. You will be assigned to care for the child at shift change. Which of the following characteristics is not associated with Down's syndrome?

1. Simian crease
2. Brachycephaly
3. Oily skin
4. Hypotonicity

17. A patient has recently experienced a (MI) within the last 4 hours. Which of the following medications would most like be administered?

1. Streptokinase
2. Atropine
3. Acetaminophen
4. Coumadin

18. A patient asks a nurse, "My doctor recommended I increase my intake of folic acid. What type of foods contain the highest concentration of folic acids?"

1. Green vegetables and liver
2. Yellow vegetables and red meat

3. Carrots
4. Milk

19. A nurse is putting together a presentation on meningitis. Which of the following microorganisms has not been linked to meningitis in humans?

1. S. pneumoniae
2. H. influenzae
3. N. meningitidis
4. Cl. difficile

20. A nurse is administering blood to a patient who has a low hemoglobin count. The patient asks how long to RBC's last in my body? The correct response is.

1. The life span of RBC is 45 days.
2. The life span of RBC is 60 days.
3. The life span of RBC is 90 days.
4. The life span of RBC is 120 days.

21. A 65 year old man has been admitted to the hospital for spinal stenosis surgery. When does the discharge training and planning began for this patient?

1. Following surgery
2. Upon admit
3. Within 48 hours of discharge
4. Preoperative discussion

22. A child is 5 years old and has been recently admitted into the hospital. According to Erickson which of the following stages is the child in?

1. Trust vs. mistrust
2. Initiative vs. guilt
3. Autonomy vs. shame
4. Intimacy vs. isolation

23. A toddler is 16 months old and has been recently admitted into the hospital. According to Erickson which of the following stages is the toddler in?

1. Trust vs. mistrust
2. Initiative vs. guilt
3. Autonomy vs. shame
4. Intimacy vs. isolation

24. A young adult is 20 years old and has been recently admitted into the hospital. According to Erickson which of the following stages is the adult in?

1. Trust vs. mistrust
2. Initiative vs. guilt
3. Autonomy vs. shame
4. Intimacy vs. isolation

25. A nurse is making rounds taking vital signs. Which of the following vital signs is abnormal?

1. 11 year old male – 90 b.p.m, 22 resp/min. , 100/70 mm Hg
2. 13 year old female – 105 b.p.m., 22 resp/min., 105/60 mm Hg
3. 5 year old male- 102 b.p.m, 24 resp/min., 90/65 mm Hg
4. 6 year old female- 100 b.p.m., 26 resp/min., 90/70 mm Hg

26. When you are taking a patient's history, she tells you she has been depressed and is dealing with an anxiety disorder. Which of the following medications would the patient most likely be taking?

1. Elavil
2. Calcitonin
3. Pergolide
4. Verapamil

27. Which of the following conditions would a nurse not administer erythromycin?

1. Campylobacteriosis infection
2. Legionnaire's disease
3. Pneumonia
4. Multiple Sclerosis

28. A patient's chart indicates a history of hyperkalemia. Which of the following would you not expect to see with this patient if this condition were acute?

1. Decreased HR
2. Paresthesias
3. Muscle weakness of the extremities
4. Migraines

29. A patient's chart indicates a history of ketoacidosis. Which of the following would you not expect to see with this patient if this condition were acute?

1. Vomiting
2. Extreme Thirst
3. Weight gain
4. Acetone breath smell

30. A patient's chart indicates a history of meningitis. Which of the following would you not expect to see with this patient if this condition were acute?

1. Increased appetite
2. Vomiting
3. Fever
4. Poor tolerance of light

31. A nurse if reviewing a patient's chart and notices that the patient suffers from conjunctivitis. Which of the following microorganisms is related to this condition?

1. Yersinia pestis
2. Helicobacter pylori
3. Vibrio cholerae
4. Haemophilus aegyptius

32. A nurse if reviewing a patient's chart and notices that the patient suffers from Lyme disease. Which of the following microorganisms is related to this condition?

1. Borrelia burgdorferi
2. Streptococcus pyogenes
3. Bacillus anthracis
4. Enterococcus faecalis

33. A fragile 87 year-old female has recently been admitted to the hospital with increased confusion and falls over last 2 weeks. She is also noted to have a mild left hemiparesis. Which of the following tests is most likely to be performed?

1. FBC (full blood count)
2. ECG (electrocardiogram)
3. Thyroid function tests
4. CT scan

34. A 84 year-old male has been loosing mobility and gaining weight over the last 2 months. The patient also has the heater running in his house 24 hours a day, even on warm days. Which of the following tests is most likely to be performed?

1. FBC (full blood count)
2. ECG (electrocardiogram)
3. Thyroid function tests
4. CT scan

35. A 20 year-old female attending college is found unconscious in her dorm room. She has a fever and a noticeable rash. She has just been admitted to the hospital. Which of the following tests is most likely to be performed first?

1. Blood sugar check
2. CT scan
3. Blood cultures
4. Arterial blood gases

36. A 28 year old male has been found wandering around in a confused pattern. The male is sweaty and pale. Which of the following tests is most likely to be performed first?

1. Blood sugar check
2. CT scan
3. Blood cultures
4. Arterial blood gases

37. A mother is inquiring about her child's ability to potty train. Which of the following factors is the most important aspect of toilet training?

1. The age of the child
2. The child ability to understand instruction.
3. The overall mental and physical abilities of the child.
4. Frequent attempts with positive reinforcement.

38. A parent calls the pediatric clinic and is frantic about the bottle of cleaning fluid her child drank 20 minutes. Which of the following is the most important instruction the nurse can give the parent?

1. This too shall pass.
2. Take the child immediately to the ER
3. Contact the Poison Control Center quickly
4. Give the child syrup of ipecac

39. A nurse is administering a shot of Vitamin K to a 30 day-old infant. Which of the following target areas is the most appropriate?

1. Gluteus maximus
2. Gluteus minimus
3. Vastus lateralis
4. Vastus medialis

40. A nurse has just started her rounds delivering medication. A new patient on her rounds is a 4 year-old boy who is non-verbal. This child does not have on any identification. What should the nurse do?

1. Contact the provider
2. Ask the child to write their name on paper.
3. Ask a coworker about the identification of the child.
4. Ask the father who is in the room the child's name.

Answers and Rationale

1. Answer: 1. and Answer: 2.

Both contraindicated with pregnancy.

2. Answer: 6. Nitro-dur

All of the others have can cause photosensitivity reactions.

3. Answer: 4. Aspirin

All of the others can cause urine discoloration.

4. Answer: 1. Corgard

Corgard could be removed from the refrigerator.

5. Answer: 4. IgG

IgG is the only immunoglobulin that can cross the placental barrier.

6. Answer: 2. Start prophylactic AZT treatment

AZT treatment is the most critical intervention.

7. Answer: 3. Autonomic neuropathy

Autonomic neuropathy can cause inability to urinate.

8. Answer: 2. Anorexia nervosa

All of the clinical signs and symptoms point to a condition of anorexia nervosa.

9. Answer: 2. Hypercalcaemia

Hypercalcaemia can cause polyuria, severe abdominal pain, and confusion.

10. Answer: 3. RH negative, RH positive

Rhogam prevents the production of anti-RH antibodies in the mother that has a Rh positive fetus.

11. Answer: 4. The effects of PKU are reversible.

The effects of PKU stay with the infant throughout their life.

12. Answer: 4. Parkinson's disease type symptoms

Aspirin overdose can lead to metabolic acidosis and cause pulmonary edema development.

13. Answer: 4. Provide a secure environment for the patient.

This patient's safety is your primary concern.

14. Answer: 3. Cough following bronchodilator utilization

The bronchodilator will allow a more productive cough.

15. Answer: 2. Weight gain

Weight gain is associated with CHF and congenital heart deficits.

16. Answer: 3. Oily skin

The skin would be dry and not oily.

17. Answer: 1. Streptokinase

Streptokinase is a clot busting drug and the best choice in this situation.

18. Answer: 1. Green vegetables and liver

Green vegetables and liver are a great source of folic acid.

19. Answer: 4. Cl. difficile

Cl. difficile has not been linked to meningitis.

20. Answer: 4. The life span of RBC is 120 days.

RBC's last for 120 days in the body.

21. Answer: 2. Upon admit

Discharge education begins upon admit.

22. Answer: 2. Initiative vs. guilt

Initiative vs. guilt- 3-6 years old

23. Answer: 3. Autonomy vs. shame

Autonomy vs Shame- 12-18 months old

24. Answer: 4. Intimacy vs. isolation

Intimacy vs. isolation- 18-35 years old

25. Answer: 2. 13 year old female – 105 b.p.m., 22 resp/min., 105/60 mm Hg

HR and Respirations are slightly increased. BP is down.

26. Answer: 1. Elavil

Elavil is a tricyclic antidepressant.

27. Answer: 4. Multiple Sclerosis

Erythromycin is used to treat conditions A-C.

28. Answer: 4. Migraines

Answer choices A-C were symptoms of acute hyperkalemia.

29. Answer: 3. Weight gain

Weight loss would be expected.

30. Answer: 1. Increased appetite

Loss of appetite would be expected.

31. Answer: 4. Haemophilus aegyptius

Answer: 1 is linked to Plague, Answer: 2 is linked to peptic ulcers, Answer: 3 is linked to Cholera.

32. Answer: 1. Borrelia burgdorferi

Answer: 2 is linked to Rheumatic fever, Answer: 3 is linked to Anthrax, Answer: D is linked to Endocarditis.

33. Answer: 4. CT scan

A CT scan would be performed for further investigation of the hemiparesis.

34. Answer: 3. Thyroid function tests

Weight gain and poor temperature tolerance indicate something may be wrong with the thyroid function.

35. Answer: 3. Blood cultures

Blood cultures would be performed to investigate the fever and rash symptoms.

36. Answer: 1. Blood sugar check

With a history of diabetes, the first response should be to check blood sugar levels.

37. Answer: 3. The overall mental and physical abilities of the child.

Age is not the greatest factor in potty training. The overall mental and physical abilities of the child is the most important factor.

38. Answer: 3. Contact the Poison Control Center quickly

The poison control center will have an exact plan of action for this child.

39. Answer: 3. Vastus lateralis

Vastus lateralis is the most appropriate location.

40. Answer: 4. Ask the father who is in the room the child's name.

In this case you are able to determine the name of the child by the father's statement. You should not withhold the medication from the child following identification.

III

1. A patient is admitted to the hospital with a diagnosis of primary hyperparathyroidism. A nurse checking the patient's lab results would expect which of the following changes in laboratory findings?

A. Elevated serum calcium.
B. Low serum parathyroid hormone (PTH).
C. Elevated serum vitamin D.
D. Low urine calcium.

2. A patient with Addison's disease asks a nurse for nutrition and diet advice. Which of the following diet modifications is NOT recommended?

A. A diet high in grains.
B. A diet with adequate caloric intake.
C. A high protein diet.
D. A restricted sodium diet.

3. A patient with a history of diabetes mellitus is in the second post-operative day following cholecystectomy. She has complained of nausea and isn't able to eat solid foods. The nurse enters the room to find the patient confused and shaky. Which of the following is the most likely explanation for the patient's symptoms?

A. Anesthesia reaction.
B. Hyperglycemia.
C. Hypoglycemia.
D. Diabetic ketoacidosis.

4. A nurse assigned to the emergency department evaluates a patient who underwent fiberoptic colonoscopy 18 hours previously. The patient reports increasing abdominal pain, fever, and chills. Which of the following conditions poses the most immediate concern?

A. Bowel perforation.
B. Viral gastroenteritis.
C. Colon cancer.
D. Diverticulitis.

5. A patient is admitted to the same day surgery unit for liver biopsy. Which of the following laboratory tests assesses coagulation?

A. Partial thromboplastin time.
B. Prothrombin time.
C. Platelet count.
D. Hemoglobin

6. A nurse is assessing a clinic patient with a diagnosis of hepatitis A. Which of the following is the most likely route of transmission?

A. Sexual contact with an infected partner.
B. Contaminated food.
C. Blood transfusion.
D. Illegal drug use.

7. A leukemia patient has a relative who wants to donate blood for transfusion. Which of the following donor medical conditions would prevent this?

A. A history of hepatitis C five years previously.
B. Cholecystitis requiring cholecystectomy one year previously.
C. Asymptomatic diverticulosis.
D. Crohn's disease in remission.

8. A physician has diagnosed acute gastritis in a clinic patient. Which of the following medications would be contraindicated for this patient?

A. Naproxen sodium (Naprosyn).
B. Calcium carbonate.
C. Clarithromycin (Biaxin).
D. Furosemide (Lasix).

9. The nurse is conducting nutrition counseling for a patient with cholecystitis. Which of the following information is important to communicate?

A. The patient must maintain a low calorie diet.
B. The patient must maintain a high protein/low carbohydrate diet.
C. The patient should limit sweets and sugary drinks.
D. The patient should limit fatty foods.

10. A patient admitted to the hospital with myocardial infarction develops severe pulmonary edema. Which of the following symptoms should the nurse expect the patient to exhibit?

A. Slow, deep respirations.
B. Stridor.

C. Bradycardia.
D. Air hunger.

11. A nurse caring for several patients on the cardiac unit is told that one is scheduled for implantation of an automatic internal cardioverter-defibrillator. Which of the following patients is most likely to have this procedure?

A. A patient admitted for myocardial infarction without cardiac muscle damage.
B. A post-operative coronary bypass patient, recovering on schedule.
C. A patient with a history of ventricular tachycardia and syncopal episodes.
D. A patient with a history of atrial tachycardia and fatigue.

12. A patient is scheduled for a magnetic resonance imaging (MRI) scan for suspected lung cancer. Which of the following is a contraindication to the study for this patient?

A. The patient is allergic to shellfish.
B. The patient has a pacemaker.
C. The patient suffers from claustrophobia.
D. The patient takes anti-psychotic medication.

13. A nurse calls a physician with the concern that a patient has developed a pulmonary embolism. Which of the following symptoms has the nurse most likely observed?

A. The patient is somnolent with decreased response to the family.
B. The patient suddenly complains of chest pain and shortness of breath.
C. The patient has developed a wet cough and the nurse hears crackles on auscultation of the lungs.
D. The patient has a fever, chills, and loss of appetite.

14. A patient comes to the emergency department with abdominal pain. Work-up reveals the presence of a rapidly enlarging abdominal aortic aneurysm. Which of the following actions should the nurse expect?

A. The patient will be admitted to the medicine unit for observation and medication.
B. The patient will be admitted to the day surgery unit for sclerotherapy.
C. The patient will be admitted to the surgical unit and resection will be scheduled.
D. The patient will be discharged home to follow-up with his cardiologist in 24 hours.

15. A patient with leukemia is receiving chemotherapy that is known to depress bone marrow. A CBC (complete blood count) reveals a platelet count of 25,000/microliter. Which of the following actions related specifically to the platelet count should be included on the nursing care plan?

A. Monitor for fever every 4 hours.
B. Require visitors to wear respiratory masks and protective clothing.
C. Consider transfusion of packed red blood cells.
D. Check for signs of bleeding, including examination of urine and stool for blood.

16. A nurse in the emergency department is observing a 4-year-old child for signs of increased intracranial pressure after a fall from a bicycle, resulting in head trauma. Which of the following signs or symptoms would be cause for concern?

A. Bulging anterior fontanel.
B. Repeated vomiting.
C. Signs of sleepiness at 10 PM.
D. Inability to read short words from a distance of 18 inches.

17. A nonimmunized child appears at the clinic with a visible rash. Which of the following observations indicates the child may have rubeola (measles)?

A. Small blue-white spots are visible on the oral mucosa.
B. The rash begins on the trunk and spreads outward.
C. There is low-grade fever.
D. The lesions have a “tear drop on a rose petal” appearance.

18. A child is seen in the emergency department for scarlet fever. Which of the following descriptions of scarlet fever is NOT correct?

A. Scarlet fever is caused by infection with group A Streptococcus bacteria.
B. “Strawberry tongue” is a characteristic sign.
C. Petechiae occur on the soft palate.
D. The pharynx is red and swollen.

19. A child weighing 30 kg arrives at the clinic with diffuse itching as the result of an allergic reaction to an insect bite. Diphenhydramine (Benadryl) 25 mg 3 times a day is prescribed. The correct pediatric dose is 5 mg/kg/day. Which of the following best describes the prescribed drug dose?

A. It is the correct dose.
B. The dose is too low.
C. The dose is too high.
D. The dose should be increased or decreased, depending on the symptoms.

20. The mother of a 2-month-old infant brings the child to the clinic for a well baby check. She is concerned because she feels only one testis in the scrotal sac. Which of the following statements about the undescended testis is the most accurate?

A. Normally, the testes are descended by birth.

B. The infant will likely require surgical intervention.

C. The infant probably has with only one testis.

D. Normally, the testes descend by one year of age.

21. A child is admitted to the hospital with a diagnosis of Wilms tumor, stage II. Which of the following statements most accurately describes this stage?

A. The tumor is less than 3 cm. in size and requires no chemotherapy.

B. The tumor did not extend beyond the kidney and was completely resected.

C. The tumor extended beyond the kidney but was completely resected.

D. The tumor has spread into the abdominal cavity and cannot be resected.

22. A teen patient is admitted to the hospital by his physician who suspects a diagnosis of acute glomerulonephritis. Which of the following findings is consistent with this diagnosis? Note: More than one answer may be correct.

A. Urine specific gravity of 1.040.

B. Urine output of 350 ml in 24 hours.

C. Brown (“tea-colored”) urine.

D. Generalized edema.

23. Which of the following conditions most commonly causes acute glomerulonephritis?

A. A congenital condition leading to renal dysfunction.

B. Prior infection with group A Streptococcus within the past 10-14 days.

C. Viral infection of the glomeruli.

D. Nephrotic syndrome.

24. An infant with hydrocele is seen in the clinic for a follow-up visit at 1 month of age. The scrotum is smaller than it was at birth, but fluid is still visible on illumination. Which of the following actions is the physician likely to recommend?

A. Massaging the groin area twice a day until the fluid is gone.

B. Referral to a surgeon for repair.

C. No treatment is necessary; the fluid is reabsorbing normally.

D. Keeping the infant in a flat, supine position until the fluid is gone.

25. A nurse is caring for a patient with peripheral vascular disease (PVD). The patient complains of burning and tingling of the hands and feet and cannot

tolerate touch of any kind. Which of the following is the most likely explanation for these symptoms?

A. Inadequate tissue perfusion leading to nerve damage.

B. Fluid overload leading to compression of nerve tissue.

C. Sensation distortion due to psychiatric disturbance.

D. Inflammation of the skin on the hands and feet.

26. A patient in the cardiac unit is concerned about the risk factors associated with atherosclerosis. Which of the following are hereditary risk factors for developing atherosclerosis?

A. Family history of heart disease.

B. Overweight.

C. Smoking.

D. Age.

27. Claudication is a well-known effect of peripheral vascular disease. Which of the following facts about claudication is correct?

A. It results when oxygen demand is greater than oxygen supply.

B. It is characterized by pain that often occurs duing rest.

C. It is a result of tissue hypoxia.

D. It is characterized by cramping and weakness.

28. A nurse is providing discharge information to a patient with peripheral vascular disease. Which of the following information should be included in instructions?

A. Walk barefoot whenever possible.

B. Use a heating pad to keep feet warm.

C. Avoid crossing the legs.

D. Use antibacterial ointment to treat skin lesions at risk of infection.

29. A patient who has been diagnosed with vasospastic disorder (Raynaud's disease) complains of cold and stiffness in the fingers. Which of the following descriptions is most likely to fit the patient?

A. An adolescent male.

B. An elderly woman.

C. A young woman.

D. An elderly man.

30. A 23 year old patient in the 27th week of pregnancy has been hospitalized on complete bed rest for 6 days. She experiences sudden shortness of breath, accompanied by chest pain. Which of the following conditions is the most likely cause of her symptoms?

A. Myocardial infarction due to a history of atherosclerosis.
B. Pulmonary embolism due to deep vein thrombosis (DVT).
C. Anxiety attack due to worries about her baby's health.
D. Congestive heart failure due to fluid overload.

31. Thrombolytic therapy is frequently used in the treatment of suspected stroke. Which of the following is a significant complication associated with thrombolytic therapy?

A. Air embolus.
B. Cerebral hemorrhage.
C. Expansion of the clot.
D. Resolution of the clot.

32. An infant is brought to the clinic by his mother, who has noticed that he holds his head in an unusual position and always faces to one side. Which of the following is the most likely explanation?

A. Torticollis, with shortening of the sternocleidomastoid muscle.
B. Craniosynostosis, with premature closure of the cranial sutures.
C. Plagiocephaly, with flattening of one side of the head.
D. Hydrocephalus, with increased head size.

33. An adolescent brings a physician's note to school stating that he is not to participate in sports due to a diagnosis of Osgood-Schlatter disease. Which of the following statements about the disease is correct?

A. The condition was caused by the student's competitive swimming schedule.
B. The student will most likely require surgical intervention.
C. The student experiences pain in the inferior aspect of the knee.
D. The student is trying to avoid participation in physical education.

34. The clinic nurse asks a 13-year-old female to bend forward at the waist with arms hanging freely. Which of the following assessments is the nurse most likely conducting?

A. Spinal flexibility.
B. Leg length disparity.
C. Hypostatic blood pressure.
D. Scoliosis.

35. A clinic nurse interviews a parent who is suspected of abusing her child. Which of the following characteristics is the nurse LEAST likely to find in an abusing parent?

A. Low self-esteem.
B. Unemployment.
C. Self-blame for the injury to the child.
D. Single status.

36. A nurse is assigned to the pediatric rheumatology clinic and is assessing a child who has just been diagnosed with juvenile idiopathic arthritis. Which of the following statements about the disease is most accurate?

A. The child has a poor chance of recovery without joint deformity.
B. Most children progress to adult rheumatoid arthritis.
C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.
D. Physical activity should be minimized.

37. A child is admitted to the hospital several days after stepping on a sharp object that punctured her athletic shoe and entered the flesh of her foot. The physician is concerned about osteomyelitis and has ordered parenteral antibiotics. Which of the following actions is done immediately before the antibiotic is started?

A. The admission orders are written.
B. A blood culture is drawn.
C. A complete blood count with differential is drawn.
D. The parents arrive.

38. A two-year-old child has sustained an injury to the leg and refuses to walk. The nurse in the emergency department documents swelling of the lower affected leg. Which of the following does the nurse suspect is the cause of the child's symptoms?

A. Possible fracture of the tibia.
B. Bruising of the gastrocnemius muscle.
C. Possible fracture of the radius.
D. No anatomic injury, the child wants his mother to carry him.

39. A toddler has recently been diagnosed with cerebral palsy. Which of the following information should the nurse provide to the parents? Note: More than one answer may be correct.

A. Regular developmental screening is important to avoid secondary developmental delays.
B. Cerebral palsy is caused by injury to the upper motor neurons and results in motor dysfunction, as well as possible ocular and speech difficulties.
C. Developmental milestones may be slightly delayed but usually will require no additional intervention.
D. Parent support groups are helpful for sharing strategies and managing health care issues.

40. A child has recently been diagnosed with Duchenne's muscular dystrophy. The parents are receiving genetic counseling prior to planning another pregnancy. Which of the following statements includes the most accurate information?

A. Duchenne's is an X-linked recessive disorder, so daughters have a 50% chance of being carriers and sons a 50% chance of developing the disease.

B. Duchenne's is an X-linked recessive disorder, so both daughters and sons have a 50% chance of developing the disease.

C. Each child has a 1 in 4 (25%) chance of developing the disorder.

D. Sons only have a 1 in 4 (25%) chance of developing the disorder.

Answers and Rationale

1. Answer: A. Elevated serum calcium.

The parathyroid glands regulate the calcium level in the blood. In hyperparathyroidism, the serum calcium level will be elevated. Parathyroid hormone levels may be high or normal but not low. The body will lower the level of vitamin D in an attempt to lower calcium. Urine calcium may be elevated, with calcium spilling over from elevated serum levels. This may cause renal stones.

2. Answer: D. A restricted sodium diet.

A patient with Addison's disease requires normal dietary sodium to prevent excess fluid loss. Adequate caloric intake is recommended with a diet high in protein and complex carbohydrates, including grains.

3. Answer: C. Hypoglycemia.

A post-operative diabetic patient who is unable to eat is likely to be suffering from hypoglycemia. Confusion and shakiness are common symptoms. An anesthesia reaction would not occur on the second post-operative day. Hyperglycemia and ketoacidosis do not cause confusion and shakiness.

4. Answer: A. Bowel perforation

Bowel perforation is the most serious complication of fiberoptic colonoscopy. Important signs include progressive abdominal pain, fever, chills, and tachycardia, which indicate advancing peritonitis. Viral gastroenteritis and colon cancer do not cause these symptoms. Diverticulitis may cause pain, fever, and chills, but is far less serious than perforation and peritonitis.

5. Answers: A, B, and C.

Prothrombin time, partial thromboplastin time, and platelet count are all included in coagulation studies. The hemoglobin level, though important information prior to an invasive procedure like liver biopsy, does not assess coagulation.

6. Answer: B. Contaminated food.

Hepatitis A is the only type that is transmitted by the fecal-oral route through contaminated food. Hepatitis B, C, and D are transmitted through infected bodily fluids.

7. Answer: A. A history of hepatitis C five years previously.

Hepatitis C is a viral infection transmitted through bodily fluids, such as blood, causing inflammation of the liver. Patients with hepatitis C may not donate blood for transfusion due to the high risk of infection in the recipient. Cholecystitis (gall bladder disease), diverticulosis, and history of Crohn's disease do not preclude blood donation.

8. Answer: A. Naproxen sodium (Naprosyn).

Naproxen sodium is a nonsteroidal anti-inflammatory drug that can cause inflammation of the upper GI tract. For this reason, it is contraindicated in a patient with gastritis. Calcium carbonate is used as an antacid for the relief of indigestion and is not contraindicated. Clarithromycin is an antibacterial often used for the treatment of Helicobacter pylori in gastritis. Furosemide is a loop diuretic and is contraindicated in a patient with gastritis.

9. Answer: D. The patient should limit fatty foods.

Cholecystitis, inflammation of the gallbladder, is most commonly caused by the presence of gallstones, which may block bile (necessary for fat absorption) from entering the intestines. Patients should decrease dietary fat by limiting foods like fatty meats, fried foods, and creamy desserts to avoid irritation of the gallbladder.

10. Answer: D. Air hunger.

Patients with pulmonary edema experience air hunger, anxiety, and agitation. Respiration is fast and shallow and heart rate increases. Stridor is noisy breathing caused by laryngeal swelling or spasm and is not associated with pulmonary edema.

11. Answer: C. A patient with a history of ventricular tachycardia and syncopal episodes.

An automatic internal cardioverter-defibrillator delivers an electric shock to the heart to terminate episodes of ventricular tachycardia and ventricular fibrillation. This is necessary in a patient with significant ventricular symptoms, such as tachycardia resulting in syncope. A patient with myocardial infarction that resolved with no permanent cardiac damage would not be a candidate. A patient recovering well from coronary bypass would not need the device. Atrial tachycardia is less serious and is treated conservatively with medication and cardioversion as a last resort.

12. Answer: B. The patient has a pacemaker.

The implanted pacemaker will interfere with the magnetic fields of the MRI scanner and may be deactivated by them. Shellfish/iodine allergy is not a contraindication because the contrast used in MRI scanning is not iodine-based. Open MRI scanners and anti-anxiety medications are available for patients with claustrophobia. Psychiatric medication is not a contraindication to MRI scanning.

13. Answer: B. The patient suddenly complains of chest pain and shortness of breath.

Typical symptoms of pulmonary embolism include chest pain, shortness of breath, and severe anxiety. The physician should be notified immediately. A patient with pulmonary embolism will not be sleepy or have a cough with crackles on exam. A patient with fever, chills and loss of appetite may be developing pneumonia.

14. Answer: C. The patient will be admitted to the surgical unit and resection will be scheduled.

A rapidly enlarging abdominal aortic aneurysm is at significant risk of rupture and should be resected as soon as possible. No other appropriate treatment options currently exist.

15. Answer: D. Check for signs of bleeding, including examination of urine and stool for blood.

A platelet count of 25,000/microliter is severely thrombocytopenic and should prompt the initiation of bleeding precautions, including monitoring urine and stool for evidence of bleeding. Monitoring for fever and requiring protective clothing are indicated to prevent infection if white blood cells are decreased. Transfusion of red cells is indicated for severe anemia.

16. Answer: B. Repeated vomiting.

Increased pressure caused by bleeding or swelling within the skull can damage delicate brain tissue and may become life threatening. Repeated vomiting can be an early sign of pressure as the vomit center within the medulla is stimulated. The anterior fontanel is closed in a 4-year-old child. Evidence of sleepiness at 10 PM is normal for a four year old. The average 4-year-old child cannot read yet, so this too is normal.

17. Answer: A. Small blue-white spots are visible on the oral mucosa.

Koplik's spots are small blue-white spots visible on the oral mucosa and are characteristic of measles infection. The body rash typically begins on the face and travels downward. High fever is often present. "Tear drop on a rose petal" refers to the lesions found in varicella (chicken pox).

18. Answer: C. Petechiae occur on the soft palate.

Petechiae on the soft palate are characteristic of rubella infection. Choices A, B, and D are characteristic of scarlet fever, a result of group A Streptococcus infection.

19. Answer: B. The dose is too low.

This child weighs 30 kg, and the pediatric dose of diphenhydramine is 5 mg/kg/day (5 X 30 = 150/day). Therefore, the correct dose is 150 mg/day. Divided into 3 doses per day, the child should receive 50 mg 3 times a day rather than 25 mg 3 times a day. Dosage should not be titrated based on symptoms without consulting a physician.

20. Answer: D. Normally, the testes descend by one year of age.

Normally, the testes descend by one year of age. In young infants, it is common for the testes to retract into the inguinal canal when the environment is cold or the cremasteric reflex is stimulated. Exam should be done in a warm room with warm hands. It is most likely that both testes are present and will descend by a year. If not, a full assessment will determine the appropriate treatment.

21. Answer: C. The tumor extended beyond the kidney but was completely resected.

The staging of Wilm's tumor is confirmed at surgery as follows: Stage I, the tumor is limited to the kidney and completely resected; stage II, the tumor extends beyond the kidney but is completely resected; stage III, residual nonhematogenous tumor is confined to the abdomen; stage IV, hematogenous metastasis has occurred with spread beyond the abdomen; and stage V, bilateral renal involvement is present at diagnosis.

22. Answers: A, B, and C

Acute glomerulonephritis is characterized by high urine specific gravity related to oliguria as well as dark "tea colored" urine caused by large amounts of red blood cells. There is periorbital edema, but generalized edema is seen in nephrotic syndrome, not acute glomerulonephritis.

23. Answer: B. Prior infection with group A Streptococcus within the past 10-14 days.

Acute glomerulonephritis is most commonly caused by the immune response to a prior upper respiratory infection with group A Streptococcus. Glomerular inflammation occurs about 10-14 days after the infection, resulting in scant, dark urine and retention of body fluid. Periorbital edema and hypertension are common signs at diagnosis.

24. Answer: C. No treatment is necessary; the fluid is reabsorbing normally.

A hydrocele is a collection of fluid in the scrotum that results from a patent tunica vaginalis. Illumination of the scrotum with a pocket light demonstrates the clear fluid. In most cases the fluid reabsorbs within the first few months of life and no treatment is necessary. Massaging the area or placing the infant in a supine position would have no effect. Surgery is not indicated.

25. Answer: A. Inadequate tissue perfusion leading to nerve damage.

Patients with peripheral vascular disease often sustain nerve damage as a result of inadequate tissue perfusion. Fluid overload is not characteristic of PVD. There is nothing to indicate psychiatric disturbance in the patient. Skin changes in PVD are secondary to decreased tissue perfusion rather than primary inflammation.

26. Answer: A. Family history of heart disease.

Family history of heart disease is an inherited risk factor that is not subject to life style change. Having a first degree relative with heart disease has been shown to significantly increase risk. Overweight and smoking are risk factors that are subject to life style change and can reduce risk significantly. Advancing age increases risk of atherosclerosis but is not a hereditary factor.

27. Answers: A, C, and D.

Claudication describes the pain experienced by a patient with peripheral vascular disease when oxygen demand in the leg muscles exceeds the oxygen supply. This most often occurs during activity when demand increases in muscle tissue. The tissue becomes hypoxic, causing cramping, weakness, and discomfort.

28. Answer: C. Avoid crossing the legs.

Patients with peripheral vascular disease should avoid crossing the legs because this can impede blood flow. Walking barefoot is not advised, as foot protection is important to avoid trauma that may lead to serious infection. Heating pads can cause injury, which can also increase the risk of infection. Skin lesions at risk for infection should be examined and treated by a physician.

29. Answer: C. A young woman.

Raynaud’s disease is most common in young women and is frequently associated with rheumatologic disorders, such as lupus and rheumatoid arthritis.

30. Answer: B. Pulmonary embolism due to deep vein thrombosis (DVT).

In a hospitalized patient on prolonged bed rest, he most likely cause of sudden onset shortness of breath and chest pain is pulmonary embolism. Pregnancy and prolonged inactivity both increase the risk of clot formation in the deep veins of the legs. These clots can then break loose and travel to the lungs. Myocardial infarction and atherosclerosis are unlikely in a 27-year-old woman, as is congestive heart failure due to fluid overload. There is no reason to suspect an anxiety disorder in this patient. Though anxiety is a possible cause of her symptoms, the seriousness of pulmonary embolism demands that it be considered first.

31. Answer: B. Cerebral hemorrhage.

Cerebral hemorrhage is a significant risk when treating a stroke victim with thrombolytic therapy intended to dissolve a suspected clot. Success of the treatment demands that it be instituted as soon as possible, often before the cause of stroke has been determined. Air embolus is not a concern. Thrombolytic therapy does not lead to expansion of the clot, but to resolution, which is the intended effect.

32. Answer: A. Torticollis, with shortening of the sternocleidomastoid muscle.

In torticollis, the sternocleidomastoid muscle is contracted, limiting range of motion of the neck and causing the chin to point to the opposing side. In craniosynostosis one of the cranial sutures, often the sagittal, closes prematurely, causing the head to grow in an abnormal shape. Plagiocephaly refers to the flattening of one side of the head, caused by the infant being placed supine in the same position over time. Hydrocephalus is caused by a build-up of cerebrospinal fluid in the brain resulting in large head size.

33. Answer: C. The student experiences pain in the inferior aspect of the knee.

Osgood-Schlatter disease occurs in adolescents in rapid growth phase when the infrapatellar ligament of the quadriceps muscle pulls on the tibial tubercle, causing pain and swelling in the inferior aspect of the knee. Osgood-Schlatter disease is commonly caused by activities that require repeated use of the quadriceps, including track and soccer. Swimming is not a likely cause. The condition is usually self-limited, responding to ice, rest, and analgesics. Continued participation will worsen the condition and the symptoms.

34. Answer: D. Scoliosis.

A check for scoliosis, a lateral deviation of the spine, is an important part of the routine adolescent exam. It is assessed by having the teen bend at the waist with arms dangling, while observing for lateral curvature and uneven rib level. Scoliosis is more common in female adolescents. Choices A, B, and C are not part of the routine adolescent exam.

35. Answer: C. Self-blame for the injury to the child.

The profile of a parent at risk of abusive behavior includes a tendency to blame the child or others for the injury sustained. These parents also have a high incidence of low self-esteem, unemployment, unstable financial situation, and single status.

36. Answer: C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.

Nonsteroidal anti-inflammatory drugs are important first line treatment for juvenile idiopathic arthritis (formerly known as juvenile rheumatoid arthritis). NSAIDs require 3-4

weeks for the therapeutic anti-inflammatory effects to be realized. Half of children with the disorder recover without joint deformity, and about a third will continue with symptoms into adulthood. Physical activity is an integral part of therapy.

37. Answer: B. A blood culture is drawn.

Antibiotics must be started after the blood culture is drawn, as they may interfere with the identification of the causative organism. The blood count will reveal the presence of infection but does not help identify an organism or guide antibiotic treatment. Parental presence is important for the adjustment of the child but not for the administration of medication.

38. Answer: A. Possible fracture of the tibia.

The child's refusal to walk, combined with swelling of the limb is suspicious for fracture. Toddlers will often continue to walk on a muscle that is bruised or strained. The radius is found in the lower arm and is not relevant to this question. Toddlers rarely feign injury to be carried, and swelling indicates a physical injury.

39. Answers: A, B, and D.

Delayed developmental milestones are characteristic of cerebral palsy, so regular screening and intervention is essential. Because of injury to upper motor neurons, children may have ocular and speech difficulties.

40. Answer: A. Duchenne's is an X-linked recessive disorder, so daughters have a 50% chance of being carriers and sons a 50% chance of developing the disease.

The recessive Duchenne gene is located on one of the two X chromosomes of a female carrier. If her son receives the X bearing the gene he will be affected. Thus, there is a 50% chance of a son being affected. Daughters are not affected, but 50% are carriers because they inherit one copy of the defective gene from the mother. The other X chromosome comes from the father, who cannot be a carrier.

1. The primary reason for rapid continuous rewarming of the area affected by frostbite is to:

A. Lessen the amount of cellular damage
B. Prevent the formation of blisters
C. Promote movement
D. Prevent pain and discomfort

2. A client recently started on hemodialysis wants to know how the dialysis will take the place of his kidneys. The nurse's response is based on the knowledge that hemodialysis works by:

A. Passing water through a dialyzing membrane
B. Eliminating plasma proteins from the blood
C. Lowering the pH by removing nonvolatile acids
D. Filtering waste through a dialyzing membrane

3. During a home visit, a client with AIDS tells the nurse that he has been exposed to measles. Which action by the nurse is most appropriate?

A. Administer an antibiotic
B. Contact the physician for an order for immune globulin
C. Administer an antiviral
D. Tell the client that he should remain in isolation for 2 weeks

4. A client hospitalized with MRSA (methicillin-resistant staph aureus) is placed on contact precautions. Which statement is true regarding precautions for infections spread by contact?

A. The client should be placed in a room with negative pressure.
B. Infection requires close contact; therefore, the door may remain open.
C. Transmission is highly likely, so the client should wear a mask at all times.
D. Infection requires skin-to-skin contact and is prevented by hand washing, gloves, and a gown.

5. A client who is admitted with an above-the-knee amputation tells the nurse that his foot hurts and itches. Which response by the nurse indicates understanding of phantom limb pain?

A. "The pain will go away in a few days."
B. "The pain is due to peripheral nervous system interruptions. I will get you some pain medication."
C. "The pain is psychological because your foot is no longer there."
D. "The pain and itching are due to the infection you had before the surgery."

6. A client with cancer of the pancreas has undergone a Whipple procedure. The nurse is aware that during the Whipple procedure, the doctor will remove the:

A. Head of the pancreas
B. Proximal third section of the small intestines
C. Stomach and duodenum
D. Esophagus and jejunum

7. The physician has ordered a minimal-bacteria diet for a client with neutropenia. The client should be taught to AVOID eating:

A. Packed fruits
B. Salt
C. Fresh raw pepper
D. Ketchup

8. A client is discharged home with a prescription for Coumadin (sodium warfarin). The client should be instructed to:

A. Have a Protime done monthly
B. Eat more fruits and vegetables
C. Drink more liquids
D. Avoid crowds

9. The nurse is assisting the physician with removal of a central venous catheter. To facilitate removal, the nurse should instruct the client to:

A. Perform the Valsalva maneuver as the catheter is advanced
B. Turn his head to the left side and hyperextend the neck
C. Take slow, deep breaths as the catheter is removed
D. Turn his head to the right while maintaining a sniffing position

10. A client has an order for streptokinase. Before administering the medication, the nurse should assess the client for:

A. Allergies to pineapples and bananas
B. A history of streptococcal infections
C. Prior therapy with phenytoin
D. A history of alcohol abuse

11. The nurse is providing discharge teaching for the client with leukemia. The client should be told to avoid:

A. Using oil- or cream-based soaps
B. Flossing between the teeth
C. The intake of salt
D. Using an electric razor

12. The nurse is changing the ties of the client with a tracheotomy. The safest method of changing the tracheotomy ties is to:

A. Apply the new tie before removing the old one.
B. Have a helper present.

C. Hold the tracheotomy with the nondominant hand while removing the old tie.
D. Ask the doctor to suture the tracheostomy in place.

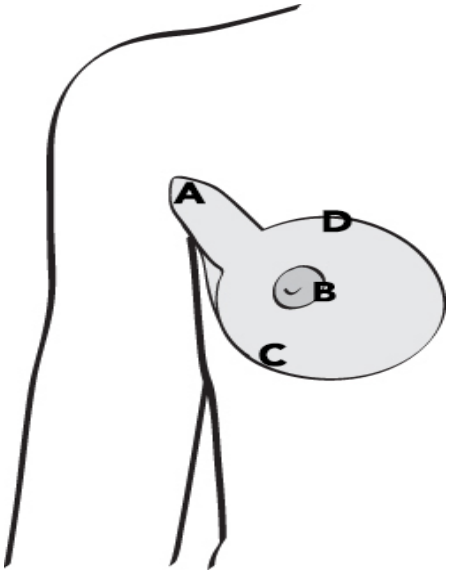
13. The nurse is monitoring a client following a lung resection. The hourly output from the chest tube was 300mL. The nurse should give priority to:

A. Turning the client to the left side
B. Milking the tube to ensure patency
C. Slowing the intravenous infusion
D. Notifying the physician

14. The infant is admitted to the unit with tetrology of falot. The nurse would anticipate an order for which medication?

A. Digoxin
B. Epinephrine
C. Aminophylline
D. Atropine

15. The nurse is educating the lady's club in self-breast exam. The nurse is aware that most malignant breast masses occur in the Tail of Spence. On the diagram below, select where the Tail of Spence is.



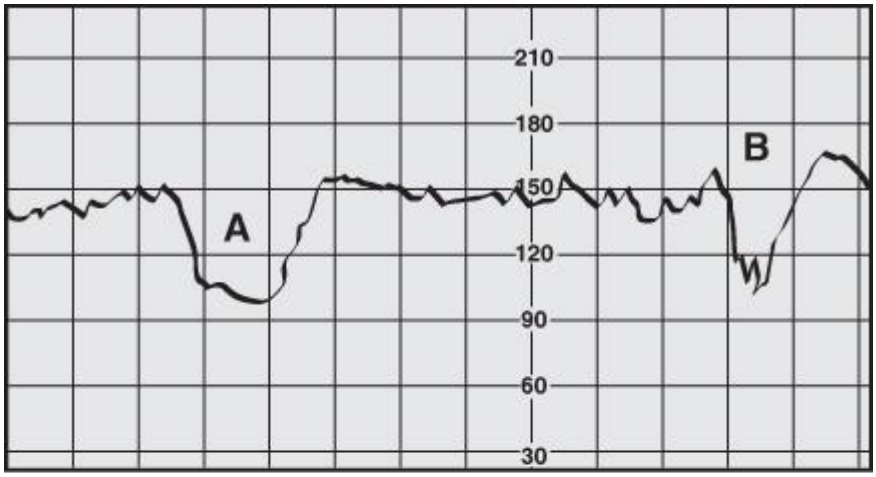
16. The toddler is admitted with a cardiac anomaly. The nurse is aware that the infant with a ventricular septal defect will:

A. Tire easily
B. Grow normally
C. Need more calories
D. Be more susceptible to viral infections

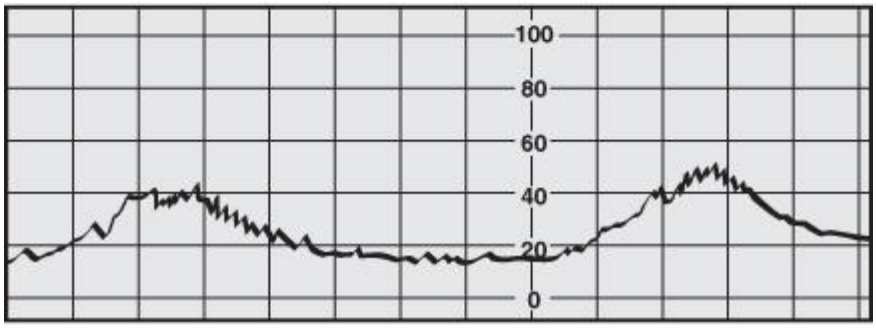
17. The nurse is monitoring a client with a history of stillborn infants. The nurse is aware that a nonstress test can be ordered for this client to:

A. Determine lung maturity
B. Measure the fetal activity
C. Show the effect of contractions on fetal heart rate
D. Measure the wellbeing of the fetus

18. The nurse is evaluating the client who was admitted 8 hours ago for induction of labor. The following graph is noted on the monitor. Which action should be taken first by the nurse?



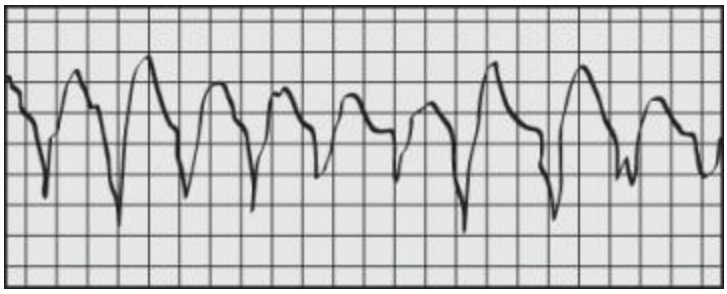
Fetal Heart Rate



Uterine Contractions

A. Instruct the client to push
B. Perform a vaginal exam
C. Turn off the Pitocin infusion
D. Place the client in a semi-Fowler's position

19. The nurse notes the following on the ECG monitor. The nurse would evaluate the cardiac arrhythmia as:



A. Atrial flutter
B. A sinus rhythm
C. Ventricular tachycardia
D. Atrial fibrillation

20. A client with clotting disorder has an order to continue Lovenox (enoxaparin) injections after discharge. The nurse should teach the client that Lovenox injections should:

A. Be injected into the deltoid muscle
B. Be injected into the abdomen
C. Aspirate after the injection
D. Clear the air from the syringe before injections

21. The nurse has a preop order to administer Valium (diazepam) 10mg and Phenergan (promethazine) 25mg. The correct method of administering these medications is to:

A. Administer the medications together in one syringe
B. Administer the medication separately
C. Administer the Valium, wait 5 minutes, and then inject the Phenergan
D. Question the order because they cannot be given at the same time

22. A client with frequent urinary tract infections asks the nurse how she can prevent the reoccurrence. The nurse should teach the client to:

A. Douche after intercourse
B. Void every 3 hours
C. Obtain a urinalysis monthly
D. Wipe from back to front after voiding

23. Which task should be assigned to the nursing assistant?

A. Placing the client in seclusion
B. Emptying the Foley catheter of the preeclamptic client
C. Feeding the client with dementia
D. Ambulating the client with a fractured hip

24. The client has recently returned from having a thyroidectomy. The nurse should keep which of the following at the bedside?

A. A tracheotomy set
B. A padded tongue blade
C. An endotracheal tube
D. An airway

25. The physician has ordered a histoplasmosis test for the elderly client. The nurse is aware that histoplasmosis is transmitted to humans by:

A. Cats
B. Dogs
C. Turtles
D. Birds

26. What's the first intervention for a patient experiencing chest pain and an p02 of 89%?

A. Administer morphine.
B. Administer oxygen.
C. Administer sublingual nitroglycerin.
D. Obtain an electrocardiogram (ECC)

27. Which of the following signs and symptoms usually signifies rapid expansion and impending rupture of an abdominal aortic aneurysm?

A. Abdominal pain.
B. Absent pedal pulses.
C. Chest pain.
D. Lower back pain.

28. In which of the following types of cardiomyopathy does cardiac output remain normal?

A. Dilated.
B. Hypertrophic.
C. Obliterative.
D. Restrictive.

29. Which of the following interventions should be your first priority when treating a patient experiencing chest pain while walking?

A. Have the patient sit down.
B. Get the patient back to bed.
C. Obtain an ECG.
D. Administer sublingual nitroglycerin.

30. Which of the following positions would best aid breathing for a patient with acute pulmonary edema?

A. Lying flat in bed.
B. Left side-lying position.

C. High Fowler's position.
D. Semi-Fowler's position.

31. A pregnant woman arrives at the emergency department (ED) with abruptio placentae at 34 weeks' gestation. She's at risk for which of the following blood dyscrasias?

A. Thrombocytopenia.
B. Idiopathic thrombocytopenic purpura (ITP).
C. Disseminated intravascular coagulation (DIC).
D. Heparin-associated thrombosis and thrombocytopenia (HATT).

32. A 16-year-old patient involved in a motor vehicle accident arrives in the ED unconscious and severely hypotensive. He's suspected to have several fractures of his pelvis and legs. Which of the following parenteral fluids is the best choice for his current condition?

A. Fresh frozen plasma.
B. 0.9% sodium chloride solution.
C. Lactated Ringer's solution.
D. Packed red blood cells.

33. Corticosteroids are potent suppressors of the body's inflammatory response. Which of the following conditions or actions do they suppress?

A. Cushing syndrome.
B. Pain receptors.
C. Immune response.
D. Neural transmission.

34. A patient infected with human immunodeficiency virus (HIV) begins zidovudine therapy. Which of the following statements best describes this drug's action?

A. It destroys the outer wall of the virus and kills it.
B. It interferes with viral replication.
C. It stimulates the immune system.
D. It promotes excretion of viral antibodies.

35. A 20-year-old patient is being treated for pneumonia. He has a persistent cough and complains of severe pain on coughing. What could you tell him to help him reduce his discomfort?

A. "Hold your cough as much as possible."
B. "Place the head of your bed flat to help with coughing."
C. "Restrict fluids to help decrease the amount of sputum."
D. "Splint your chest wall with a pillow for comfort."

36. A 19-year-old patient comes to the ED with acute asthma. His respiratory rate is 44 breaths/minute, and he appears to be in acute respiratory distress. Which of the following actions should you take first?

A. Take a full medical history.
B. Give a bronchodilator by nebulizer.
C. Apply a cardiac monitor to the patient.
D. Provide emotional support for the patient.

37. A firefighter who was involved in extinguishing a house fire is being treated for smoke inhalation. He develops severe hypoxia 48 hours after the incident, requiring intubation and mechanical ventilation. Which of the following conditions has he most likely developed?

A. Acute respiratory distress syndrome (ARDS).
B. Atelectasis.
C. Bronchitis.
D. Pneumonia.

38. Which of the following measures best determines that a patient who had a pneumothorax no longer needs a chest tube?

A. You see a lot of drainage from the chest tube.
B. Arterial blood gas (ABG) levels are normal.
C. The chest X-ray continues to show the lung is 35% deflated.
D. The water-seal chamber doesn't fluctuate when no suction is applied.

39. Which of the following nursing interventions should you use to prevent footdrop and contractures in a patient recovering from a subdural hematoma?

A. High-top sneakers.
B. Low-dose heparin therapy.
C. Physical therapy consultation.
D. Sequential compressive device.

40. Which of the following signs of increased intracranial pressure (ICP) would appear first after head trauma?

A. Bradycardia.
B. Large amounts of very dilute urine.
C. Restlessness and confusion.
D. Widened pulse pressure.

41. When giving intravenous (I.V.) phenytoin, which of the following methods should you use?

A. Use an in-line filter.
B. Withhold other anticonvulsants.
C. Mix the drug with saline solution only.
D. Flush the I.V. catheter with dextrose solution.

42. After surgical repair of a hip, which of the following positions is best for the patient's legs and hips?

A. Abduction.
B. Adduction.
C. Prone.
D. Subluxated.

43. Which of the following factors should be the primary focus of nursing management in a patient with acute pancreatitis?

A. Nutrition management.
B. Fluid and electrolyte balance.
C. Management of hypoglycemia.
D. Pain control.

44. After a liver biopsy, place the patient in which of the following positions?

A. Left side-lying, with the bed flat.
B. Right side-lying, with the bed flat.
C. Left side-lying, with the bed in semi-Fowler's position.
D. Right side-lying, with the bed in semi-Fowler's position.

45. Which of the following potentially serious complications could occur with therapy for hypothyroidism?

A. Acute hemolytic reaction.
B. Angina or cardiac arrhythmia.
C. Retinopathy.
D. Thrombocytopenia.

46. Adequate fluid replacement and vasopressin replacement are objectives of therapy for which of the following disease processes?

A. Diabetes mellitus.
B. Diabetes insipidus.
C. Diabetic ketoacidosis.
D. Syndrome of inappropriate antidiuretic hormone secretion (SIADH).

47. Patients with Type 1 diabetes mellitus may require which of the following changes to their daily routine during periods of infection?

A. No changes.
B. Less insulin.
C. More insulin.
D. Oral diabetic agents.

48. On a follow-up visit after having a vaginal hysterectomy, a 32-year-old patient has a decreased hematocrit level. Which of the following complications does this suggest?

A. Hematoma.
B. Hypovolemia.
C. Infection.
D. Pulmonary embolus (PE).

49. A patient has partial-thickness burns to both legs and portions of his trunk. Which of the following I.V. fluids is given first?

A. Albumin.
B. D5W.
C. Lactated Ringer's solution.
D. 0.9% sodium chloride solution with 2 mEq of potassium per 100 ml.

50. Which of the following techniques is correct for obtaining a wound culture specimen from a surgical site?

A. Thoroughly irrigate the wound before collecting the specimen.
B. Use a sterile swab and wipe the crusty area around the outside of the wound.
C. Gently roll a sterile swab from the center of the wound outward to collect drainage.
D. Use a sterile swab to collect drainage from the dressing.

Answers and Rationale

1. Answer: A. Lessen the amount of cellular damage

Rapid continuous rewarming of a frostbite primarily lessens cellular damage. It does not prevent formation of blisters. It does promote movement, but this is not the primary reason for rapid rewarming. It might increase pain for a short period of time as the feeling comes back into the extremity; therefore, answers B, C, and D are incorrect.

2. Answer: D. Filtering waste through a dialyzing membrane

Hemodialysis works by using a dialyzing membrane to filter waste that has accumulated in the blood. It does not pass water through a dialyzing membrane nor does it eliminate plasma proteins or lower the pH, so answers A, B, and C are incorrect.

3. Answer: B. Contact the physician for an order for immune globulin

The client who is immunosuppressed and is exposed to measles should be treated with medications to boost his immunity to the virus. An antibiotic or antiviral will not protect the client and it is too late to place the client in isolation, so answers A, C, and D are incorrect.

4. Answer: D. Infection requires skin-to-skin contact and is prevented by hand washing, gloves, and a gown.

The client with MRSA should be placed in isolation. Gloves, a gown, and a mask should be used when caring for the client and hand washing is very important. The door should remain closed, but a negative-pressure room is not necessary, so answers A and B are incorrect. MRSA is spread by contact with blood or body fluid or by touching the skin of the client. It is cultured from the nasal passages of the client, so the client should be instructed to cover his nose and mouth when he sneezes or coughs. It is not necessary for the client to wear the mask at all times; the nurse should wear the mask, so answer C is incorrect.

5. Answer: B. "The pain is due to peripheral nervous system interruptions. I will get you some pain medication."

Pain related to phantom limb syndrome is due to peripheral nervous system interruption. Answer: A. is incorrect because phantom limb pain can last several months or indefinitely. Answer: C. is incorrect because it is not psychological. It is also not due to infections, as stated in answer D.

6. Answer: A. Head of the pancreas

During a Whipple procedure the head of the pancreas, which is a part of the stomach, the jejunum, and a portion of the stomach are removed and anastomosed. Answer: B. is incorrect because the proximal third of the small intestine is not removed. The entire stomach is not removed, as in answer C, and in answer D, the esophagus is not removed.

7. Answer: C. Fresh raw pepper

Fresh raw or whole pepper are not allowed unless thoroughly cooked in food. Canned fruits are allowed since they are processed and pasteurized. Salt, ketchup, and sugar are allowed.

8. Answer: A. Have a Protime done monthly

Coumadin is an anticoagulant. One of the tests for bleeding time is a Protime. This test should be done monthly. Eating more fruits and vegetables is not necessary, and dark-green vegetables contain vitamin K, which increases clotting, so answer B is incorrect. Drinking more liquids and avoiding crowds is not necessary, so answers C and D are incorrect.

9. Answer: A. Perform the Valsalva maneuver as the catheter is advanced

The client who is having a central venous catheter removed should be told to hold his breath and bear down. This prevents air from entering the line. Answers B, C, and D will not facilitate removal.

10. Answer: B. A history of streptococcal infections

Clients with a history of streptococcal infections could have antibodies that render the streptokinase ineffective. There is no reason to assess the client for allergies to

pineapples or bananas, there is no correlation to the use of phenytoin and streptokinase, and a history of alcohol abuse is also not a factor in the order for streptokinase; therefore, answers A, C, and D are incorrect.

11. Answer: B. Flossing between the teeth

The client who is immune-suppressed and has bone marrow suppression should be taught not to floss his teeth because platelets are decreased. Using oils and cream-based soaps is allowed, as is eating salt and using an electric razor; therefore, answers A, C, and D are incorrect.

12. Answer: A. Apply the new tie before removing the old one.

The best method and safest way to change the ties of a tracheotomy is to apply the new ones before removing the old ones. Having a helper is good, but the helper might not prevent the client from coughing out the tracheotomy. Answer: C. is not the best way to prevent the client from coughing out the tracheotomy. Asking the doctor to suture the tracheotomy in place is not appropriate.

13. Answer: D. Notifying the physician

The output of 300 mL is indicative of hemorrhage and should be reported immediately. Answer: A. does nothing to help the client. Milking the tube is done only with an order and will not help in this situation, and slowing the intravenous infusion is not correct; thus, answers B and C are incorrect.

14. Answer: A. Digoxin

The infant with Tetralogy of Fallot involves four heart defects: A large ventricular septal defect (VSD), Pulmonary stenosis, Right ventricular hypertrophy and, An overriding aorta. He will be treated with digoxin to slow and strengthen the heart. Epinephrine, aminophylline, and atropine will speed the heart rate and are not used in this client; therefore, answers B, C, and D are incorrect.

15. Answer: A.

The Tail of Spence is located in the upper outer quadrant of the breast.

16. Answer: A. Tire easily

The toddler with a ventricular septal defect will tire easily. He will not grow normally but will not need more calories. He will be susceptible to bacterial infection, but he will be no more susceptible to viral infections than other children. Therefore, answers B, C, and D are incorrect.

17. Answer: B. Measure the fetal activity

A nonstress test determines periodic movement of the fetus. It does not determine lung maturity, show contractions, or measure neurological well-being, making answers A, C, and D incorrect.

18. Answer: C. Turn off the Pitocin infusion

The monitor indicates variable decelerations caused by cord compression. If Pitocin is infusing, the nurse should turn off the Pitocin. Instructing the client to push is incorrect because pushing could increase the decelerations and because the client is 8cm dilated, making answer A incorrect. Performing a vaginal exam should be done after turning off the Pitocin, and placing the client in a semi-Fowler's position is not appropriate for this situation; therefore, answers B and D are incorrect.

19. Answer: C. Ventricular tachycardia

The graph indicates ventricular tachycardia. The answers in A, B, and D are not noted on the ECG strip.

20. Answer: B. Be injected into the abdomen

Lovenox injections should be given in the abdomen, not in the deltoid muscle. The client should not aspirate after the injection or clear the air from the syringe before injection. Therefore, answers A, C, and D are incorrect.

21. Answer: B. Administer the medication separately

Valium is not given in the same syringe with other medications, so answer A (Douche after intercourse) is incorrect. These medications can be given to the same client, so answer D (Ambulating the client with a fractured hip) is incorrect. In answer C (Feeding the client with dementia), it is not necessary to wait to inject the second medication. Valium is an antianxiety medication, and Phenergan is used as an antiemetic.

22. Answer: B. Void every 3 hours

Voiding every 3 hours prevents stagnant urine from collecting in the bladder, where bacteria can grow. Douching is not recommended and obtaining a urinalysis monthly is not necessary, making answers A and C incorrect. The client should practice wiping from front to back after voiding and bowel movements, so answer D is incorrect.

23. Answer: C. Feeding the client with dementia

Of these clients, the one who should be assigned to the care of the nursing assistant is the client with dementia. Only an RN or the physician can place the client in seclusion, so answer A (Placing the client in seclusion) is incorrect. The nurse should empty the Foley catheter of the preeclamptic client because the client is unstable, making answer B incorrect. A nurse or physical therapist should ambulate the client with a fractured hip, so answer D is incorrect.

24. Answer: A. A tracheotomy set

The client who has recently had a thyroidectomy is at risk for tracheal edema. A padded tongue blade is used for seizures and not for the client with tracheal edema, so answer B is incorrect. If the client experiences tracheal edema, the endotracheal tube or airway will not correct the problem, so answers C and D are incorrect.

25. Answer: D. Birds

Histoplasmosis is a fungus carried by birds. It is not transmitted to humans by cats, dogs, or turtles. Therefore, answers A, B, and C are incorrect.

26. Answer: B. Administer oxygen.

Administering supplemental oxygen to the patient is the first priority. Administer oxygen to increase SpO_2 to greater than 90% to help prevent further cardiac damage. Sublingualnitroglycerin and morphine are commonly administered after oxygen.

27. Answer: D. Lower back pain.

Lower back pain results from expansion of the aneurysm. The expansion applies pressure in the abdomen, and the pain is referred to the lower back.

- Option A: Abdominal pain is the most common symptom resulting from impaired circulation.
- Option B: Absent pedal pulses are a sign of no circulation and would occur after a ruptured aneurysm or in peripheral vascular disease.
- Option C: Chest pain usually is associated with coronary artery or pulmonary disease.

28. Answer: B. Hypertrophic

Cardiac output isn't affected by hypertrophic cardiomyopathy because the size of the ventricle remains relatively unchanged. Dilated cardiomyopathy, obliterative cardiomyopathy, and restrictive cardiomyopathy all decrease cardiac output.

29. Answer: A. Have the patient sit down.

The initial priority is to decrease oxygen consumption by sitting the patient down. Administer sublingual nitroglycerin (Option D) as you simultaneously do the ECG. When the patient's condition is stabilized, he can be returned to bed (Option B).

30. Answer: C. High Fowler's position.

High Fowler's position facilitates breathing by reducing venous return. Lying flat and side-lying positions worsen breathing and increase the heart's workload.

31. Answer: C. Disseminated intravascular coagulation (DIC).

Abruptio placentae is a cause of DIC because it activates the clotting cascade after hemorrhage.

- Option A: Thrombocytopenia results from decreased production of platelets.
- Option B: ITP doesn't have a definitive cause.
- Option D: A patient with abruptio placentae wouldn't get heparin and, as a result, wouldn't be at risk for HATT.

32. Answer: D. Packed red blood cells.

In a trauma situation, the first blood product given is unmatched (O negative) packed red blood cells.

- Option A: Fresh frozen plasma often is used to replace clotting factors.
- Options B and C: Lactated Ringer's solution or 0.9% sodium chloride is used to increase volume and blood pressure, but too much of these crystalloids will dilute the blood and won't improve oxygen-carrying capacity.

33. Answer: C. Immune response.

Corticosteroids suppress eosinophils, lymphocytes, and natural-killer cells, inhibiting the natural inflammatory process in an infected or injured part of the body. This helps resolve inflammation, stabilizes lysosomal membranes, decreases capillary permeability, and depresses phagocytosis of tissues by white blood cells, thus blocking the release of more inflammatory materials. Excessive corticosteroid therapy can lead to Cushing's syndrome.

34. Answer: B. It interferes with viral replication.

Zidovudine inhibits DNA synthesis in HIV, thus interfering with viral replication. The drug doesn't destroy the viral wall, stimulate the immune system, or promote HIV antibody excretion.

35. Answer: D. "Splint your chest wall with a pillow for comfort."

Showing this patient how to splint his chest wall will help decrease discomfort when coughing.

- Option A: Holding in his coughs will only increase his pain.
- Option B: Placing the head of the bed flat may increase the frequency of his cough and his work of breathing.
- Option C: Increasing fluid intake will help thin the secretions, making it easier for him to clear them.

36. Answer: B. Give a bronchodilator by nebulizer.

The patient having an acute asthma attack needs more oxygen delivered to his lungs and body. Nebulized bronchodilators open airways and increase the amount of oxygen delivered.

- Option C: The patient may not need cardiac monitoring because he's only 19 years old, unless he has a medical history of cardiac problems.
- Options A and D: Important but not priority as of the moment; emotional support can help calm the patient but can be done after medical intervention.

37. Answer: A. Acute respiratory distress syndrome (ARDS).

Severe hypoxia after smoke inhalation typically is related to ARDS. The other choices aren't typically associated with smoke inhalation.

38. Answer: D. The water-seal chamber doesn't fluctuate when no suction is applied.

The chest tube isn't removed until the patient's lung has adequately re-expanded and is expected to stay that way. One indication of reexpansion is the cessation of fluctuation in the water-seal chamber when suction isn't applied.

- Option C: The chest X-ray should show that the lung is re-expanded.
- Option A: Drainage should be minimal before the chest tube is removed.
- Option B: An ABG test isn't necessary if clinical assessment criteria are met.

39. Answer: A. High-top sneakers.

High-top sneakers are used to prevent foot drop and contractures in patients with neurologic conditions. Option C: A consult with physical therapy is important to prevent foot drop, but you can use high-top sneakers independently.

40. Answer: C. Restlessness and confusion.

The earliest sign of increased ICP is a change in mental status.

- Option A: Bradycardia and widened pulse pressure occur later.
- Option B: The patient may void a lot of very dilute urine if his posterior pituitary is damaged.

41. Answer: C. Mix the drug with saline solution only.

Phenytoin is compatible only with saline solutions; dextrose causes an insoluble precipitate to form. You needn't withhold additional anticonvulsants or use an in-line filter (Option B.).

42. Answer: A. Abduction

After surgical repair of the hip, keep the legs and hips abducted to stabilize the prosthesis in the acetabulum.

43. Answer: B. Fluid and electrolyte balance.

Acute pancreatitis is commonly associated with fluid isolation and accumulation in the bowel secondary to ileus or peripancreatic edema. Fluid and electrolyte loss from vomiting is a major concern. Therefore, your priority is to manage hypovolemia and restore electrolyte balance.

- Options A & D: Pain control and nutrition also are important, but not priority.
- Option C: Patients are at risk for hyperglycemia, not hypoglycemia.

44. Answer: B. Right side-lying, with the bed flat.

Positioning the patient on his right side with the bed flat will splint the biopsy site and minimize bleeding. The other positions won't do this and may cause more bleeding at the site or internally.

45. Answer: B. Angina or cardiac arrhythmia.

Precipitation of angina or cardiac arrhythmia is a potentially serious complication of hypothyroidism treatment.

- Option A: Acute hemolytic reaction is a complication of blood transfusions.
- Option C: Retinopathy typically is a complication of diabetes mellitus.
- Option D: Thrombocytopenia doesn't result from treating hypothyroidism.

46. Answer: B. Diabetes insipidus.

Maintaining adequate fluid and replacing vasopressin are the main objectives in treating diabetes insipidus.

- Option A: Diabetes is a chronic condition associated with abnormally high levels of sugar (glucose) in the blood. Insulin produced by the pancreas lowers blood glucose.
- Option C: Diabetic ketoacidosis is a result of severe insulin insufficiency.
- Option D: An excess of antidiuretic hormone leads to SIADH, causing the patient to retain fluid.

47. Answer: C. More insulin.

During periods of infection or illness, patients with Type 1 diabetes may need even more insulin to compensate for increased blood glucose levels.

48. Answer: A. Hematoma.

A decreased hematocrit level is a sign of hematoma, a delayed complication of abdominal and vaginal hysterectomy.

- Option B: Symptoms of hypovolemia include increased hematocrit and hemoglobin values.
- Option C: Infection manifests with fever and high WBC count.
- Option D: Symptoms of a PE include dyspnea, chest pain, cough, hemoptysis, restlessness, and signs of shock.

49. Answer: C. Lactated Ringer's solution.

Lactated Ringer's solution replaces lost sodium and corrects metabolic acidosis, both of which commonly occur following a burn.

- Option A: Albumin is used as adjunct therapy, not primary fluid replacement.
- Option B: Dextrose isn't given to burn patients during the first 24 hours because it can cause pseudodiabetes.

Option D: The patient is hyperkalemic from the potassium shift from the intracellular space to the plasma, so potassium would be detrimental.

50. Answer: C. Gently roll a sterile swab from the center of the wound outward to collect drainage.

Rolling a swab from the center outward is the right way to obtain a culture specimen from a wound.

- Option A: Irrigating the wound washes away drainage, debris, and many of the colonizing or infecting microorganisms.
- Option B: The outside of the wound and the dressing may be colonized with microorganisms that haven't affected the wound, so specimens from these sites could give inaccurate results.

1. A nurse is administering IV furosemide to a patient admitted with congestiveheart failure. After the infusion, which of the following symptoms is NOT expected?

A. Increased urinary output.
B. Decreased edema.
C. Decreased pain.
D. Decreased blood pressure.

2. There are a number of risk factors associated with coronary artery disease. Which of the following is a modifiable risk factor?

A. Obesity.
B. Heredity.
C. Gender.
D. Age.

3. Tissue plasminogen activator (t-PA) is considered for treatment of a patient who arrives in the emergency department following onset of symptoms of myocardial infarction. Which of the following is a contraindication for treatment with t-PA?

A. Worsening chest pain that began earlier in the evening.
B. History of cerebral hemorrhage.
C. History of prior myocardial infarction.
D. Hypertension.

4. Following myocardial infarction, a hospitalized patient is encouraged to practice frequent leg exercises and ambulate in the hallway as directed by his physician. Which of the following choices reflects the purpose of exercise for this patient?

A. Increases fitness and prevents future heart attacks.
B. Prevents bedsores.
C. Prevents DVT (deep vein thrombosis).
D. Prevent constipations.

5. A patient arrives in the emergency department with symptoms of myocardial infarction, progressing to cardiogenic shock. Which of the following symptoms should the nurse expect the patient to exhibit with cardiogenic shock?

A. Hypertension.
B. Bradycardia.
C. Bounding pulse.
D. Confusion.

6. A patient with a history of congestive heart failure arrives at the clinic complaining of dyspnea. Which of the following actions is the first the nurse should perform?

A. Ask the patient to lie down on the exam table.
B. Draw blood for chemistry panel and arterial blood gas (ABG).
C. Send the patient for a chest x-ray.
D. Check blood pressure.

7. A clinic patient has recently been prescribed nitroglycerin for treatment of angina. He calls the nurse complaining of frequent headaches. Which of the following responses to the patient is correct?

A. “Stop taking the nitroglycerin and see if the headaches improve.”
B. “Go to the emergency department to be checked because nitroglycerin can cause bleeding in the brain.”
C. “Headaches are a frequent side effect of nitroglycerine because it causes vasodilation.”
D. “The headaches are unlikely to be related to the nitroglycerin, so you should see your doctor for further investigation.”

8. A patient received surgery and chemotherapy for colon cancer, completing therapy 3 months previously, and she is now in remission. At a follow-up appointment, she complains of fatigue following activity and difficulty with concentration at her weekly bridge games. Which of the following explanations could account for her symptoms?

A. The symptoms may be the result of anemia caused by chemotherapy.
B. The patient may be immunosuppressed.
C. The patient may be depressed.
D. The patient may be dehydrated.

9. A clinic patient has a hemoglobin concentration of 10.8 g/dL and reports sticking to a strict vegetarian diet. Which of the follow nutritional advice is appropriate?

A. The diet is providing adequate sources of iron and requires no changes.
B. The patient should add meat to her diet; a vegetarian diet is not advised.
C. The patient should use iron cookware to prepare foods, such as dark green, leafy vegetables and legumes, which are high in iron.
D. A cup of coffee or tea should be added to every meal.

10. A hospitalized patient is receiving packed red blood cells (PRBCs) for treatment of severe anemia. Which of the following is the most accurate statement?

A. Transfusion reaction is most likely immediately after the infusion is completed.
B. PRBCs are best infused slowly through a 20g. IV catheter.
C. PRBCs should be flushed with a 5% dextrose solution.
D. A nurse should remain in the room during the first 15 minutes of infusion.

11. A patient who has received chemotherapy for cancer treatment is given an injection of Epoetin. Which of the following should reflect the findings in a complete blood count (CBC) drawn several days later?

A. An increase in neutrophil count.
B. An increase in hematocrit.
C. An increase in platelet count.
D. An increase in serum iron.

12. A patient is admitted to the hospital with suspected polycythemia vera. Which of the following symptoms is consistent with the diagnosis? Select all that applies.

A. Weight loss.
B. Increased clotting time.
C. Hypertension.
D. Headaches.

13. A nurse is caring for a patient with a platelet count of 20,000/microliter. Which of the following is an important intervention?

A. Observe for evidence of spontaneous bleeding.
B. Limit visitors to family only.
C. Give aspirin in case of headaches.
D. Impose immune precautions.

14. A nurse in the emergency department assesses a patient who has been taking long-term corticosteroids to treat renal disease. Which of the following is a typical side effect of corticosteroid treatment? Note: More than one answer may be correct.

A. Hypertension.
B. Cushingoid features.
C. Hyponatremia.
D. Low serum albumin.

15. A nurse is caring for patients in the oncology unit. Which of the following is the most important nursing action when caring for a neutropenic patient?

A. Change the disposable mask immediately after use.
B. Change gloves immediately after use.
C. Minimize patient contact.
D. Minimize conversation with the patient.

16. A patient is undergoing the induction stage of treatment for leukemia. The nurse teaches family members about infectious precautions. Which of the following statements by family members indicates that the family needs more education?

A. We will bring in books and magazines for entertainment.
B. We will bring in personal care items for comfort.
C. We will bring in fresh flowers to brighten the room.
D. We will bring in family pictures and get well cards.

17. A nurse is caring for a patient with acute lymphoblastic leukemia (ALL). Which of the following is the most likely age range of the patient?

A. 3-10 years.
B. 25-35 years.
C. 45-55 years.
D. over 60 years.

18. A patient is admitted to the oncology unit for diagnosis of suspected Hodgkin's disease. Which of the following symptoms is typical of Hodgkin's disease?

A. Painful cervical lymph nodes.
B. Night sweats and fatigue.
C. Nausea and vomiting.
D. Weight gain.

19. The Hodgkin's disease patient described in the question above undergoes a lymph node biopsy for definitive diagnosis. If the diagnosis of Hodgkin's disease were correct, which of the following cells would the pathologist expect to find?

A. Reed-Sternberg cells.
B. Lymphoblastic cells.
C. Gaucher's cells.
D. Rieder's cells

20. A patient is about to undergo bone marrow aspiration and biopsy and expresses fear and anxiety about the procedure. Which of the following is the most effective nursing response?

A. Warn the patient to stay very still because the smallest movement will increase her pain.

B. Encourage the family to stay in the room for the procedure.
C. Stay with the patient and focus on slow, deep breathing for relaxation.
D. Delay the procedure to allow the patient to deal with her feelings.

21. A 43-year-old African American male is admitted with sickle cell anemia. The nurse plans to assess circulation in the lower extremities every 2 hours. Which of the following outcome criteria would the nurse use?

A. Body temperature of 99°F or less
B. Toes moved in active range of motion
C. Sensation reported when soles of feet are touched
D. Capillary refill of < 3 seconds

22. A 30-year-old male from Haiti is brought to the emergency department in sickle cell crisis. What is the best position for this client?

A. Side-lying with knees flexed
B. Knee-chest
C. High Fowler's with knees flexed
D. Semi-Fowler's with legs extended on the bed

23. A 25-year-old male is admitted in sickle cell crisis. Which of the following interventions would be of highest priority for this client?

A. Taking hourly blood pressures with mechanical cuff
B. Encouraging fluid intake of at least 200mL per hour
C. Position in high Fowler's with knee gatch raised
D. Administering Tylenol as ordered

24. Which of the following foods would the nurse encourage the client in sickle cell crisis to eat?

A. Peaches
B. Cottage cheese
C. Popsicle
D. Lima beans

25. A newly admitted client has sickle cell crisis. The nurse is planning care based on assessment of the client. The client is complaining of severe pain in his feet and hands. The pulse oximetry is 92. Which of the following interventions would be implemented first? Assume that there are orders for each intervention.

A. Adjust the room temperature
B. Give a bolus of IV fluids
C. Start O2
D. Administer meperidine (Demerol) 75 mg IV push

26. The nurse is instructing a client with iron-deficiency anemia. Which of the following meal plans would the nurse expect the client to select?

A. Roast beef, gelatin salad, green beans, and peach pie
B. Chicken salad sandwich, coleslaw, French fries, ice cream
C. Egg salad on wheat bread, carrot sticks, lettuce salad, raisin pie
D. Pork chop, creamed potatoes, corn, and coconut cake

27. Clients with sickle cell anemia are taught to avoid activities that cause hypoxia and hypoxemia. Which of the following activities would the nurse recommend?

A. A family vacation in the Rocky Mountains
B. Chaperoning the local boys club on a snow-skiing trip
C. Traveling by airplane for business trips
D. A bus trip to the Museum of Natural History

28. The nurse is conducting an admission assessment of a client with vitamin B12 deficiency. Which of the following would the nurse include in the physical assessment?

A. Palpate the spleen
B. Take the blood pressure
C. Examine the feet for petechiae
D. Examine the tongue

29. An African American female comes to the outpatient clinic. The physician suspects vitamin B12 deficiency anemia. Because jaundice is often a clinical manifestation of this type of anemia, what body part would be the best indicator?

A. Conjunctiva of the eye
B. Soles of the feet
C. Roof of the mouth
D. Shins

30. The nurse is conducting a physical assessment on a client with anemia. Which of the following clinical manifestations would be most indicative of the anemia?

A. BP 146/88
B. Respirations 28 shallow
C. Weight gain of 10 pounds in 6 months
D. Pink complexion

31. The nurse is teaching the client with polycythemia vera about prevention of complications of the disease. Which of the following statements by the client indicates a need for further teaching?

A. “I will drink 500mL of fluid or less each day.”
B. “I will wear support hose when I am up.”
C. “I will use an electric razor for shaving.”
D. “I will eat foods low in iron.”

32. A 33-year-old male is being evaluated for possible acute leukemia. Which of the following would the nurse inquire about as a part of the assessment?

A. The client collects stamps as a hobby.
B. The client recently lost his job as a postal worker.
C. The client had radiation for treatment of Hodgkin’s disease as a teenager.
D. The client’s brother had leukemia as a child.

33. An African American client is admitted with acute leukemia. The nurse is assessing for signs and symptoms of bleeding. Where is the best site for examining for the presence of petechiae?

A. The abdomen
B. The thorax
C. The earlobes
D. The soles of the feet

34. A client with acute leukemia is admitted to the oncology unit. Which of the following would be most important for the nurse to inquire?

A. “Have you noticed a change in sleeping habits recently?”
B. “Have you had a respiratory infection in the last 6 months?”
C. “Have you lost weight recently?”
D. “Have you noticed changes in your alertness?”

35. Which of the following would be the priority nursing diagnosis for the adult client with acute leukemia?

A. Oral mucous membrane, altered related to chemotherapy
B. Risk for injury related to thrombocytopenia
C. Fatigue related to the disease process
D. Interrupted family processes related to life-threatening illness of a family member

36. A 21-year-old male with Hodgkin’s lymphoma is a senior at the local university. He is engaged to be married and is to begin a new job upon graduation. Which of the following diagnoses would be a priority for this client?

A. Sexual dysfunction related to radiation therapy
B. Anticipatory grieving related to terminal illness
C. Tissue integrity related to prolonged bed rest
D. Fatigue related to chemotherapy

37. A client has autoimmune thrombocytopenic purpura. To determine the client’s response to treatment, the nurse would monitor:

A. Platelet count
B. White blood cell count

C. Potassium levels
D. Partial prothrombin time (PTT)

38. The home health nurse is visiting a client with autoimmune thrombocytopenic purpura (ATP). The client's platelet count currently is 80, It will be most important to teach the client and family about:

A. Bleeding precautions
B. Prevention of falls
C. Oxygen therapy
D. Conservation of energy

39. A client with a pituitary tumor has had a transsphenoidal hypophysectomy. Which of the following interventions would be appropriate for this client?

A. Place the client in Trendelenburg position for postural drainage
B. Encourage coughing and deep breathing every 2 hours
C. Elevate the head of the bed 30°
D. Encourage the Valsalva maneuver for bowel movements

40. The client with a history of diabetes insipidus is admitted with polyuria, polydipsia, and mental confusion. The priority intervention for this client is:

A. Measure the urinary output
B. Check the vital signs
C. Encourage increased fluid intake
D. Weigh the client

41. A client with hemophilia has a nosebleed. Which nursing action is most appropriate to control the bleeding?

A. Place the client in a sitting position with the head hyperextended
B. Pack the nares tightly with gauze to apply pressure to the source of bleeding
C. Pinch the soft lower part of the nose for a minimum of 5 minutes
D. Apply ice packs to the forehead and back of the neck

42. A client has had a unilateral adrenalectomy to remove a tumor. To prevent complications, the most important measurement in the immediate postoperative period for the nurse to take is:

A. Blood pressure
B. Temperature
C. Output
D. Specific gravity

43. A client with Addison's disease has been admitted with a history of nausea and vomiting for the past 3 days. The client is receiving IV glucocorticoids (Solu-Medrol). Which of the following interventions would the nurse implement?

A. Glucometer readings as ordered
B. Intake/output measurements

C. Sodium and potassium levels monitored
D. Daily weights

44. A client had a total thyroidectomy yesterday. The client is complaining of tingling around the mouth and in the fingers and toes. What would the nurse's next action be?

A. Obtain a crash cart
B. Check the calcium level
C. Assess the dressing for drainage
D. Assess the blood pressure for hypertension

45. A 32-year-old mother of three is brought to the clinic. Her pulse is 52, there is a weight gain of 30 pounds in 4 months, and the client is wearing two sweaters. The client is diagnosed with hypothyroidism. Which of the following nursing diagnoses is of highest priority?

A. Impaired physical mobility related to decreased endurance
B. Hypothermia r/t decreased metabolic rate
C. Disturbed thought processes r/t interstitial edema
D. Decreased cardiac output r/t bradycardia

Answers and Rationale

1. Answer: C. Decreased pain.

Furosemide, a loop diuretic, does not alter pain. Furosemide acts on the kidneys to increase urinary output. Fluid may move from the periphery, decreasing edema. Fluid load is reduced, lowering blood pressure.

2. Answer: A. Obesity.

Obesity is an important risk factor for coronary artery disease that can be modified by improved diet and weight loss. Family history of coronary artery disease, male gender, and advancing age increase risk but cannot be modified.

3. Answer: B. History of cerebral hemorrhage.

A history of cerebral hemorrhage is a contraindication to tPA because it may increase the risk of bleeding. TPA acts by dissolving the clot blocking the coronary artery and

works best when administered within 6 hours of onset of symptoms. Prior MI is not a contraindication to tPA. Patients receiving tPA should be observed for changes in blood pressure, as tPA may cause hypotension.

4. Answer: C. Prevents DVT (deep vein thrombosis).

Exercise is important for all hospitalized patients to prevent deep vein thrombosis. Muscular contraction promotes venous return and prevents hemostasis in the lower extremities. This exercise is not sufficiently vigorous to increase physical fitness, nor is it intended to prevent bedsores or constipation.

5. Answer: D. Confusion.

Cardiogenic shock severely impairs the pumping function of the heart muscle, causing diminished blood flow to the organs of the body. This results in diminished brain function and confusion, as well as hypotension, tachycardia, and weak pulse. Cardiogenic shock is a serious complication of myocardial infarction with a high mortality rate.

6. Answer: D. Check blood pressure.

A patient with congestive heart failure and dyspnea may have pulmonary edema, which can cause severe hypertension. Therefore, taking the patient's blood pressure should be the first action. Lying flat on the exam table would likely worsen the dyspnea, and the patient may not tolerate it. Blood draws for chemistry and ABG will be required, but not prior to the blood pressure assessment.

7. Answer: C. "Headaches are a frequent side effect of nitroglycerine because it causes vasodilation."

Nitroglycerin is a potent vasodilator and often produces unwanted effects such as headache, dizziness, and hypotension. Patients should be counseled, and the dose titrated, to minimize these effects. In spite of the side effects, nitroglycerin is effective at reducing myocardial oxygen consumption and increasing blood flow. The patient should not stop the medication. Nitroglycerine does not cause bleeding in the brain.

8. Answer: A. The symptoms may be the result of anemia caused by chemotherapy.

Three months after surgery and chemotherapy the patient is likely to be feeling the after-effects, which often includes anemia because of bone-marrow suppression. There is no evidence that the patient is immunosuppressed, and fatigue is not a typical symptom of immunosuppression. The information given does not indicate that depression or dehydration is a cause of her symptoms.

9. Answer: C. The patient should use iron cookware to prepare foods, such as dark green, leafy vegetables and legumes, which are high in iron.

Normal hemoglobin values range from 11.5-15.0. This vegetarian patient is mildly anemic. When food is prepared in iron cookware its iron content is increased. In addition, dark green leafy vegetables, such as spinach and kale, and legumes are high in iron. Mild anemia does not require that animal sources of iron be added to the diet.

Many non-animal sources are available. Coffee and tea increase gastrointestinal activity and inhibit absorption of iron.

10. Answer: D. A nurse should remain in the room during the first 15 minutes of infusion.

Transfusion reaction is most likely during the first 15 minutes of infusion, and a nurse should be present during this period. PRBCs should be infused through a 19g or larger IV catheter to avoid slow flow, which can cause clotting. PRBCs must be flushed with 0.45% normal saline solution. Other intravenous solutions will hemolyze the cells.

11. Answer: B. An increase in hematocrit.

Epoetin is a form of erythropoietin, which stimulates the production of red blood cells, causing an increase in hematocrit. Epoetin is given to patients who are anemic, often as a result of chemotherapy treatment. Epoetin has no effect on neutrophils, platelets, or serum iron.

12. Answers: B, C, and D.

Polycythemia vera is a condition in which the bone marrow produces too many red blood cells. This causes an increase in hematocrit and viscosity of the blood. Patients can experience headaches, dizziness, and visual disturbances. Cardiovascular effects include increased blood pressure and delayed clotting time. Weight loss is not a manifestation of polycythemia vera.

13. Answer: A. Observe for evidence of spontaneous bleeding.

Platelet counts under 30,000/microliter may cause spontaneous petechiae and bruising, particularly in the extremities. When the count falls below 15,000, spontaneous bleeding into the brain and internal organs may occur. Headaches may be a sign and should be watched for. Aspirin disables platelets and should never be used in the presence of thrombocytopenia. Thrombocytopenia does not compromise immunity, and there is no reason to limit visitors as long as any physical trauma is prevented.

14. Answers: A, B, and D.

Side effects of corticosteroids include weight gain, fluid retention with hypertension, Cushingoid features, a low serum albumin, and suppressed inflammatory response. Patients are encouraged to eat a diet high in protein, vitamins, and minerals and low in sodium. Corticosteroids cause hypernatremia and not hyponatremia.

15. Answer: B. Change gloves immediately after use.

The neutropenic patient is at risk of infection. Changing gloves immediately after use protects patients from contamination with organisms picked up on hospital surfaces. This contamination can have serious consequences for an immunocompromised patient. Changing the respiratory mask is desirable, but not nearly as urgent as changing gloves. Minimizing contact and conversation are not necessary and may cause nursing staff to miss changes in the patient's symptoms or condition.

16. Answer: C. We will bring in fresh flowers to brighten the room.

During induction chemotherapy, the leukemia patient is severely immunocompromised and at risk of serious infection. Fresh flowers, fruit, and plants can carry microbes and should be avoided. Books, pictures, and other personal items can be cleaned with antimicrobials before being brought into the room to minimize the risk of contamination.

17. Answer: A. 3-10 years.

The peak incidence of ALL is at 4 years (range 3-10). It is uncommon after the mid-teen years. The peak incidence of chronic myelogenous leukemia (CML) is 45-55 years. The peak incidence of acute myelogenous leukemia (AML) occurs at 60 years. Two-thirds of cases of chronic lymphocytic leukemia (CLL) occur after 60 years.

18. Answer: B. Night sweats and fatigue.

Symptoms of Hodgkin's disease include night sweats, fatigue, weakness, and tachycardia. The disease is characterized by painless, enlarged cervical lymph nodes. Weight loss occurs early in the disease. Nausea and vomiting are not typically symptoms of Hodgkin's disease.

19. Answer: A. Reed-Sternberg cells.

A definitive diagnosis of Hodgkin's disease is made if Reed-Sternberg cells are found on pathologic examination of the excised lymph node. Lymphoblasts are immature cells found in the bone marrow of patients with acute lymphoblastic leukemia. Gaucher's cells are large storage cells found in patients with Gaucher's disease. Rieder's cells are myeloblasts found in patients with acute myelogenous leukemia.

20. Answer: C. Stay with the patient and focus on slow, deep breathing for relaxation.

Slow, deep breathing is the most effective method of reducing anxiety and stress. It reduces the level of carbon dioxide in the brain to increase calm and relaxation. Warning the patient to remain still will likely increase her anxiety. Encouraging family members to stay with the patient may make her worry about their anxiety as well as her own. Delaying the procedure is unlikely to allay her fears.

21. Answer: D. Capillary refill of < 3 seconds

It is important to assess the extremities for blood vessel occlusion in the client with sickle cell anemia because a change in capillary refill would indicate a change in circulation. Body temperature, motion, and sensation would not give information regarding peripheral circulation; therefore, answers A, B, and C are incorrect.

22. Answer: D. Semi-Fowler's with legs extended on the bed

Placing the client in semi-Fowler's position provides the best oxygenation for this client. Flexion of the hips and knees, which includes the knee-chest position, impedes circulation and is not correct positioning for this client. Therefore, answers A, B, and C are incorrect.

23. Answer: B. Encouraging fluid intake of at least 200mL per hour

It is important to keep the client in sickle cell crisis hydrated to prevent further sickling of the blood. Answer A is incorrect because a mechanical cuff places too much pressure

on the arm. Answer C is incorrect because raising the knee gatch impedes circulation. Answer D is incorrect because Tylenol is too mild an analgesic for the client in crisis.

24. Answer: C. Popsicle

Hydration is important in the client with sickle cell disease to prevent thrombus formation. Popsicles, gelatin, juice, and pudding have high fluid content. The foods in answers A, B, and D do not aid in hydration and are, therefore, incorrect.

25. Answer: C. Start O2

The most prominent clinical manifestation of sickle cell crisis is pain. However, the pulse oximetry indicates that oxygen levels are low; thus, oxygenation takes precedence over pain relief. Answer A is incorrect because although a warm environment reduces pain and minimizes sickling, it would not be a priority. Answer B is incorrect because although hydration is important, it would not require a bolus. Answer D is incorrect becauseDemerol is acidifying to the blood and increases sickling.

26. Answer: C. Egg salad on wheat bread, carrot sticks, lettuce salad, raisin pie

Egg yolks, wheat bread, carrots, raisins, and green, leafy vegetables are all high in iron, which is an important mineral for this client. Roast beef, cabbage, and pork chops are also high in iron, but the side dishes accompanying these choices are not; therefore, answers A, B, and D are incorrect.

27. Answer: D. A bus trip to the Museum of Natural History

Taking a trip to the museum is the only answer that does not pose a threat. A family vacation in the Rocky Mountains at high altitudes, cold temperatures, and airplane travel can cause sickling episodes and should be avoided; therefore, answers A, B, and C are incorrect.

28. Answer: D. Examine the tongue

The tongue is smooth and beefy red in the client with vitamin B12 deficiency, so examining the tongue should be included in the physical assessment. Bleeding, splenomegaly, and blood pressure changes do not occur, making answers A, B, and C incorrect.

29. Answer: C. Roof of the mouth

The oral mucosa and hard palate (roof of the mouth) are the best indicators of jaundice in dark-skinned persons. The conjunctiva can have normal deposits of fat, which give a yellowish hue; thus, answer A is incorrect. The soles of the feet can be yellow if they are calloused, making answer B incorrect; the shins would be an area of darker pigment, so answer D is incorrect.

30. Answer: B. Respirations 28 shallow

When there are fewer red blood cells, there is less hemoglobin and less oxygen. Therefore, the client is often short of breath, as indicated in answer B. The client with anemia is often pale in color, has weight loss, and may be hypotensive. Answers A, C, and D are within normal and, therefore, are incorrect.

31. Answer: A. “I will drink 500mL of fluid or less each day.”

The client with polycythemia vera is at risk for thrombus formation. Hydrating the client with at least 3L of fluid per day is important in preventing clot formation, so the statement to drink less than 500mL is incorrect. Answers B, C, and D are incorrect because they all contribute to the prevention of complications. Support hose promotes venous return, the electric razor prevents bleeding due to injury, and a diet low in iron is essential to preventing further red cell formation.

32. Answer: C. The client had radiation for treatment of Hodgkin's disease as a teenager.

Radiation treatment for other types of cancer can result in leukemia. Some hobbies and occupations involving chemicals are linked to leukemia, but not the ones in these answers; therefore, answers A and B are incorrect. Answer D is incorrect because the incidence of leukemia is higher in twins than in siblings.

33. Answer: D. The soles of the feet

Petechiae are not usually visualized on dark skin. The soles of the feet and palms of the hand provide a lighter surface for assessing the client for petechiae. Answers A, B, and C are incorrect because the skin might be too dark to make an assessment.

34. Answer: B. "Have you had a respiratory infection in the last 6 months?"

The client with leukemia is at risk for infection and has often had recurrent respiratory infections during the previous 6 months. Insomnolence, weight loss, and a decrease in alertness also occur in leukemia, but bleeding tendencies and infections are the primary clinical manifestations; therefore, answers A, C, and D are incorrect.

35. Answer: B. Risk for injury related to thrombocytopenia

The client with acute leukemia has bleeding tendencies due to decreased platelet counts, and any injury would exacerbate the problem. The client would require close monitoring for hemorrhage, which is of higher priority than the diagnoses in answers A, C, and D, which are incorrect.

36. Answer: A. Sexual dysfunction related to radiation therapy

Radiation therapy often causes sterility in male clients and would be of primary importance to this client. The psychosocial needs of the client are important to address in light of the age and life choices. Hodgkin's disease, however, has a good prognosis when diagnosed early. Answers B, C, and D are incorrect because they are of lesser priority.

37. Answer: A. Platelet count

Clients with autoimmune thrombocytopenic purpura (ATP) have low platelet counts, making answer A the correct answer. White cell counts, potassium levels, and PTT are not affected in ATP; thus, answers B, C, and D are incorrect.

38. Answer: A. Bleeding precautions

The normal platelet count is 120,000–400, Bleeding occurs in clients with low platelets. The priority is to prevent and minimize bleeding. Oxygenation in answer C is important, but platelets do not carry oxygen. Answers B and D are of lesser priority and are incorrect in this instance.

39. Answer: C. Elevate the head of the bed 30°

Elevating the head of the bed 30° avoids pressure on the sella turcica and alleviates headaches. Answers A, B, and D are incorrect because Trendelenburg, Valsalva maneuver, and coughing all increase the intracranial pressure.

40. Answer: B. Check the vital signs

The large amount of fluid loss can cause fluid and electrolyte imbalance that should be corrected. The loss of electrolytes would be reflected in the vital signs. Measuring the urinary output is important, but the stem already says that the client has polyuria, so answer A is incorrect. Encouraging fluid intake will not correct the problem, making answer C incorrect. Answer D is incorrect because weighing the client is not necessary at this time.

41. Answer: C. Pinch the soft lower part of the nose for a minimum of 5 minutes

The client should be positioned upright and leaning forward, to prevent aspiration of blood. Answers A, B, and D are incorrect because direct pressure to the nose stops the bleeding, and ice packs should be applied directly to the nose as well. If a pack is necessary, the nares are loosely packed.

42. Answer: A. Blood pressure

Blood pressure is the best indicator of cardiovascular collapse in the client who has had an adrenal gland removed. The remaining gland might have been suppressed due to the tumor activity. Temperature would be an indicator of infection, decreased output would be a clinical manifestation but would take longer to occur than blood pressure changes, and specific gravity changes occur with other disorders; therefore, answers B, C, and D are incorrect.

43. Answer: A. Glucometer readings as ordered

IV glucocorticoids raise the glucose levels and often require coverage with insulin. Answer B is not necessary at this time, sodium and potassium levels would be monitored when the client is receiving mineralocorticoids, and daily weights is unnecessary; therefore, answers B, C, and D are incorrect.

44. Answer: B. Check the calcium level

The parathyroid glands are responsible for calcium production and can be damaged during a thyroidectomy. The tingling is due to low calcium levels. The crash cart would be needed in respiratory distress but would not be the next action to take; thus, answer

A is incorrect. Hypertension occurs in thyroid storm and the drainage would occur in hemorrhage, so answers C and D are incorrect.

45. Answer: D. Decreased cardiac output r/t bradycardia

The decrease in pulse can affect the cardiac output and lead to shock, which would take precedence over the other choices; therefore, answers A, B, and C are incorrect.

1. The client is having an arteriogram. During the procedure, the client tells the nurse, "I'm feeling really hot." Which response would be best?

A. "You are having an allergic reaction. I will get an order for Benadryl."
B. "That feeling of warmth is normal when the dye is injected."
C. "That feeling of warmth indicates that the clots in the coronary vessels are dissolving."
D. "I will tell your doctor and let him explain to you the reason for the hot feeling that you are experiencing."

2. The nurse is observing several healthcare workers providing care. Which action by the healthcare worker indicates a need for further teaching?

A. The nursing assistant wears gloves while giving the client a bath.
B. The nurse wears goggles while drawing blood from the client.
C. The doctor washes his hands before examining the client.
D. The nurse wears gloves to take the client's vital signs.

3. The client is having electroconvulsive therapy for treatment of severe depression. Which of the following indicates that the client's ECT has been effective?

A. The client loses consciousness.
B. The client vomits.
C. The client's ECG indicates tachycardia.
D. The client has a grand mal seizure.

4. The 5-year-old is being tested for enterobiasis (pinworms). To collect a specimen for assessment of pinworms, the nurse should teach the mother to:

A. Examine the perianal area with a flashlight 2 or 3 hours after the child is asleep
B. Scrape the skin with a piece of cardboard and bring it to the clinic
C. Obtain a stool specimen in the afternoon
D. Bring a hair sample to the clinic for evaluation

5. The nurse is teaching the mother regarding treatment for enterobiasis. Which instruction should be given regarding the medication?

A. Treatment is not recommended for children less than 10 years of age.
B. The entire family should be treated.
C. Medication therapy will continue for 1 year.
D. Intravenous antibiotic therapy will be ordered.

6. The registered nurse is making assignments for the day. Which client should be assigned to the pregnant nurse?

A. The client receiving linear accelerator radiation therapy for lung cancer
B. The client with a radium implant for cervical cancer
C. The client who has just been administered soluble brachytherapy for thyroid cancer
D. The client who returned from placement of iridium seeds for prostate cancer

7. The nurse is planning room assignments for the day. Which client should be assigned to a private room if only one is available?

A. The client with Cushing's disease
B. The client with diabetes
C. The client with acromegaly
D. The client with myxedema

8. The nurse caring for a client in the neonatal intensive care unit administers adult-strength Digitalis to the 3-pound infant. As a result of her actions, the baby suffers permanent heart and brain damage. The nurse can be charged with:

A. Negligence
B. Tort
C. Assault
D. Malpractice

9. Which assignment should not be performed by the licensed practical nurse?

A. Inserting a Foley catheter
B. Discontinuing a nasogastric tube
C. Obtaining a sputum specimen
D. Starting a blood transfusion

10. The client returns to the unit from surgery with a blood pressure of 90/50, pulse 132, and respirations 30. Which action by the nurse should receive priority?

A. Continuing to monitor the vital signs
B. Contacting the physician
C. Asking the client how he feels
D. Asking the LPN to continue the post-op care

11. Which nurse should be assigned to care for the postpartum client with preeclampsia?

A. The RN with 2 weeks of experience in postpartum
B. The RN with 3 years of experience in labor and delivery
C. The RN with 10 years of experience in surgery
D. The RN with 1 year of experience in the neonatal intensive care unit

12. Which information should be reported to the state Board of Nursing?

A. The facility fails to provide literature in both Spanish and English.
B. The narcotic count has been incorrect on the unit for the past 3 days.
C. The client fails to receive an itemized account of his bills and services received during his hospital stay.
D. The nursing assistant assigned to the client with hepatitis fails to feed the client and give the bath.

13. The nurse is suspected of charting medication administration that he did not give. After talking to the nurse, the charge nurse should:
A. Call the Board of Nursing
B. File a formal reprimand

C. Terminate the nurse
D. Charge the nurse with a tort

14. The home health nurse is planning for the day's visits. Which client should be seen first?

A. The 78-year-old who had a gastrectomy 3 weeks ago and has a PEG tube
B. The 5-month-old discharged 1 week ago with pneumonia who is being treated with amoxicillin liquid suspension
C. The 50-year-old with MRSA being treated with Vancomycin via a PICC line
D. The 30-year-old with an exacerbation of multiple sclerosis being treated with cortisone via a centrally placed venous catheter

15. The emergency room is flooded with clients injured in a tornado. Which clients can be assigned to share a room in the emergency department during the disaster?

A. A schizophrenic client having visual and auditory hallucinations and the client with ulcerative colitis
B. The client who is 6 months pregnant with abdominal pain and the client with facial lacerations and a broken arm
C. A child whose pupils are fixed and dilated and his parents, and a client with a frontal head injury
D. The client who arrives with a large puncture wound to the abdomen and the client with chest pain

16. The nurse is caring for a 6-year-old client admitted with a diagnosis of conjunctivitis. Before administering eye drops, the nurse should recognize that it is essential to consider which of the following?

A. The eye should be cleansed with warm water, removing any exudate, before instilling the eyedrops.
B. The child should be allowed to instill his own eye drops.
C. The mother should be allowed to instill the eyedrops.
D. If the eye is clear from any redness or edema, the eyedrops should be held.

17. The nurse is discussing meal planning with the mother of a 2-year-old toddler. Which of the following statements, if made by the mother, would require a need for further instruction?

A. "It is okay to give my child white grape juice for breakfast."
B. "My child can have a grilled cheese sandwich for lunch."
C. "We are going on a camping trip this weekend, and I have bought hot dogs to grill for his lunch."
D. "For a snack, my child can have ice cream."

18. A 2-year-old toddler is admitted to the hospital. Which of the following nursing interventions would you expect?

A. Ask the parent/guardian to leave the room when assessments are being performed.
B. Ask the parent/guardian to take the child's favorite blanket home because anything from the outside should not be brought into the hospital.

C. Ask the parent/guardian to room-in with the child.
D. If the child is screaming, tell him this is inappropriate behavior.

19. Which instruction should be given to the client who is fitted for a behind-the-ear hearing aid?

A. Remove the mold and clean every week.
B. Store the hearing aid in a warm place.
C. Clean the lint from the hearing aid with a toothpick.
D. Change the batteries weekly.

20. A priority nursing diagnosis for a child being admitted from surgery following a tonsillectomy is:

A. Body image disturbance
B. Impaired verbal communication
C. Risk for aspiration
D. Pain

21. A client with bacterial pneumonia is admitted to the pediatric unit. What would the nurse expect the admitting assessment to reveal?

A. High fever
B. Nonproductive cough
C. Rhinitis
D. Vomiting and diarrhea

22. The nurse is caring for a client admitted with epiglottitis. Because of the possibility of complete obstruction of the airway, which of the following should the nurse have available?

A. Intravenous access supplies
B. A tracheostomy set
C. Intravenous fluid administration pump
D. Supplemental oxygen

23. A 25-year-old client with Grave's disease is admitted to the unit. What would the nurse expect the admitting assessment to reveal?

A. Bradycardia
B. Decreased appetite
C. Exophthalmos
D. Weight gain

24. The nurse is providing dietary instructions to the mother of an 8-year-old child diagnosed with celiac disease. Which of the following foods, if selected by the mother, would indicate her understanding of the dietary instructions?
A. Ham sandwich on whole-wheat toast
B. Spaghetti and meatballs

C. Hamburger with ketchup
D. Cheese omelet

25. The nurse is caring for an 80-year-old with chronic bronchitis. Upon the morning rounds, the nurse finds an O2 sat of 76%. Which of the following actions should the nurse take first?

A. Notify the physician
B. Recheck the O2 saturation level in 15 minutes
C. Apply oxygen by mask
D. Assess the pulse

26. A gravida 3 para 0 is admitted to the labor and delivery unit. The doctor performs an amniotomy. Which observation would the nurse be expected to make after the amniotomy?

A. Fetal heart tones 160bpm
B. A moderate amount of straw-colored fluid
C. A small amount of greenish fluid
D. A small segment of the umbilical cord

27. The client is admitted to the unit. A vaginal exam reveals that she is 2cm dilated. Which of the following statements would the nurse expect her to make?

A. "We have a name picked out for the baby."
B. "I need to push when I have a contraction."
C. "I can't concentrate if anyone is touching me."
D. "When can I get my epidural?"

28. The client is having fetal heart rates of 90–110 bpm during the contractions. The first action the nurse should take is:

A. Reposition the monitor
B. Turn the client to her left side
C. Ask the client to ambulate
D. Prepare the client for delivery

29. In evaluating the effectiveness of IV Pitocin for a client with secondary dystocia, the nurse should expect:

A. A painless delivery
B. Cervical effacement
C. Infrequent contractions
D. Progressive cervical dilation

30. A vaginal exam reveals a footling breech presentation. The nurse should take which of the following actions at this time?

A. Anticipate the need for a Caesarean section
B. Apply the fetal heart monitor
C. Place the client in Genupectoral position
D. Perform an ultrasound exam

31. A vaginal exam reveals that the cervix is 4cm dilated, with intact membranes and a fetal heart tone rate of 160–170 bpm. The nurse decides to apply an external fetal monitor. The rationale for this implementation is:

A. The cervix is closed.
B. The membranes are still intact.
C. The fetal heart tones are within normal limits.
D. The contractions are intense enough for insertion of an internal monitor.

32. The following are all nursing diagnoses appropriate for a gravida 1 para 0 inlabor. Which one would be most appropriate for the primigravida as she completes the early phase of labor?

A. Impaired gas exchange related to hyperventilation
B. Alteration in placental perfusion related to maternal position
C. Impaired physical mobility related to fetal-monitoring equipment
D. Potential fluid volume deficit related to decreased fluid intake

33. As the client reaches 8 cm dilation, the nurse notes late decelerations on the fetal monitor. The FHR baseline is 165–175 bpm with variability of 0–2bpm. What is the most likely explanation of this pattern?

A. The baby is asleep.
B. The umbilical cord is compressed.
C. There is a vagal response.
D. There is uteroplacental insufficiency.

34. The nurse notes variable decelerations on the fetal monitor strip. The most appropriate initial action would be to:

A. Notify her doctor
B. Start an IV
C. Reposition the client
D. Readjust the monitor

35. Which of the following is a characteristic of a reassuring fetal heart ratepattern?

A. A fetal heart rate of 170–180 bpm
B. A baseline variability of 25–35 bpm
C. Ominous periodic changes
D. Acceleration of FHR with fetal movements

36. The rationale for inserting a French catheter every hour for the client with epidural anesthesia is:

A. The bladder fills more rapidly because of the medication used for the epidural.
B. Her level of consciousness is such that she is in a trancelike state.
C. The sensation of the bladder filling is diminished or lost.
D. She is embarrassed to ask for the bedpan that frequently.

37. A client in the family planning clinic asks the nurse about the most likely time for her to conceive. The nurse explains that conception is most likely to occur when:

A. Estrogen levels are low.
B. Luteinizing hormone is high.
C. The endometrial lining is thin.
D. The progesterone level is low.

38. A client tells the nurse that she plans to use the rhythm method of birth control. The nurse is aware that the success of the rhythm method depends on the:

A. Age of the client
B. Frequency of intercourse
C. Regularity of the menses
D. Range of the client's temperature

39. A client with diabetes asks the nurse for advice regarding methods of birth control. Which method of birth control is most suitable for the client with diabetes?

A. Intrauterine device
B. Oral contraceptives
C. Diaphragm
D. Contraceptive sponge

40. The doctor suspects that the client has an ectopic pregnancy. Which symptom is consistent with a diagnosis of ectopic pregnancy?

A. Painless vaginal bleeding
B. Abdominal cramping
C. Throbbing pain in the upper quadrant
D. Sudden, stabbing pain in the lower quadrant

41. The nurse is teaching a pregnant client about nutritional needs during pregnancy. Which menu selection will best meet the nutritional needs of the pregnant client?

A. Hamburger pattie, green beans, French fries, and iced tea
B. Roast beef sandwich, potato chips, baked beans, and cola
C. Baked chicken, fruit cup, potato salad, coleslaw, yogurt, and iced tea
D. Fish sandwich, gelatin with fruit, and coffee

42. The client with hyperemesis gravidarum is at risk for developing:

A. Respiratory alkalosis without dehydration
B. Metabolic acidosis with dehydration
C. Respiratory acidosis without dehydration
D. Metabolic alkalosis with dehydration

43. A client tells the doctor that she is about 20 weeks pregnant. The most definitive sign of pregnancy is:

A. Elevated human chorionic gonadotropin
B. The presence of fetal heart tones
C. Uterine enlargement
D. Breast enlargement and tenderness

44. The nurse is caring for a neonate whose mother is diabetic. The nurse will expect the neonate to be:

A. Hypoglycemic, small for gestational age
B. Hyperglycemic, large for gestational age
C. Hypoglycemic, large for gestational age
D. Hyperglycemic, small for gestational age

45. Which of the following instructions should be included in the nurse's teaching regarding oral contraceptives?

A. Weight gain should be reported to the physician.
B. An alternate method of birth control is needed when taking antibiotics.
C. If the client misses one or more pills, two pills should be taken per day for 1 week.
D. Changes in the menstrual flow should be reported to the physician.

46. The nurse is discussing breastfeeding with a postpartum client. Breastfeedingis contraindicated in the postpartum client with:

A. Diabetes
B. Positive HIV
C. Hypertension
D. Thyroid disease

47. A client is admitted to the labor and delivery unit complaining of vaginal bleeding with very little discomfort. The nurse's first action should be to:

A. Assess the fetal heart tones
B. Check for cervical dilation
C. Check for firmness of the uterus
D. Obtain a detailed history

48. A client telephones the emergency room stating that she thinks that she is inlabor. The nurse should tell the client that labor has probably begun when:

A. Her contractions are 2 minutes apart.
B. She has back pain and a bloody discharge.
C. She experiences abdominal pain and frequent urination.
D. Her contractions are 5 minutes apart.

49. The nurse is teaching a group of prenatal clients about the effects of cigarette smoke on fetal development. Which characteristic is associated with babies born to mothers who smoked during pregnancy?

A. Low birth weight
B. Large for gestational age
C. Preterm birth, but appropriate size for gestation
D. Growth retardation in weight and length

50. The physician has ordered an injection of RhoGam for the postpartum client whose blood type is A negative but whose baby is O positive. To providepostpartum prophylaxis, RhoGam should be administered:

A. Within 72 hours of delivery
B. Within 1 week of delivery
C. Within 2 weeks of delivery
D. Within 1 month of delivery

Answers and Rationale

1. Answer: B. "That feeling of warmth is normal when the dye is injected."
It is normal for the client to have a warm sensation when dye is injected. Answers A, C, and D indicate that the nurse believes that the hot feeling is abnormal, so they are incorrect.
2. Answer: D. The nurse wears gloves to take the client's vital signs.
It is not necessary to wear gloves to take the vital signs of the client. If the client has active infection with methicillin-resistant staphylococcus aureus, gloves should be worn. The health care workers in answers A, B, and C indicate knowledge of infection control by their actions.
3. Answer: D. The client has a grand mal seizure.

During ECT, the client will have a grand mal seizure. This indicates completion of the electroconvulsive therapy. Answers A, B, and C do not indicate that the ECT has been effective, so are incorrect.

4. Answer: A. Examine the perianal area with a flashlight 2 or 3 hours after the child is asleep

Infection with pinworms begins when the eggs are ingested or inhaled. The eggs hatch in the upper intestine and mature in 2–8 weeks. The females then mate and migrate out the anus, where they lay up to 17,000 eggs. This causes intense itching. The mother should be told to use a flashlight to examine the rectal area about 2–3 hours after the child is asleep. Placing clear tape on a tongue blade will allow the eggs to adhere to the tape. The specimen should then be brought in to be evaluated. There is no need to scrape the skin, collect a stool specimen, or bring a sample of hair, so answers B, C, and D are incorrect.

5. Answer: B. The entire family should be treated.

Enterobiasis, or pinworms, is treated with Vermox (mebendazole) or Antiminth (pyrantel pamoate). The entire family should be treated to ensure that no eggs remain. Because a single treatment is usually sufficient, there is usually good compliance. The family should then be tested again in 2 weeks to ensure that no eggs remain. Answers A, C, and D are incorrect statements.

6. Answer: A. The client receiving linear accelerator radiation therapy for lung cancer

The pregnant nurse should not be assigned to any client with radioactivity present. The client receiving linear accelerator therapy travels to the radium department for therapy. The radiation stays in the department, so the client is not radioactive. The clients in answers B, C, and D pose a risk to the pregnant nurse. These clients are radioactive in very small doses, especially upon returning from the procedures. For approximately 72 hours, the clients should dispose of urine and feces in special containers and use plastic spoons and forks.

7. Answer: A. The client with Cushing's disease

The client with Cushing's disease has adrenocortical hypersecretion. This increase in the level of cortisone causes the client to be immunosuppressed. In answer B, the client with diabetes poses no risk to other clients. The client in answer C has an increase in growth hormone and poses no risk to himself or others. The client in answer D has hypothyroidism or myxedema and poses no risk to others or himself.

8. Answer: D. Malpractice

The nurse could be charged with malpractice, which is failing to perform, or performing an act that causes harm to the client. Giving the infant an overdose falls into this category. Answers A, B, and C are incorrect because they apply to other wrongful acts. Negligence is failing to perform care for the client; a tort is a wrongful act committed on the client or their belongings; and assault is a violent physical or verbal attack.

9. Answer: D. Starting a blood transfusion

The licensed practical nurse should not be assigned to begin a blood transfusion. The licensed practical nurse can insert a Foley catheter, discontinue a nasogastric tube, and collect sputum specimen; therefore, answers A, B, and C are incorrect.

10. Answer: B. Contacting the physician

The vital signs are abnormal and should be reported immediately. Continuing to monitor the vital signs can result in deterioration of the client's condition, making answer A incorrect. Asking the client how he feels in answer C will only provide subjective data, and the nurse in answer D is not the best nurse to assign because this client is unstable.

11. Answer: B. The RN with 3 years of experience in labor and delivery

The nurse with 3 years of experience in labor and delivery knows the most about possible complications involving preeclampsia. The nurse in answer A is a new nurse to the unit, and the nurses in answers C and D have no experience with the postpartum client.

12. Answer: B. The narcotic count has been incorrect on the unit for the past 3 days.

The Joint Commission on Accreditation of Hospitals will probably be interested in the problems in answers A and C. The failure of the nursing assistant to care for the client with hepatitis might result in termination, but is not of interest to the Joint Commission.

13. Answer: B. File a formal reprimand

The next action after discussing the problem with the nurse is to document the incident by filing a formal reprimand. If the behavior continues or if harm has resulted to the client, the nurse may be terminated and reported to the Board of Nursing, but these are not the first actions requested in the stem. A tort is a wrongful act to the client or his belongings and is not indicated in this instance. Therefore, Answers A, C, and D are incorrect.

14. Answer: D. The 30-year-old with an exacerbation of multiple sclerosis being treated with cortisone via a centrally placed venous catheter

The client at highest risk for complications is the client with multiple sclerosis who is being treated with cortisone via the central line. The others are more stable. MRSA is methicillin-resistant staphylococcus aureus. Vancomycin is the drug of choice and is given at scheduled times to maintain blood levels of the drug. The clients in answers A, B, and C are more stable and can be seen later.

15. Answer: B. The client who is 6 months pregnant with abdominal pain and the client with facial lacerations and a broken arm

The pregnant client and the client with a broken arm and facial lacerations are the best choices for placing in the same room. The clients in answers A, C, and D need to be placed in separate rooms due to the serious natures of their injuries.

16. Answer: A. The eye should be cleansed with warm water, removing any exudate, before instilling the eyedrops.

Before instilling eye drops, the nurse should cleanse the area with water. A 6-year-old child is not developmentally ready to instill his own eyedrops, so answer B is incorrect. Although the mother of the child can instill the eyedrops, the area must be cleansed before administration, making answer C incorrect. Although the eye might appear to be clear, the nurse should instill the eyedrops, as ordered, so answer D is incorrect.

17. Answer: C. "We are going on a camping trip this weekend, and I have bought hot dogs to grill for his lunch."

Remember the ABCs (airway, breathing, circulation) when answering this question. Answer C because a hotdog is the size and shape of the child's trachea and poses a risk of aspiration. Answers A, B, and C are incorrect because white grape juice, a grilled cheese sandwich, and ice cream do not pose a risk of aspiration for a child.

18. Answer: C. Ask the parent/guardian to room-in with the child.

The nurse should encourage rooming-in to promote parent-child attachment. It is okay for the parents to be in the room for assessment of the child. Allowing the child to have items that are familiar to him is allowed and encouraged; therefore, answers A and B are incorrect. Answer D is not part of the nurse's responsibilities.

19. Answer: B. Store the hearing aid in a warm place.

The hearing aid should be stored in a warm, dry place. It should be cleaned daily but should not be moldy, so answer A is incorrect. A toothpick is inappropriate to use to clean the aid; the toothpick might break off in the hearing aide, making answer C incorrect. Changing the batteries weekly, as in answer D, is not necessary.

20. Answer: C. Risk for aspiration

Always remember your ABCs (airway, breathing, circulation) when selecting an answer. Although answers B and D might be appropriate for this child, answer C should have the highest priority. Answer A does not apply for a child who has undergone a tonsillectomy.

21. Answer: A. High fever

If the child has bacterial pneumonia, a high fever is usually present. Bacterial pneumonia usually presents with a productive cough, not a nonproductive cough, making answer B incorrect. Rhinitis is often seen with viral pneumonia, and vomiting and diarrhea are usually not seen with pneumonia, so answers C and D are incorrect.

22. Answer: B. A tracheostomy set

For a child with epiglottitis and the possibility of complete obstruction of the airway, emergency tracheostomy equipment should always be kept at the bedside. Intravenous supplies, fluid, and oxygen will not treat an obstruction; therefore, answers A, C, and D are incorrect.

23. Answer: C. Exophthalmos

Exophthalmos (protrusion of eyeballs) often occurs with hyperthyroidism. The client with hyperthyroidism will often exhibit tachycardia, increased appetite, and weight loss; therefore, answers A, B, and D are incorrect.

24. Answer: D. Cheese omelet

The child with celiac disease should be on a gluten-free diet. Answers A, B, and C all contain gluten, while answer D gives the only choice of foods that does not contain gluten.

25. Answer: C. Apply oxygen by mask

Remember the ABCs (airway, breathing, circulation) when answering this question. Before notifying the physician or assessing the pulse, oxygen should be applied to increase the oxygen saturation, so answers A and D are incorrect. The normal oxygen saturation for a child is 92%–100%, making answer B incorrect.

26. Answer: B. A moderate amount of straw-colored fluid

An amniotomy is an artificial rupture of membranes and normal amniotic fluid is straw-colored and odorless. Fetal heart tones of 160 indicate tachycardia, and greenish fluid is indicative of meconium, so answers A and C are incorrect. If the nurse notes the umbilical cord, the client is experiencing a prolapsed cord, so answer D is incorrect and would need to be reported immediately.

27. Answer: D. "When can I get my epidural?"

Dilation of 2 cm marks the end of the latent phase of labor. Answer A is a vague answer, answer B indicates the end of the first stage of labor, and answer C indicates the transition phase.

28. Answer: B. Turn the client to her left side

The normal fetal heart rate is 120–160 bpm; 100–110bpm is bradycardia. The first action would be to turn the client to the left side and apply oxygen. Answer A is not indicated at this time. Answer C is not the best action for clients experiencing bradycardia. There is no data to indicate the need to move the client to the delivery room at this time.

29. Answer: D. Progressive cervical dilation

The expected effect of Pitocin is cervical dilation. Pitocin causes more intense contractions, which can increase the pain, making answer A incorrect. Cervical effacement is caused by pressure on the presenting part, so answer B is incorrect. Answer C is opposite the action of Pitocin.

30. Answer: B. Apply the fetal heart monitor

Applying a fetal heart monitor is the correct action at this time. There is no need to prepare for a Caesarean section or to place the client in Genupectoral position (knee-chest), so answers A and C are incorrect. Answer D is incorrect because there is no need for an ultrasound based on the finding.

31. Answer: B. The membranes are still intact.

The nurse decides to apply an external monitor because the membranes are intact. Answers A, C, and D are incorrect. The cervix is dilated enough to use an internal monitor, if necessary. An internal monitor can be applied if the client is at 0-station. Contraction intensity has no bearing on the application of the fetal monitor.

32. Answer: D. Potential fluid volume deficit related to decreased fluid intake

Clients admitted in labor are told not to eat during labor, to avoid nausea and vomiting. Ice chips may be allowed, but this amount of fluid might not be sufficient to prevent fluid volume deficit. In answer A, impaired gas exchange related to hyperventilation would be indicated during the transition phase. Answers B and C are not correct in relation to the stem.

33. Answer: D. There is uteroplacental insufficiency.

This information indicates a late deceleration. This type of deceleration is caused by uteroplacental lack of oxygen. Answer A has no relation to the readings, so it's incorrect; answer B results in a variable deceleration; and answer C is indicative of an early deceleration.

34. Answer: C. Reposition the client

The initial action by the nurse observing a late deceleration should turn the client to the side—preferably, the left side. Administering oxygen is also indicated. Answer A might

be necessary but not before turning the client to her side. Answer B is not necessary at this time. Answer D is incorrect because there is no data to indicate that the monitor has been applied incorrectly.

35. Answer: D. Acceleration of FHR with fetal movements

Accelerations with movement are normal. Answers A, B, and C indicate ominous findings on the fetal heart monitor.

36. Answer: C. The sensation of the bladder filling is diminished or lost.

Epidural anesthesia decreases the urge to void and sensation of a full bladder. A full bladder will decrease the progression of labor. Answers A, B, and D are incorrect for the stem.

37. Answer: B. Luteinizing hormone is high.

Luteinizing hormone released by the pituitary is responsible for ovulation. At about day 14, the continued increase in estrogen stimulates the release of luteinizing hormone from the anterior pituitary. The LH surge is responsible for ovulation, or the release of the dominant follicle in preparation for conception, which occurs within the next 10–12 hours after the LH levels peak. Answers A, C, and D are incorrect because estrogen levels are high at the beginning of ovulation, the endometrial lining is thick, not thin, and the progesteronelevels are high, not low.

38. Answer: C. Regularity of the menses

The success of the rhythm method of birth control is dependent on the client's menses being regular. It is not dependent on the age of the client, frequency of intercourse, or range of the client's temperature; therefore, answers A, B, and D are incorrect.

39. Answer: C. Diaphragm

The best method of birth control for the client with diabetes is the diaphragm. A permanent intrauterine device can cause a continuing inflammatory response in diabetics that should be avoided, oral contraceptives tend to elevate blood glucose levels, and contraceptive sponges are not good at preventing pregnancy. Therefore, answers A, B, and D are incorrect.

40. Answer: D. Sudden, stabbing pain in the lower quadrant

The signs of an ectopic pregnancy are vague until the fallopian tube ruptures. The client will complain of sudden, stabbing pain in the lower quadrant that radiates down the leg or up into the chest. Painless vaginal bleeding is a sign of placenta previa, abdominal cramping is a sign of labor, and throbbing pain in the upper quadrant is not a sign of anectopic pregnancy, making answers A, B, and C incorrect.

41. Answer: C. Baked chicken, fruit cup, potato salad, coleslaw, yogurt, and iced tea

All of the choices are tasty, but the pregnant client needs a diet that is balanced and has increased amounts of calcium. Answer A is lacking in fruits and milk. Answer B contains the potato chips, which contain a large amount of sodium. Answer C contains meat, fruit, potato salad, and yogurt, which has about 360 mg of calcium. Answer D is not the best diet because it lacks vegetables and milk products.

42. Answer: B. Metabolic acidosis with dehydration

The client with hyperemesis has persistent nausea and vomiting. With vomiting comes dehydration. When the client is dehydrated, she will have metabolic acidosis. Answers

A and C are incorrect because they are respiratory dehydration. Answer D is incorrect because the client will not be in alkalosis with persistent vomiting.

43. Answer: B. The presence of fetal heart tones

The most definitive diagnosis of pregnancy is the presence of fetal heart tones. The signs in answers A, C, and D are subjective and might be related to other medical conditions. Answers A and C may be related to a hydatidiform mole, and answer D is often present before menses or with the use of oral contraceptives.

44. Answer: C. Hypoglycemic, large for gestational age

The infant of a diabetic mother is usually large for gestational age. After birth, glucose levels fall rapidly due to the absence of glucose from the mother. Answer A is incorrect because the infant will not be small for gestational age. Answer B is incorrect because the infant will not be hyperglycemic. Answer D is incorrect because the infant will be large, not small, and will be hypoglycemic, not hyperglycemic.

45. Answer: B. An alternate method of birth control is needed when taking antibiotics.

When the client is taking oral contraceptives and begins antibiotics, another method of birth control should be used. Antibiotics decrease the effectiveness of oral contraceptives. Approximately 5–10 pounds of weight gain is not unusual, so answer A is incorrect. If the client misses a birth control pill, she should be instructed to take the pill as soon as she remembers the pill. Answer C is incorrect. If she misses two, she should take two; if she misses more than two, she should take the missed pills but use another method of birth control for the remainder of the cycle. Answer D is incorrect because changes in menstrual flow are expected in clients using oral contraceptives. Often these clients have lighter menses.

46. Answer: B. Positive HIV

Clients with HIV should not breastfeed because the infection can be transmitted to the baby through breast milk. The clients in answers A, C, and D—those with diabetes, hypertension, and thyroid disease—can be allowed to breastfeed.

47. Answer: A. Assess the fetal heart tones

The symptoms of painless vaginal bleeding are consistent with placenta previa. Answers B, C, and D are incorrect. Cervical check for dilation is contraindicated because this can increase the bleeding. Checking for firmness of the uterus can be done, but the first action should be to check the fetal heart tones. A detailed history can be done later.

48. Answer: D. Her contractions are 5 minutes apart.

The client should be advised to come to the labor and delivery unit when the contractions are every 5 minutes and consistent. She should also be told to report to the hospital if she experiences rupture of membranes or extreme bleeding. She should not wait until the contractions are every 2 minutes or until she has bloody discharge, so answers A and B are incorrect. Answer C is a vague answer and can be related to a urinary tract infection.

49. Answer: A. Low birth weight

Infants of mothers who smoke are often low in birth weight. Infants who are large for gestational age are associated with diabetic mothers, so answer B is incorrect. Preterm births are associated with smoking, but not with appropriate size for gestation, making answer C incorrect. Growth retardation is associated with smoking, but this does not affect the infant length; therefore, answer D is incorrect.

50. Answer: A. Within 72 hours of delivery

To provide protection against antibody production, RhoGam should be given within 72 hours. The answers in B, C, and D are too late to provide antibody protection. RhoGam can also be given during pregnancy.

1. After the physician performs an amniotomy, the nurse's first action should be to assess the:
A. Degree of cervical dilation
B. Fetal heart tones
C. Client's vital signs
D. Client's level of discomfort

2. A client is admitted to the labor and delivery unit. The nurse performs a vaginal exam and determines that the client's cervix is 5 cm dilated with 75% effacement. Based on the nurse's assessment the client is in which phase of labor?
A. Active
B. Latent
C. Transition
D. Early

3. A newborn with narcotic abstinence syndrome is admitted to the nursery. Nursing care of the newborn should include:
A. Teaching the mother to provide tactile stimulation
B. Wrapping the newborn snugly in a blanket
C. Placing the newborn in the infant seat
D. Initiating an early infant-stimulation program

4. A client elects to have epidural anesthesia to relieve the discomfort of labor. Following the initiation of epidural anesthesia, the nurse should give priority to:
A. Checking for cervical dilation
B. Placing the client in a supine position
C. Checking the client's blood pressure
D. Obtaining a fetal heart rate

5. The nurse is aware that the best way to prevent postoperative wound infection in the surgical client is to:
A. Administer a prescribed antibiotic
B. Wash her hands for 2 minutes before care
C. Wear a mask when providing care
D. Ask the client to cover her mouth when she coughs

6. The elderly client is admitted to the emergency room. Which symptom is the client with a fractured hip most likely to exhibit?
A. Pain
B. Disalignment
C. Cool extremity
D. Absence of pedal pulses

7. The nurse knows that a 60-year-old female client's susceptibility to osteoporosis is most likely related to:
A. Lack of exercise
B. Hormonal disturbances
C. Lack of calcium
D. Genetic predisposition

8. A 2-year-old is admitted for repair of a fractured femur and is placed in Bryant's traction. Which finding by the nurse indicates that the traction is working properly?

A. The infant no longer complains of pain.
B. The buttocks are 15° off the bed.
C. The legs are suspended in the traction.
D. The pins are secured within the pulley.

9. A client with a fractured hip has been placed in Buck's traction. Which statement is true regarding balanced skeletal traction? Balanced skeletal traction:

A. Utilizes a Steinman pin
B. Requires that both legs be secured
C. Utilizes Kirschner wires
D. Is used primarily to heal the fractured hips

10. The client is admitted for an open reduction internal fixation of a fractured hip. Immediately following surgery, the nurse should give priority to assessing the:

A. Serum collection (Davol) drain
B. Client's pain
C. Nutritional status
D. Immobilizer

11. Which statement made by the family member caring for the client with a percutaneous gastrostomy tube indicates understanding of the nurse's teaching?

A. "I must flush the tube with water after feedings and clamp the tube."
B. "I must check placement four times per day."
C. "I will report to the doctor any signs of indigestion."
D. "If my father is unable to swallow, I will discontinue the feeding and call the clinic."

12. The nurse is assessing the client with a total knee replacement 2 hours postoperative. Which information requires notification of the doctor?

A. Bleeding on the dressing is 3cm in diameter.
B. The client has a temperature of 100.6°F (38.1°C).
C. The client's hematocrit is 26%.
D. The urinary output has been 60 during the last 2 hours.

13. The nurse is caring for the client with a 5-year-old diagnosis of plumbism. Which information in the health history is most likely related to the development of plumbism?

A. The client has traveled out of the country in the last 6 months.
B. The client's parents are skilled stained-glass artists.
C. The client lives in a house built in 1
D. The client has several brothers and sisters.

14. A client with a total hip replacement requires special equipment. Which equipment would assist the client with a total hip replacement with activities of daily living?

A. High-seat commode
B. Recliner
C. TENS unit
D. Abduction pillow

15. An elderly client with an abdominal surgery is admitted to the unit following surgery. In anticipation of complications of anesthesia and narcotic administration, the nurse should:

A. Administer oxygen via nasal cannula
B. Have narcan (naloxone) available
C. Prepare to administer blood products
D. Prepare to do cardio resuscitation

16. Which roommate would be most suitable for the 6-year-old male with a fractured femur in Russell's traction?

A. 16-year-old female with scoliosis
B. 12-year-old male with a fractured femur
C. 10-year-old male with sarcoma
D. 6-year-old male with osteomyelitis

17. A client with osteoarthritis has a prescription for Celebrex (celecoxib). Which instruction should be included in the discharge teaching?

A. Take the medication with milk.
B. Report chest pain.
C. Remain upright after taking for 30 minutes.
D. Allow 6 weeks for optimal effects.

18. A client with a fractured tibia has a plaster-of-Paris cast applied to immobilize the fracture. Which action by the nurse indicates understanding of a plaster-of-Paris cast? The nurse:

A. Handles the cast with the fingertips
B. Petals the cast
C. Dries the cast with a hair dryer
D. Allows 24 hours before bearing weight

19. The teenager with a fiberglass cast asks the nurse if it will be okay to allow his friends to autograph his cast. Which response would be best?

A. "It will be alright for your friends to autograph the cast."
B. "Because the cast is made of plaster, autographing can weaken the cast."
C. "If they don't use chalk to autograph, it is okay."
D. "Autographing or writing on the cast in any form will harm the cast."

20. The nurse is assigned to care for the client with a Steinmann pin. During pin care, she notes that the LPN uses sterile gloves and Q-tips to clean the pin. Which action should the nurse take at this time?

A. Assisting the LPN with opening sterile packages and peroxide
B. Telling the LPN that clean gloves are allowed

C. Telling the LPN that the registered nurse should perform pin care
D. Asking the LPN to clean the weights and pulleys with peroxide

21. A child with scoliosis has a spica cast applied. Which action specific to the spica cast should be taken?

A. Check the bowel sounds
B. Assess the blood pressure
C. Offer pain medication
D. Check for swelling

22. The client with a cervical fracture is placed in traction. Which type of traction will be utilized at the time of discharge?

A. Russell's traction
B. Buck's traction
C. Halo traction
D. Crutchfield tong traction

23. A client with a total knee replacement has a CPM (continuous passive motion device) applied during the post-operative period. Which statement made by the nurse indicates understanding of the CPM machine?

A. "Use of the CPM will permit the client to ambulate during the therapy."
B. "The CPM machine controls should be positioned distal to the site."
C. "If the client complains of pain during the therapy, I will turn off the machine and call the doctor."
D. "Use of the CPM machine will alleviate the need for physical therapy after the client is discharged."

24. A client with a fractured hip is being taught correct use of the walker. The nurse is aware that the correct use of the walker is achieved if the:

A. Palms rest lightly on the handles
B. Elbows are flexed 0°
C. Client walks to the front of the walker
D. Client carries the walker

25. When assessing a laboring client, the nurse finds a prolapsed cord. The nurse should:

A. Attempt to replace the cord
B. Place the client on her left side
C. Elevate the client's hips
D. Cover the cord with a dry, sterile gauze

Answers and Rationale

1. Answer: B. Fetal heart tones

When the membranes rupture, there is often a transient drop in the fetal heart tones. The heart tones should return to baseline quickly. Any alteration in fetal heart tones,

such as bradycardia or tachycardia, should be reported. After the fetal heart tones are assessed, the nurse should evaluate the cervical dilation, vital signs, and level of discomfort, making answers A, C, and D incorrect.

2. Answer: A. Active

The active phase of labor occurs when the client is dilated 4–7cm. The latent or early phase of labor is from 1cm to 3cm in dilation, so answers B and D are incorrect. The transition phase of labor is 8–10cm in dilation, making answer C incorrect.

3. Answer: B. Wrapping the newborn snugly in a blanket

The infant of an addicted mother will undergo withdrawal. Snugly wrapping the infant in a blanket will help prevent the muscle irritability that these babies often experience. Teaching the mother to provide tactile stimulation or provide for early infant stimulation are incorrect because he is irritable and needs quiet and little stimulation at this time, so answers A and D are incorrect. Placing the infant in an infant seat in answer C is incorrect because this will also cause movement that can increase muscle irritability.

4. Answer: C. Checking the client's blood pressure

Following epidural anesthesia, the client should be checked for hypotension and signs of shock every 5 minutes for 15 minutes. The client can be checked for cervical dilation later after she is stable. The client should not be positioned supine because the anesthesia can move above the respiratory center and the client can stop breathing. Fetal heart tones should be assessed after the blood pressure is checked. Therefore, answers A, B, and D are incorrect.

5. Answer: B. Wash her hands for 2 minutes before care

The best way to prevent post-operative wound infection is hand washing. Use of prescribed antibiotics will treat infection, not prevent infections, making answer A incorrect. Wearing a mask and asking the client to cover her mouth are good practices but will not prevent wound infections; therefore, answers C and D are incorrect.

6. Answer: B. Disalignment

The client with a hip fracture will most likely have misalignment. Answers A, C, and D are incorrect because all fractures cause pain, and coolness of the extremities and absence of pulses are indicative of compartment syndrome or peripheral vascular disease.

7. Answer: B. Hormonal disturbances

After menopause, women lack hormones necessary to absorb and utilize calcium. Doing weight-bearing exercises and taking calcium supplements can help to prevent osteoporosis but are not causes, so answers A and C are incorrect. Body types that

frequently experience osteoporosis are thin Caucasian females, but they are not most likely related to osteoporosis, so answer D is incorrect.

8. Answer: B. The buttocks are 15° off the bed.

The infant's hips should be off the bed approximately 15° in Bryant's traction. Answer A is incorrect because this does not indicate that the traction is working correctly, nor does C. Answer D is incorrect because Bryant's traction is a skin traction, not a skeletal traction.

9. Answer A. Utilizes a Steinman pin

Balanced skeletal traction uses pins and screws. A Steinman pin goes through large bones and is used to stabilize large bones such as the femur. Answer B is incorrect because only the affected leg is in traction. Kirschner wires are used to stabilize small bones such as fingers and toes, as in answer C. Answer D is incorrect because this type of traction is not used for fractured hips.

10. Answer A. Serum collection (Davol) drain

Bleeding is a common complication of orthopedic surgery. The blood-collection device should be checked frequently to ensure that the client is not hemorrhaging. The client's pain should be assessed, but this is not life-threatening. When the client is in less danger, the nutritional status should be assessed and an immobilizer is not used; thus, answers B, C, and D are incorrect.

11. Answer A. "I must flush the tube with water after feedings and clamp the tube."

The client's family member should be taught to flush the tube after each feeding and clamp the tube. The placement should be checked before feedings, and indigestion can occur with the PEG tube, just as it can occur with any client, so answers B and C are incorrect. Medications can be ordered for indigestion, but it is not a reason for alarm. A percutaneous endoscopy gastrostomy tube is used for clients who have experienced difficulty swallowing. The tube is inserted directly into the stomach and does not require swallowing; therefore, answer D is incorrect.

12. Answer C. The client's hematocrit is 26%.

The client with a total knee replacement should be assessed for anemia. A hematocrit of 26% is extremely low and might require a blood transfusion. Bleeding of 2cm on the dressing is not extreme. Circle and date and time the bleeding and monitor for changes in the client's status. A low-grade temperature is not unusual after surgery. Ensure that the client is well hydrated, and recheck the temperature in 1 hour. If the temperature is above 100.6°F (38.1°C), report this finding to the doctor. Tylenol will probably be ordered. Voiding after surgery is also not uncommon and no need for concern; therefore answers A, B, and D are incorrect.

13. Answer B. The client's parents are skilled stained-glass artists.

Plumbism is lead poisoning. One factor associated with the consumption of lead is eating from pottery made in Central America or Mexico that is unfired. The child lives in a house built after 1976 (this is when lead was taken out of paint), and the parents make stained glass as a hobby. Stained glass is put together with lead, which can drop on the work area, where the child can consume the lead beads. Answer A is incorrect because simply traveling out of the country does not increase the risk. In answer C, the house was built after the lead was removed with the paint. Answer D is unrelated to the stem.

14. Answer: A. High-seat commode

The equipment that can help with activities of daily living is the high-seat commode. The hip should be kept higher than the knee. The recliner is good because it prevents 90° flexion but not daily activities. A TENS (Transcutaneous Electrical Nerve Stimulation) unit helps with pain management and an abduction pillow is used to prevent adduction of the hip and possibly dislocation of the prosthesis; therefore, answers B, C, and D are incorrect.

15. Answer: B. Have narcan (naloxone) available

Narcan is the antidote for narcotic overdose. If hypoxia occurs, the client should have oxygen administered by mask, not cannula. There is no data to support the administration of blood products or cardiac resuscitation, so answers A, C, and D are incorrect.

16. Answer: B. 12-year-old male with a fractured femur

The 6-year-old should have a roommate as close to the same age as possible, so the 12-year-old is the best match. The 10-year-old with sarcoma has cancer and will be treated with chemotherapy that makes him immune suppressed, the 6-year-old with osteomyelitis is infected, and the client in answer A is too old and is female; therefore, answers A, C, and D are incorrect.

17. Answer: B. Report chest pain.

Cox II inhibitors have been associated with heart attacks and strokes. Any changes in cardiac status or signs of a stroke should be reported immediately, along with any changes in bowel or bladder habits because bleeding has been linked to use of Cox II inhibitors. The client does not have to take the medication with milk, remain upright, or allow 6 weeks for optimal effect, so answers A, C, and D are incorrect.

18. Answer: D. Allows 24 hours before bearing weight

A plaster-of-Paris cast takes 24 hours to dry, and the client should not bear weight for 24 hours. The cast should be handled with the palms, not the fingertips, so answer A is incorrect. Petaling a cast is covering the end of the cast with cast batting or a sock, to prevent skin irritation and flaking of the skin under the cast, making answer B incorrect.

The client should be told not to dry the cast with a hair dryer because this causes hot spots and could burn the client. This also causes unequal drying; thus, answer C is incorrect.

19. Answer: A. "It will be alright for your friends to autograph the cast."

There is no reason that the client's friends should not be allowed to autograph the cast; it will not harm the cast in any way, so answers B, C, and D are incorrect.

20. Answer: A. Assisting the LPN with opening sterile packages and peroxide

The nurse is performing the pin care correctly when she uses sterile gloves and Q-tips. A licensed practical nurse can perform pin care, there is no need to clean the weights, and the nurse can help with opening the packages but it isn't required; therefore, answers B, C, and D are incorrect.

21. Answer: A. Check the bowel sounds

A body cast or spica cast extends from the upper abdomen to the knees or below. Bowel sounds should be checked to ensure that the client is not experiencing a paralytic ileus. Checking the blood pressure is a treatment for any client, offering pain medication is not called for, and checking for swelling isn't specific to the stem, so answers B, C, and D are incorrect.

22. Answer: C. Halo traction

Halo traction will be ordered for the client with a cervical fracture. Russell's traction is used for bones of the lower extremities, as is Buck's traction. Crutchfield tongs are used while in the hospital and the client is immobile; therefore, answers A, B, and D are incorrect.

23. Answer: B. "The CPM machine controls should be positioned distal to the site."

The controller for the continuous passive-motion device should be placed away from the client. Many clients complain of pain while having treatments with the CPM, so they might turn off the machine. The CPM flexes and extends the leg. The client is in the bed during CPM therapy, so answer A is incorrect. Answer C is incorrect because clients will experience pain with the treatment. Use of the CPM does not alleviate the need for physical therapy, as suggested in answer D.

24. Answer: A. Palms rest lightly on the handles

The client's palms should rest lightly on the handles. The elbows should be flexed no more than 30° but should not be extended. Answer B is incorrect because 0° is not a relaxed angle for the elbows and will not facilitate correct walker use. The client should walk to the middle of the walker, not to the front of the walker, making answer C

incorrect. The client should be taught not to carry the walker because this would not provide stability; thus, answer D is incorrect.

25. Answer: C. Elevate the client's hips.

The client with a prolapsed cord should be treated by elevating the hips and covering the cord with a moist, sterile saline gauze. The nurse should use her fingers to push up on the presenting part until a cesarean section can be performed. Answers A, B, and D are incorrect. The nurse should not attempt to replace the cord, turn the client on the side, or cover with a dry gauze.

1. The client presents to the clinic with a serum cholesterol of 275 mg/dL and is placed on rosuvastatin (Crestor). Which instruction should be given to the client?

A. Report muscle weakness to the physician.
B. Allow six months for the drug to take effect.
C. Take the medication with fruit juice.
D. Ask the doctor to perform a complete blood count before starting the medication.

2. The client is admitted to the hospital with hypertensive crises. Diazoxide (Hyperstat) is ordered. During administration, the nurse should:

A. Utilize an infusion pump
B. Check the blood glucose level
C. Place the client in Trendelenburg position
D. Cover the solution with foil

3. The 6-month-old client with a ventral septal defect is receiving Digitalis for regulation of his heart rate. Which finding should be reported to the doctor?

A. Blood pressure of 126/80
B. Blood glucose of 110 mg/dL
C. Heart rate of 60 bpm
D. Respiratory rate of 30 per minute

4. The client admitted with angina is given a prescription for nitroglycerin. The client should be instructed to:

A. Replenish his supply every 3 months
B. Take one every 15 minutes if pain occurs
C. Leave the medication in the brown bottle
D. Crush the medication and take with water

5. The client is instructed regarding foods that are low in fat and cholesterol. Which diet selection is lowest in saturated fats?

A. Macaroni and cheese
B. Shrimp with rice
C. Turkey breast
D. Spaghetti

6. The client is admitted with left-sided congestive heart failure. In assessing the client for edema, the nurse should check the:

A. Feet
B. Neck
C. Hands
D. Sacrum

7. The nurse is checking the client's central venous pressure. The nurse should place the zero of the manometer at the:

A. Phlebostatic axis
B. PMI
C. Erb's point
D. Tail of Spence

8. The physician orders lisinopril (Zestril) and furosemide (Lasix) to be administered concomitantly to the client with hypertension. The nurse should:

A. Question the order
B. Administer the medications
C. Administer separately
D. Contact the pharmacy

9. The best method of evaluating the amount of peripheral edema is:

A. Weighing the client daily
B. Measuring the extremity
C. Measuring the intake and output
D. Checking for pitting

10. A client with vaginal cancer is being treated with a radioactive vaginal implant. The client's husband asks the nurse if he can spend the night with his wife. The nurse should explain that:

A. Overnight stays by family members is against hospital policy.
B. There is no need for him to stay because staffing is adequate.
C. His wife will rest much better knowing that he is at home.
D. Visitation is limited to 30 minutes when the implant is in place.

11. The nurse is caring for a client hospitalized with a facial stroke. Which diet selection would be suited to the client?

A. Roast beef sandwich, potato chips, pickle spear, iced tea
B. Split pea soup, mashed potatoes, pudding, milk
C. Tomato soup, cheese toast, Jello, coffee
D. Hamburger, baked beans, fruit cup, iced tea

12. The physician has prescribed Novolog insulin for a client with diabetes mellitus. Which statement indicates that the client knows when the peak action of the insulin occurs?

A. "I will make sure I eat breakfast within 10 minutes of taking my insulin."
B. "I will need to carry candy or some form of sugar with me all the time."
C. "I will eat a snack around three o'clock each afternoon."
D. "I can save my dessert from supper for a bedtime snack."

13. The nurse is teaching basic infant care to a group of first-time parents. The nurse should explain that a sponge bath is recommended for the first 2 weeks of life because:

A. New parents need time to learn how to hold the baby.
B. The umbilical cord needs time to separate.
C. Newborn skin is easily traumatized by washing.
D. The chance of chilling the baby outweighs the benefits of bathing.

14. A client with leukemia is receiving Trimetrexate. After reviewing the client's chart, the physician orders Wellcovorin (leucovorin calcium). The rationale for administering leucovorin calcium to a client receiving Trimetrexate is to:
A. Treat iron-deficiency anemia caused by chemotherapeutic agents
B. Create a synergistic effect that shortens treatment time
C. Increase the number of circulating neutrophils
D. Reverse drug toxicity and prevent tissue damage

15. A 4-month-old is brought to the well-baby clinic for immunization. In addition to the DPT and polio vaccines, the baby should receive:
A. HibTITER
B. Mumps vaccine
C. Hepatitis B vaccine
D. MMR

16. The physician has prescribed Nexium (esomeprazole) for a client with erosive gastritis. The nurse should administer the medication:
A. 30 minutes before meals
B. With each meal
C. In a single dose at bedtime
D. 30 minutes after meals

17. A client on the psychiatric unit is in an uncontrolled rage and is threatening other clients and staff. What is the most appropriate action for the nurse to take?
A. Call security for assistance and prepare to sedate the client.
B. Tell the client to calm down and ask him if he would like to play cards.
C. Tell the client that if he continues his behavior he will be punished.
D. Leave the client alone until he calms down.

18. When the nurse checks the fundus of a client on the first postpartum day, she notes that the fundus is firm, is at the level of the umbilicus, and is displaced to the right. The next action the nurse should take is to:
A. Check the client for bladder distention
B. Assess the blood pressure for hypotension
C. Determine whether an oxytocic drug was given
D. Check for the expulsion of small clots

19. A client is admitted to the hospital with a temperature of 99.8°F, complaints of blood-tinged hemoptysis, fatigue, and night sweats. The client's symptoms are consistent with a diagnosis of:
A. Pneumonia
B. Reaction to antiviral medication

C. Tuberculosis
D. Superinfection due to low CD4 count

20. The client is seen in the clinic for treatment of migraine headaches. The drug Imitrex (sumatriptan succinate) is prescribed for the client. Which of the following in the client's history should be reported to the doctor?

A. Diabetes
B. Prinzmetal's angina
C. Cancer
D. Cluster headaches

21. The client with suspected meningitis is admitted to the unit. The doctor is performing an assessment to determine meningeal irritation and spinal nerve root inflammation. A positive Kernig's sign is charted if the nurse notes:

A. Pain on flexion of the hip and knee
B. Nuchal rigidity on flexion of the neck
C. Pain when the head is turned to the left side
D. Dizziness when changing positions

22. The client with Alzheimer's disease is being assisted with activities of daily living when the nurse notes that the client uses her toothbrush to brush her hair. The nurse is aware that the client is exhibiting:

A. Agnosia
B. Apraxia
C. Anomia
D. Aphasia

23. The client with dementia is experiencing confusion late in the afternoon and before bedtime. The nurse is aware that the client is experiencing what is known as:

A. Chronic fatigue syndrome
B. Normal aging
C. Sundowning
D. Delusions

24. The client with confusion says to the nurse, "I haven't had anything to eat all day long. When are they going to bring breakfast?" The nurse saw the client in the day room eating breakfast with other clients 30 minutes before this conversation. Which response would be best for the nurse to make?

A. "You know you had breakfast 30 minutes ago."
B. "I am so sorry that they didn't get you breakfast. I'll report it to the charge nurse."
C. "I'll get you some juice and toast. Would you like something else?"
D. "You will have to wait a while; lunch will be here in a little while."

25. The doctor has prescribed Exelon (rivastigmine) for the client with Alzheimer's disease. Which side effect is most often associated with this drug?

A. Urinary incontinence
B. Headaches

C. Confusion
D. Nausea

26. A client is admitted to the labor and delivery unit in active labor. During examination, the nurse notes a papular lesion on the perineum. Which initial action is most appropriate?

A. Document the finding
B. Report the finding to the doctor
C. Prepare the client for a C-section
D. Continue primary care as prescribed

27. A client with a diagnosis of HPV is at risk for which of the following?

A. Hodgkin's lymphoma
B. Cervical cancer
C. Multiple myeloma
D. Ovarian cancer

28. During the initial interview, the client reports that she has a lesion on the perineum. Further investigation reveals a small blister on the vulva that is painful to touch. The nurse is aware that the most likely source of the lesion is:

A. Syphilis
B. Herpes
C. Gonorrhea
D. Condylomata

29. A client visiting a family planning clinic is suspected of having an STI. The best diagnostic test for treponema pallidum is:

A. Venereal Disease Research Lab (VDRL)
B. Rapid plasma reagin (RPR)
C. Florescent treponemal antibody (FTA)
D. Thayer-Martin culture (TMC)

30. A 15-year-old primigravida is admitted with a tentative diagnosis of HELLP syndrome. Which laboratory finding is associated with HELLP syndrome?

A. Elevated blood glucose
B. Elevated platelet count
C. Elevated creatinine clearance
D. Elevated hepatic enzymes

31. The nurse is assessing the deep tendon reflexes of a client with preeclampsia. Which method is used to elicit the biceps reflex?

A. The nurse places her thumb on the muscle inset in the antecubital space and taps the thumb briskly with the reflex hammer.
B. The nurse loosely suspends the client's arm in an open hand while tapping the back of the client's elbow.

C. The nurse instructs the client to dangle her legs as the nurse strikes the area below the patella with the blunt side of the reflex hammer.
D. The nurse instructs the client to place her arms loosely at her side as the nurse strikes the muscle insert just above the wrist.

32. A primigravida with diabetes is admitted to the labor and delivery unit at 34 weeks gestation. Which doctor's order should the nurse question?

A. Magnesium sulfate 4gm (25%) IV
B. Brethine 10 mcg IV
C. Stadol 1 mg IV push every 4 hours as needed prn for pain
D. Ancef 2gm IVPB every 6 hours

33. A diabetic multigravida is scheduled for an amniocentesis at 32 weeks gestation to determine the L/S ratio and phosphatidyl glycerol level. The L/S ratio is 1:1 and the presence of phosphatidylglycerol is noted. The nurse's assessment of this data is:

A. The infant is at low risk for congenital anomalies.
B. The infant is at high risk for intrauterine growth retardation.
C. The infant is at high risk for respiratory distress syndrome.
D. The infant is at high risk for birth trauma.

34. Which observation in the newborn of a diabetic mother would require immediate nursing intervention?

A. Crying
B. Wakefulness
C. Jitteriness
D. Yawning

35. The nurse caring for a client receiving intravenous magnesium sulfate must closely observe for side effects associated with drug therapy. An expected side effect of magnesium sulfate is:

A. Decreased urinary output
B. Hypersomnolence
C. Absence of knee jerk reflex
D. Decreased respiratory rate

36. The client has elected to have epidural anesthesia to relieve labor pain. If the client experiences hypotension, the nurse would:
A. Place her in Trendelenburg position
B. Decrease the rate of IV infusion
C. Administer oxygen per nasal cannula
D. Increase the rate of the IV infusion

37. A client has cancer of the pancreas. The nurse should be most concerned about which nursing diagnosis?

A. Alteration in nutrition
B. Alteration in bowel elimination
C. Alteration in skin integrity
D. Ineffective individual coping

38. The nurse is caring for a client with ascites. Which is the best method to use for determining early ascites?

A. Inspection of the abdomen for enlargement
B. Bimanual palpation for hepatomegaly
C. Daily measurement of abdominal girth
D. Assessment for a fluid wave

39. The client arrives in the emergency department after a motor vehicle accident. Nursing assessment findings include BP 80/34, pulse rate 120, and respirations 20. Which is the client's most appropriate priority nursing diagnosis?

A. Alteration in cerebral tissue perfusion
B. Fluid volume deficit
C. Ineffective airway clearance
D. Alteration in sensory perception

40. The home health nurse is visiting an 18-year-old with osteogenesis imperfecta. Which information obtained on the visit would cause the most concern? The client:

A. Likes to play football
B. Drinks several carbonated drinks per day
C. Has two sisters with sickle cell tract
D. Is taking acetaminophen to control pain

41. The nurse working the organ transplant unit is caring for a client with a white blood cell count of During evening visitation, a visitor brings a basket of fruit. What action should the nurse take?

A. Allow the client to keep the fruit
B. Place the fruit next to the bed for easy access by the client
C. Offer to wash the fruit for the client
D. Tell the family members to take the fruit home

42. The nurse is caring for the client following a laryngectomy when suddenly the client becomes nonresponsive and pale, with a BP of 90/40 systolic. The initial nurse's action should be to:

A. Place the client in Trendelenburg position
B. Increase the infusion of Dextrose in normal saline
C. Administer atropine intravenously
D. Move the emergency cart to the bedside

43. The client admitted 2 days earlier with a lung resection accidentally pulls out the chest tube. Which action by the nurse indicates understanding of the management of chest tubes?

A. Order a chest x-ray
B. Reinsert the tube
C. Cover the insertion site with a Vaseline gauze
D. Call the doctor

44. A client being treated with sodium warfarin has a Protime of 120 seconds. Which intervention would be most important to include in the nursing care plan?

A. Assess for signs of abnormal bleeding
B. Anticipate an increase in the Coumadin dosage
C. Instruct the client regarding the drug therapy
D. Increase the frequency of neurological assessments

45. Which selection would provide the most calcium for the client who is 4 months pregnant?

A. A granola bar
B. A bran muffin
C. A cup of yogurt
D. A glass of fruit juice

46. The client with preeclampsia is admitted to the unit with an order for magnesium sulfate. Which action by the nurse indicates understanding of the possible side effects of magnesium sulfate?

A. The nurse places a sign over the bed not to check blood pressure in the right arm.
B. The nurse places a padded tongue blade at the bedside.
C. The nurse inserts a Foley catheter.
D. The nurse darkens the room.

47. A 6-year-old client is admitted to the unit with a hemoglobin of 6g/dL. The physician has written an order to transfuse 2 units of whole blood. When discussing the treatment, the child's mother tells the nurse that she does not believe in having blood transfusions and that she will not allow her child to have the treatment. What nursing action is most appropriate?

A. Ask the mother to leave while the blood transfusion is in progress
B. Encourage the mother to reconsider
C. Explain the consequences without treatment
D. Notify the physician of the mother's refusal

48. A client is admitted to the unit 2 hours after an explosion causes burns to the face. The nurse would be most concerned with the client developing which of the following?

A. Hypovolemia
B. Laryngeal edema
C. Hypernatremia
D. Hyperkalemia

49. The nurse is evaluating nutritional outcomes for a with anorexia nervosa. Which data best indicates that the plan of care is effective?

A. The client selects a balanced diet from the menu.
B. The client's hemoglobin and hematocrit improve.
C. The client's tissue turgor improves.
D. The client gains weight.

50. The client is admitted following repair of a fractured tibia and cast application. Which nursing assessment should be reported to the doctor?

A. Pain beneath the cast
B. Warm toes
C. Pedal pulses weak and rapid
D. Paresthesia of the toes

Answers and Rationale

1. Answer: A. Report muscle weakness to the physician.

The client taking antilipidemics should be encouraged to report muscle weakness because this is a sign of rhabdomyolysis. The medication takes effect within 1 month of beginning therapy, so answer B is incorrect. The medication should be taken with water because fruit juice, particularly grapefruit, can decrease the effectiveness, making answer C incorrect. Liver function studies should be checked before beginning the medication, not after the fact, making answer D incorrect.

2. Answer: B. Check the blood glucose level

Hyperstat is given IV push for hypertensive crises, but it often causes hyperglycemia. The glucose level will drop rapidly when stopped. Answer A is incorrect because the hyperstat is given by IV push. The client should be placed in dorsal recumbent position, not a Trendelenburg position, as stated in answer C. Answer D is incorrect because the medication does not have to be covered with foil.

3. Answer: C. Heart rate of 60 bpm

A heart rate of 60 in the baby should be reported immediately. The dose should be held if the heart rate is below 100 bpm. The blood glucose, blood pressure, and respirations are within normal limits; thus answers A, B, and D are incorrect.

4. Answer: C. Leave the medication in the brown bottle

Nitroglycerine should be kept in a brown bottle (or even a special air- and water-tight, solid or plated silver or gold container) because of its instability and tendency to become less potent when exposed to air, light, or water. The supply should be replenished every 6 months, not 3 months, and one tablet should be taken every 5 minutes until pain subsides, so answers A and B are incorrect. If the pain does not subside, the client should report to the emergency room. The medication should be taken sublingually and should not be crushed, as stated in answer D.

5. Answer: C. Turkey breast

Turkey contains the least amount of fats and cholesterol. Liver, eggs, beef, cream sauces, shrimp, cheese, and chocolate should be avoided by the client; thus, answers A, B, and D are incorrect. The client should bake meat rather than frying to avoid adding fat to the meat during cooking.

6. Answer: B. Neck

The jugular veins in the neck should be assessed for distension. The other parts of the body will be edematous in right-sided congestive heart failure, not left-sided; thus, answers A, C, and D are incorrect.

7. Answer: A. Phlebostatic axis

The phlebostatic axis is located at the fifth intercostals space midaxillary line and is the correct placement of the manometer. The PMI or point of maximal impulse is located at

the fifth intercostals space midclavicular line, so answer B is incorrect. Erb's point is the point at which you can hear the valves close simultaneously, making answer C incorrect. The Tail of Spence (the upper outer quadrant) is the area where most breast cancers are located and has nothing to do with placement of a manometer; thus, answer D is incorrect.

8. Answer: B. Administer the medications

Zestril is an ACE inhibitor and is frequently given with a diuretic such as Lasix for hypertension. Answers A, C, and D are incorrect because the order is accurate. There is no need to question the order, administer the medication separately, or contact the pharmacy.

9. Answer: B. Measuring the extremity

The best indicator of peripheral edema is measuring the extremity. A paper tape measure should be used rather than one of plastic or cloth, and the area should be marked with a pen, providing the most objective assessment. Answer A is incorrect because weighing the client will not indicate peripheral edema. Answer C is incorrect because checking the intake and output will not indicate peripheral edema. Answer D is incorrect because checking for pitting edema is less reliable than measuring with a paper tape measure.

10. Answer: D. Visitation is limited to 30 minutes when the implant is in place.

Clients with radium implants should have close contact limited to 30 minutes per visit. The general rule is limiting time spent exposed to radium, putting distance between people and the radium source, and using lead to shield against the radium. Teaching the family member these principles is extremely important. Answers A, B, and C are not empathetic and do not address the question; therefore, they are incorrect.

11. Answer: B. Split pea soup, mashed potatoes, pudding, milk

The client with a facial stroke will have difficulty swallowing and chewing, and the foods in answer B provide the least amount of chewing. The foods in answers A, C, and D would require more chewing and, thus, are incorrect.

12. Answer: A. "I will make sure I eat breakfast within 10 minutes of taking my insulin."

NovoLog insulin onsets very quickly, so food should be available within 10–15 minutes of taking the insulin. Answer B does not address a particular type of insulin, so it is incorrect. NPH insulin peaks in 8–12 hours, so a snack should be eaten at the expected peak time. It may not be 3 p.m. as stated in answer C. Answer D is incorrect because there is no need to save the dessert until bedtime.

13. Answer: B. The umbilical cord needs time to separate.

The umbilical cord needs time to dry and fall off before putting the infant in the tub. Although answers A, C, and D might be important, they are not the primary answer to the question.

14. Answer: D. Reverse drug toxicity and prevent tissue damage

Leucovorin is the antidote for Methotrexate and Trimetrexate which are folic acid antagonists. Leucovorin is a folic acid derivative. Answers A, B, and C are incorrect because Leucovorin does not treat iron deficiency, increased neutrophils, or have a synergistic effect.

15. Answer: A. HibTITER

The Haemophilus influenza vaccine is given at 4 months with the polio vaccine. Answers B, C, and D are incorrect because these vaccines are given later in life.

16. Answer: A. 30 minutes before meals.

Proton pump inhibitors reduce the production of acid in the stomach. Proton pump inhibitors work best when they are taken 30 minutes before the first meal of the day.

17. Answer: A. Call security for assistance and prepare to sedate the client.

If the client is a threat to the staff and to other clients the nurse should call for help and prepare to administer a medication such as Haldol to sedate him. Answer B is incorrect because simply telling the client to calm down will not work. Answer C is incorrect because telling the client that if he continues he will be punished is a threat and may further anger him. Answer D is incorrect because if the client is left alone he might harm himself.

18. Answer: A. Check the client for bladder distention

If the fundus of the client is displaced to the side, this might indicate a full bladder. The next action by the nurse should be to check for bladder distention and catheterize, if necessary. The answers in B, C, and D are actions that relate to postpartal hemorrhage.

19. Answer: C. Tuberculosis

A low-grade temperature, blood-tinged sputum, fatigue, and night sweats are symptoms consistent with tuberculosis. If the answer in A had said pneumocystis pneumonia, answer A would have been consistent with the symptoms given in the stem, but just saying pneumonia isn't specific enough to diagnose the problem. Answers B and D are not directly related to the stem.

20. Answer: B. Prinzmetal's angina

If the client has a history of Prinzmetal's angina, he should not be prescribed triptan preparations because they cause vasoconstriction and coronary spasms. There is no contraindication for taking triptan drugs in clients with diabetes, cancer, or cluster headaches making answers A, C, and D incorrect.

21. Answer: A. Pain on flexion of the hip and knee

Kernig's sign is positive if pain occurs on flexion of the hip and knee. The Brudzinski reflex is positive if pain occurs on flexion of the head and neck onto the chest so answer B is incorrect. Answers C and D might be present but are not related to Kernig's sign.

22. Answer: B. Apraxia

Apraxia is the inability to use objects appropriately. Agnosia is loss of sensory comprehension, anomia is the inability to find words, and aphasia is the inability to speak or understand so answers A, C, and D are incorrect.

23. Answer: C. Sundowning

Increased confusion at night is known as “sundowning” syndrome. This increased confusion occurs when the sun begins to set and continues during the night. Answer A is incorrect because fatigue is not necessarily present. Increased confusion at night is not part of normal aging; therefore, answer B is incorrect. A delusion is a firm, fixed belief; therefore, answer D is incorrect.

24. Answer: C. “I’ll get you some juice and toast. Would you like something else?”

The client who is confused might forget that he ate earlier. Don’t argue with the client. Simply get him something to eat that will satisfy him until lunch. Answers A and D are incorrect because the nurse is dismissing the client. Answer B is validating the delusion.

25. Answer: D. Nausea

Nausea and gastrointestinal upset are very common in clients taking acetylcholinesterase inhibitors such as Exelon. Other side effects include liver toxicity, dizziness, unsteadiness, and clumsiness. The client might already be experiencing urinary incontinence or headaches, but they are not necessarily associated; and the client with Alzheimer’s disease is already confused. Therefore, answers A, B, and C are incorrect.

26. Answer: B. Report the finding to the doctor

Any lesion should be reported to the doctor. This can indicate a herpes lesion. Clients with open lesions related to herpes are delivered by Cesarean section because there is a possibility of transmission of the infection to the fetus with direct contact to lesions. It is not enough to document the finding, so answer A is incorrect. The physician must make the decision to perform a C-section, making answer C incorrect. It is not enough to continue primary care, so answer D is incorrect.

27. Answer: B. Cervical cancer

The client with HPV is at higher risk for cervical and vaginal cancer related to this STI. She is not at higher risk for the other cancers mentioned in answers A, C, and D, so those are incorrect.

28. Answer: B. Herpes

A lesion that is painful is most likely a herpetic lesion. A chancre lesion associated with syphilis is not painful, so answer A is incorrect. Condylomata lesions are painless warts, so answer D is incorrect. In answer C, gonorrhea does not present as a lesion, but is exhibited by a yellow discharge.

29. Answer: C. Fluorescent treponemal antibody (FTA)

Fluorescent treponemal antibody (FTA) is the test for treponema pallidum. VDRL and RPR are screening tests done for syphilis, so answers A and B are incorrect. The Thayer-Martin culture is done for gonorrhea, so answer D is incorrect.

30. Answer: D. Elevated hepatic enzymes

The criteria for HELLP is hemolysis, elevated liver enzymes, and low platelet count. In answer A, an elevated blood glucose level is not associated with HELLP. Platelets are decreased, not elevated, in HELLP syndrome as stated in answer B. The creatinine levels are elevated in renal disease and are not associated with HELLP syndrome so answer C is incorrect.

31. Answer: A. The nurse places her thumb on the muscle inset in the antecubital space and taps the thumb briskly with the reflex hammer.

Answer B elicits the triceps reflex, so it is incorrect. Answer C elicits the patella reflex, making it incorrect. Answer D elicits the radial nerve, so it is incorrect.

32. Answer: B. Brethine 10 mcg IV

Brethine is used cautiously because it raises the blood glucose levels. Answers A, C, and D are all medications that are commonly used in the diabetic client, so they are incorrect.

33. Answer: C. The infant is at high risk for respiratory distress syndrome.

When the L/S ratio reaches 2:1, the lungs are considered to be mature. The infant will most likely be small for gestational age and will not be at risk for birth trauma, so answer D is incorrect. The L/S ratio does not indicate congenital anomalies, as stated in answer A, and the infant is not at risk for intrauterine growth retardation, making answer B incorrect.

34. Answer: C. Jitteriness

Jitteriness is a sign of seizure in the neonate. Crying, wakefulness, and yawning are expected in the newborn, so answers A, B, and D are incorrect.

35. Answer: B. Hypersomnolence

The client is expected to become sleepy, have hot flashes, and be lethargic. A decreasing urinary output, absence of the knee-jerk reflex, and decreased respirations indicate toxicity, so answers A, C, and D are incorrect.

36. Answer: D. Increase the rate of the IV infusion

If the client experiences hypotension after an injection of epidural anesthetic, the nurse should turn her to the left side, apply oxygen by mask, and speed the IV infusion. If the blood pressure does not return to normal, the physician should be contacted. Epinephrine should be kept for emergency administration. Answer A is incorrect because placing the client in Trendelenburg position (head down) will allow the

anesthesia to move up above the respiratory center, thereby decreasing the diaphragm's ability to move up and down and ventilate the client. In answer B, the IV rate should be increased, not decreased. In answer C, the oxygen should be applied by mask, not cannula.

37. Answer: A. Alteration in nutrition

Cancer of the pancreas frequently leads to severe nausea and vomiting and altered nutrition. The other problems are of lesser concern; thus, answers B, C, and D are incorrect.

38. Answer: C. Daily measurement of abdominal girth

Measuring with a paper tape measure and marking the area that is measured is the most objective method of estimating ascites. Inspecting and checking for fluid waves are more subjective, so answers A and B are incorrect. Palpation of the liver will not tell the amount of ascites; thus, answer D is incorrect.

39. Answer: B. Fluid volume deficit

The vital signs indicate hypovolemic shock. They do not indicate cerebral tissue perfusion, airway clearance, or sensory perception alterations, so answers A, C, and D are incorrect.

40. Answer: A. Likes to play football

The client with osteogenesis imperfecta is at risk for pathological fractures and is likely to experience these fractures if he participates in contact sports. The client might experience symptoms of hypoxia if he becomes dehydrated or deoxygenated; extreme exercise, especially in warm weather, can exacerbate the condition. Answers B, C, and D are not factors for concern.

41. Answer: D. Tell the family members to take the fruit home

The client with neutropenia should not have fresh fruit because it should be peeled and/or cooked before eating. He should also not eat foods grown on or in the ground or eat from the salad bar. The nurse should remove potted or cut flowers from the room as well. Any source of bacteria should be eliminated, if possible. Answers A, B, and C will not help prevent bacterial invasions.

42. Answer: B. Increase the infusion of Dextrose in normal saline

In clients who have not had surgery to the face or neck, the answer would be answer A; however, in this situation, this could further interfere with the airway. Increasing the infusion and placing the client in supine position would be better. Answers C is incorrect because it is not necessary at this time and could cause hyponatremia and further hypotension. Answer D is not necessary at this time.

43. Answer: C. Cover the insertion site with a Vaseline gauze

If the client pulls the chest tube out of the chest, the nurse's first action should be to cover the insertion site with an occlusive dressing. Afterward, the nurse should call the doctor, who will order a chest x-ray and possibly reinsert the tube. Answers A, B, and D are not the first action to be taken.

44. Answer: A. Assess for signs of abnormal bleeding

The normal Protime is 12–20 seconds. A Protime of 120 seconds indicates an extremely prolonged Protime and can result in a spontaneous bleeding episode. Answers B, C, and D may be needed at a later time but are not the most important actions to take first.

45. Answer: C. A cup of yogurt

The food with the most calcium is the yogurt. Answers A, B, and D are good choices, but not as good as the yogurt, which has approximately 400 mg of calcium.

46. Answer: C. The nurse inserts a Foley catheter.

The client receiving magnesium sulfate should have a Foley catheter in place, and hourly intake and output should be checked. There is no need to refrain from checking the blood pressure in the right arm. A padded tongue blade should be kept in the room at the bedside, just in case of a seizure, but this is not related to the magnesium sulfate infusion. Darkening the room is unnecessary, so answers A, B, and D are incorrect.

47. Answer: D. Notify the physician of the mother's refusal

If the client's mother refuses the blood transfusion, the doctor should be notified. Because the client is a minor, the court might order treatment. Answer A is incorrect. Because it is not the primary responsibility for the nurse to encourage the mother to consent or explain the consequences, so answers B and C are incorrect.

48. Answer: B. Laryngeal edema

The nurse should be most concerned with laryngeal edema because of the area of burn. The next priority should be answer A, as well as hyponatremia and hypokalemia in C and D, but these answers are not of primary concern so are incorrect.

49. Answer: D. The client gains weight.

The client with anorexia shows the most improvement by weight gain. Selecting a balanced diet does little good if the client will not eat, so answer A is incorrect. The hematocrit might improve by several means, such as blood transfusion, but that does not indicate improvement in the anorexic condition; therefore, answer B is incorrect. The tissue turgor indicates fluid stasis, not improvement of anorexia, so answer C is incorrect.

50. Answer: D. Paresthesia of the toes

At this time, pain beneath the cast is normal. The client's toes should be warm to the touch, and pulses should be present. Paresthesia is not normal and might indicate compartment syndrome. Therefore, Answers A, B, and C are incorrect.

1. A client with a history of abusing barbiturates abruptly stops taking the medication. The nurse should give priority to assessing the client for:

A. Depression and suicidal ideation
B. Tachycardia and diarrhea
C. Muscle cramping and abdominal pain
D. Tachycardia and euphoric mood

2. During the assessment of a laboring client, the nurse notes that the FHT are loudest in the upper-right quadrant. The infant is most likely in which position?

A. Right breech presentation
B. Right occiput anterior presentation
C. Left sacral anterior presentation
D. Left occipital transverse presentation

3. The primary physiological alteration in the development of asthma is:

A. Bronchiolar inflammation and dyspnea
B. Hypersecretion of abnormally viscous mucus
C. Infectious processes causing mucosal edema
D. Spasm of bronchial smooth muscle

4. A client with mania is unable to finish her dinner. To help her maintain sufficient nourishment, the nurse should:

A. Serve high-calorie foods she can carry with her
B. Encourage her appetite by sending out for her favorite foods
C. Serve her small, attractively arranged portions
D. Allow her in the unit kitchen for extra food whenever she pleases

5. To maintain Bryant's traction, the nurse must make certain that the child's:

A. Hips are resting on the bed, with the legs suspended at a right angle to the bed
B. Hips are slightly elevated above the bed and the legs are suspended at a right angle to the bed
C. Hips are elevated above the level of the body on a pillow and the legs are suspended parallel to the bed
D. Hips and legs are flat on the bed, with the traction positioned at the foot of the bed

6. Which action by the nurse indicates understanding of herpes zoster?

A. The nurse covers the lesions with a sterile dressing.
B. The nurse wears gloves when providing care.
C. The nurse administers a prescribed antibiotic.
D. The nurse administers oxygen.

7. The client has an order for a trough to be drawn on the client receiving Vancomycin. The nurse is aware that the nurse should contact the lab for them to collect the blood:

A. 15 minutes after the infusion
B. 30 minutes before the infusion
C. 1 hour after the infusion
D. 2 hours after the infusion

8. The client using a diaphragm should be instructed to:

A. Refrain from keeping the diaphragm in longer than 4 hours
B. Keep the diaphragm in a cool location
C. Have the diaphragm resized if she gains 5 pounds
D. Have the diaphragm resized if she has any surgery

9. The nurse is providing postpartum teaching for a mother planning to breastfeed her infant. Which of the client's statements indicates the need for additional teaching?

A. "I'm wearing a support bra."
B. "I'm expressing milk from my breast."
C. "I'm drinking four glasses of fluid during a 24-hour period."
D. "While I'm in the shower, I'll allow the water to run over my breasts."

10. Damage to the VII cranial nerve results in:

A. Facial pain
B. Absence of ability to smell
C. Absence of eye movement
D. Tinnitus

11. A client is receiving Pyridium (phenazopyridine hydrochloride) for a urinary tract infection. The client should be taught that the medication may:

A. Cause diarrhea
B. Change the color of her urine
C. Cause mental confusion
D. Cause changes in taste

12. Which of the following tests should be performed before beginning a prescription of Accutane?

A. Check the calcium level
B. Perform a pregnancy test
C. Monitor apical pulse
D. Obtain a creatinine level

13. A client with AIDS is taking Zovirax (acyclovir). Which nursing intervention is most critical during the administration of acyclovir?

A. Limit the client's activity
B. Encourage a high-carbohydrate diet

C. Utilize an incentive spirometer to improve respiratory function
D. Encourage fluids

14. A client is admitted for an MRI. The nurse should question the client regarding:

A. Pregnancy
B. A titanium hip replacement
C. Allergies to antibiotics
D. Inability to move his feet

15. The nurse is caring for the client receiving Amphotericin B. Which of the following indicates that the client has experienced toxicity to this drug?

A. Changes in vision
B. Nausea
C. Urinary frequency
D. Changes in skin color

16. The nurse should visit which of the following clients first?

A. The client with diabetes with a blood glucose of 95mg/dL
B. The client with hypertension being maintained on Lisinopril
C. The client with chest pain and a history of angina
D. The client with Raynaud's disease

17. A client with cystic fibrosis is taking pancreatic enzymes. The nurse should administer this medication:

A. Once per day in the morning
B. Three times per day with meals
C. Once per day at bedtime
D. Four times per day

18. Cataracts result in opacity of the crystalline lens. Which of the following best explains the functions of the lens?

A. The lens controls stimulation of the retina.
B. The lens orchestrates eye movement.
C. The lens focuses light rays on the retina.
D. The lens magnifies small objects.

19. A client who has glaucoma is to have miotic eye drops instilled in both eyes. The nurse knows that the purpose of the medication is to:

A. Anesthetize the cornea
B. Dilate the pupils
C. Constrict the pupils
D. Paralyze the muscles of accommodation

20. A client with a severe corneal ulcer has an order for Gentamycin gtt. q 4 hours and Neomycin 1 gtt q 4 hours. Which of the following schedules should be used when administering the drops?

A. Allow 5 minutes between the two medications.
B. The medications may be used together.
C. The medications should be separated by a cycloplegic drug.
D. The medications should not be used in the same client.

21. The client with color blindness will most likely have problems distinguishing which of the following colors?

A. Orange
B. Violet
C. Red
D. White

22. The client with a pacemaker should be taught to:

A. Report ankle edema
B. Check his blood pressure daily
C. Refrain from using a microwave oven
D. Monitor his pulse rate

23. The client with enuresis is being taught regarding bladder retraining. The nurse should advise the client to refrain from drinking after:

A. 1900
B. 1200
C. 1000
D. 0700

24. Which of the following diet instructions should be given to the client with recurring urinary tract infections?

A. Increase intake of meats.
B. Avoid citrus fruits.
C. Perform pericare with hydrogen peroxide.
D. Drink a glass of cranberry juice every day.

25. The physician has prescribed NPH insulin for a client with diabetes mellitus. Which statement indicates that the client knows when the peak action of the insulin occurs?

A. “I will make sure I eat breakfast within 2 hours of taking my insulin.”
B. “I will need to carry candy or some form of sugar with me all the time.”
C. “I will eat a snack around three o’clock each afternoon.”
D. “I can save my dessert from supper for a bedtime snack.”

26. The nurse is caring for a 30-year-old male admitted with a stab wound. While in the emergency room, a chest tube is inserted. Which of the following explains the primary rationale for insertion of chest tubes?

A. The tube will allow for equalization of the lung expansion.
B. Chest tubes serve as a method of draining blood and serous fluid and assist in reinflating the lungs.
C. Chest tubes relieve pain associated with a collapsed lung.
D. Chest tubes assist with cardiac function by stabilizing lung expansion.

27. A client who delivered this morning tells the nurse that she plans to breastfeed her baby. The nurse is aware that successful breastfeeding is most dependent on the:

A. Mother's educational level
B. Infant's birth weight
C. Size of the mother's breast
D. Mother's desire to breastfeed

28. The nurse is monitoring the progress of a client in labor. Which finding should be reported to the physician immediately?

A. The presence of scant bloody discharge
B. Frequent urination
C. The presence of green-tinged amniotic fluid
D. Moderate uterine contractions

29. The nurse is measuring the duration of the client's contractions. Which statement is true regarding the measurement of the duration of contractions?

A. Duration is measured by timing from the beginning of one contraction to the beginning of the next contraction.
B. Duration is measured by timing from the end of one contraction to the beginning of the next contraction.
C. Duration is measured by timing from the beginning of one contraction to the end of the same contraction.
D. Duration is measured by timing from the peak of one contraction to the end of the same contraction.

30. The physician has ordered an intravenous infusion of Pitocin for the induction of labor. When caring for the obstetric client receiving intravenous Pitocin, the nurse should monitor for:
A. Maternal hypoglycemia
B. Fetal bradycardia
C. Maternal hyperreflexia
D. Fetal movement

31. A client with diabetes visits the prenatal clinic at 28 weeks gestation. Which statement is true regarding insulin needs during pregnancy?

A. Insulin requirements moderate as the pregnancy progresses.
B. A decreased need for insulin occurs during the second trimester.
C. Elevations in human chorionic gonadotrophin decrease the need for insulin.
D. Fetal development depends on adequate insulin regulation.

32. A client in the prenatal clinic is assessed to have a blood pressure of 180/96. The nurse should give priority to:

A. Providing a calm environment
B. Obtaining a diet history
C. Administering an analgesic
D. Assessing fetal heart tones

33. A primigravida, age 42, is 6 weeks pregnant. Based on the client's age, her infant is at risk for:

A. Down syndrome
B. Respiratory distress syndrome
C. Turner's syndrome
D. Pathological jaundice

34. A client with a missed abortion at 29 weeks gestation is admitted to the hospital. The client will most likely be treated with:

A. Magnesium sulfate
B. Calcium gluconate
C. Dinoprostone (Prostin E.)
D. Bromocriptine (Parlodel)

35. A client with preeclampsia has been receiving an infusion containing magnesium sulfate for a blood pressure that is 160/80; deep tendon reflexes are 1 plus, and the urinary output for the past hour is 100mL. The nurse should:

A. Continue the infusion of magnesium sulfate while monitoring the client's blood pressure
B. Stop the infusion of magnesium sulfate and contact the physician
C. Slow the infusion rate and turn the client on her left side
D. Administer calcium gluconate IV push and continue to monitor the blood pressure

36. Which statement made by the nurse describes the inheritance pattern of autosomal recessive disorders?

A. An affected newborn has unaffected parents.
B. An affected newborn has one affected parent.
C. Affected parents have a one in four chance of passing on the defective gene.
D. Affected parents have unaffected children who are carriers.

37. A pregnant client, age 32, asks the nurse why her doctor has recommended a serum alpha fetoprotein. The nurse should explain that the doctor has recommended the test:

A. Because it is a state law
B. To detect cardiovascular defects
C. Because of her age
D. To detect neurological defects

38. A client with hypothyroidism asks the nurse if she will still need to take thyroid medication during the pregnancy. The nurse's response is based on the knowledge that:

A. There is no need to take thyroid medication because the fetus's thyroid produces a thyroid-stimulating hormone.
B. Regulation of thyroid medication is more difficult because the thyroid gland increases in size during pregnancy.
C. It is more difficult to maintain thyroid regulation during pregnancy due to a slowing of metabolism.
D. Fetal growth is arrested if thyroid medication is continued during pregnancy.

39. The nurse is responsible for performing a neonatal assessment on a full-term infant. At 1 minute, the nurse could expect to find:

A. An apical pulse of 100
B. An absence of tonus
C. Cyanosis of the feet and hands
D. Jaundice of the skin and sclera

40. A client with sickle cell anemia is admitted to the labor and delivery unit during the first phase of labor. The nurse should anticipate the client's need for:

A. Supplemental oxygen
B. Fluid restriction
C. Blood transfusion
D. Delivery by Caesarean section

41. A client with diabetes has an order for ultrasonography. Preparation for an ultrasound includes:

A. Increasing fluid intake
B. Limiting ambulation
C. Administering an enema
D. Withholding food for 8 hours

42. An infant who weighs 8 pounds at birth would be expected to weigh how many pounds at 1 year?

A. 14 pounds
B. 16 pounds

C. 18 pounds
D. 24 pounds

43. A pregnant client with a history of alcohol addiction is scheduled for a nonstress test. The nonstress test:

A. Determines the lung maturity of the fetus
B. Measures the activity of the fetus
C. Shows the effect of contractions on the fetal heart rate
D. Measures the neurological well-being of the fetus

44. A full-term male has hypospadias. Which statement describes hypospadias?

A. The urethral opening is absent.
B. The urethra opens on the dorsal side of the penis.
C. The penis is shorter than usual.
D. The urethral meatus opens on the underside of the penis.

45. A gravida 3 para 2 is admitted to the labor unit. Vaginal exam reveals that the client's cervix is 8 cm dilated, with complete effacement. The priority nursing diagnosis at this time is:

A. Alteration in coping related to pain
B. Potential for injury related to precipitate delivery
C. Alteration in elimination related to anesthesia
D. Potential for fluid volume deficit related to NPO status

46. The client with varicella will most likely have an order for which category of medication?

A. Antibiotics
B. Antipyretics
C. Antivirals
D. Anticoagulants

47. A client is admitted complaining of chest pain. Which of the following drug orders should the nurse question?

A. Nitroglycerin
B. Ampicillin
C. Propranolol
D. Verapamil

48. Which of the following instructions should be included in the teaching for the client with rheumatoid arthritis?

A. Avoid exercise because it fatigues the joints.
B. Take prescribed anti-inflammatory medications with meals.
C. Alternate hot and cold packs to affected joints.
D. Avoid weight-bearing activity.

49. A client with acute pancreatitis is experiencing severe abdominal pain. Which of the following orders should be questioned by the nurse?

A. Meperidine 100 mg IM q 4 hours PRN pain
B. Mylanta 30 ccs q 4 hours via NG
C. Cimetidine 300 mg PO q.i.d.
D. Morphine 8 mg IM q 4 hours PRN pain

50. The client is admitted to the chemical dependence unit with an order for continuous observation. The nurse is aware that the doctor has ordered continuous observation because:

A. Hallucinogenic drugs create both stimulant and depressant effects.
B. Hallucinogenic drugs induce a state of altered perception.
C. Hallucinogenic drugs produce severe respiratory depression.
D. Hallucinogenic drugs induce rapid physical dependence.

Answers and Rationale

1. Answer: B. Tachycardia and diarrhea

Barbiturates create a sedative effect. When the client stops taking barbiturates, he will experience tachycardia, diarrhea, and tachypnea. Answer A is incorrect even though depression and suicidal ideation go along with barbiturate use; it is not the priority. Muscle cramps and abdominal pain are vague symptoms that could be associated with other problems. Tachycardia is associated with stopping barbiturates, but euphoria is not.

2. Answer: A. Right breech presentation

If the fetal heart tones are heard in the right upper abdomen, the infant is in a breech presentation. If the infant is positioned in the right occiput anterior presentation, the FHTs will be located in the right lower quadrant, so answer B is incorrect. If the fetus is in the sacral position, the FHTs will be located in the center of the abdomen, so answer C is incorrect. If the FHTs are heard in the left lower abdomen, the infant is most likely in the left occiput transverse position, making answer D incorrect.

3. Answer: D. Spasm of bronchial smooth muscle

Asthma is the presence of bronchial spasms. This spasm can be brought on by allergies or anxiety. Answer A is incorrect because the primary physiological alteration is not inflammation. Answer B is incorrect because there is the production of abnormally viscous mucus, not a primary alteration. Answer C is incorrect because infection is not primary to asthma.

4. Answer: A. Serve high-calorie foods she can carry with her

The client with mania is seldom sitting long enough to eat and burns many calories for energy. Answer B is incorrect because the client should be treated the same as other clients. Small meals are not a correct option for this client. Allowing her into the kitchen gives her privileges that other clients do not have and should not be allowed, so answer D is incorrect.

5. Answer: B. Hips are slightly elevated above the bed and the legs are suspended at a right angle to the bed

Bryant's traction is used for fractured femurs and dislocated hips. The hips should be elevated 15° off the bed. Answer A is incorrect because the hips should not be resting on the bed. Answer C is incorrect because the hips should not be above the level of the body. Answer D is incorrect because the hips and legs should not be flat on the bed.

6. Answer: B. The nurse wears gloves when providing care.

Herpes zoster is shingles. Clients with shingles should be placed in contact precautions. Wearing gloves during care will prevent transmission of the virus. Covering the lesions with a sterile gauze is not necessary, antibiotics are not prescribed for herpes zoster, and oxygen is not necessary for shingles; therefore, answers A, C, and D are incorrect.

7. Answer: B. 30 minutes before the infusion

A trough level should be drawn 30 minutes before the third or fourth dose. The times in answers A, C, and D are incorrect times to draw blood levels.

8. Answer: B. Keep the diaphragm in a cool location

The client using a diaphragm should keep the diaphragm in a cool location. Answers A, C, and D are incorrect. She should refrain from leaving the diaphragm in longer than 8 hours, not 4 hours. She should have the diaphragm resized when she gains or loses 10 pounds or has abdominal surgery.

9. Answer: C. "I'm drinking four glasses of fluid during a 24-hour period."

Mothers who plan to breastfeed should drink plenty of liquids, and four glasses is not enough in a 24-hour period. Wearing a support bra is a good practice for the mother who is breastfeeding as well as the mother who plans to bottle-feed, so answer A is incorrect. Expressing milk from the breast will stimulate milk production, making answer B incorrect. Allowing the water to run over the breast will also facilitate "letdown," when the milk begins to be produced; thus, answer D is incorrect.

10. Answer: A. Facial pain

The facial nerve is cranial nerve VII. If damage occurs, the client will experience facial pain. The auditory nerve is responsible for hearing loss and tinnitus, eye movement is controlled by the Trochlear or C IV, and the olfactory nerve controls smell; therefore, answers B, C, and D are incorrect.

11. Answer: B. Change the color of her urine

Clients taking Pyridium should be taught that the medication will turn the urine orange or red. It is not associated with diarrhea, mental confusion, or changes in taste; therefore, answers A, C, and D are incorrect. Pyridium can also cause a yellowish color to skin and sclera if taken in large doses.

12. Answer: B. Perform a pregnancy test

Accutane is contraindicated for use by pregnant clients because it causes teratogenic effects. Calcium levels, apical pulse, and creatinine levels are not necessary; therefore, answers A, C, and D are incorrect.

13. Answer: D. Encourage fluids

Clients taking Acyclovir should be encouraged to drink plenty of fluids because renal impairment can occur. Limiting activity is not necessary, nor is eating a high-carbohydrate diet. Use of an incentive spirometer is not specific to clients taking Acyclovir; therefore, answers A, B, and C are incorrect.

14. Answer: A. Pregnancy

Although there are no evidence to suggest MRI scans can pose a risk during pregnancy, it is considered precaution to not perform MRI during pregnancy, particularly in the first three months. This is particularly the case during the first trimester of

pregnancy, as organogenesis takes place during this period. The concerns in pregnancy are the same as for MRI in general, but the fetus may be more sensitive to the effects—particularly to heating and to noise. Clients with a titanium hip replacement can have an MRI. No antibiotics are used with this test and the client should remain still only when instructed, so answers C and D are not specific to this test.

15. Answer: D. Changes in skin color

Clients taking Amphotericin B should be monitored for liver, renal, and bone marrow function because this drug is toxic to the kidneys and liver, and causes bone marrow suppression. Jaundice is a sign of liver toxicity and is not specific to the use of Amphotericin B. Changes in vision are not related, and nausea is a side effect, not a sign of toxicity; nor is urinary frequency. Thus, answers A, B, and C are incorrect.

16. Answer: C. The client with chest pain and a history of angina

The client with chest pain should be seen first because this could indicate a myocardial infarction. The client in answer A has a blood glucose within normal limits. The client in answer B is maintained on blood pressure medication. The client in answer D is in no distress.

17. Answer: B. Three times per day with meals

Pancreatic enzymes should be given with meals for optimal effects. These enzymes assist the body in digesting needed nutrients. Answers A, C, and D are incorrect methods of administering pancreatic enzymes.

18. Answer: C. The lens focuses light rays on the retina.

The lens allows light to pass through the pupil and focus light on the retina. The lens does not stimulate the retina, assist with eye movement, or magnify small objects, so answers A, B, and D are incorrect.

19. Answer: C. Constrict the pupils

Miotic eye drops constrict the pupil and allow aqueous humor to drain out of the Canal of Schlemm. They do not anesthetize the cornea, dilate the pupil, or paralyze the muscles of the eye, making answers A, B, and D incorrect.

20. Answer: A. Allow 5 minutes between the two medications.

When using eyedrops, allow 5 minutes between the two medications; therefore, answer B is incorrect. These medications can be used by the same client but it is not necessary to use a cycloplegic with these medications, making answers C and D incorrect.

21. Answer: B. Violet

Clients with color blindness will most likely have problems distinguishing violets, blues, and green. The colors in answers A, C, and D are less commonly affected.

22. Answer: D. Monitor his pulse rate

The client with a pacemaker should be taught to count and record his pulse rate. Answers A, B, and C are incorrect. Ankle edema is a sign of right-sided congestive heart failure. Although this is not normal, it is often present in clients with heart disease. If the edema is present in the hands and face, it should be reported. Checking the blood pressure daily is not necessary for these clients. The client with a pacemaker can use a microwave oven, but he should stand about 5 feet from the oven while it is operating.

23. Answer: A. 1900

Clients who are being retrained for bladder control should be taught to withhold fluids after about 7 p.m., or 1 The times in answers B, C, and D are too early in the day.

24. Answer: D. Drink a glass of cranberry juice every day.

Cranberry juice is more alkaline and, when metabolized by the body, is excreted with acidic urine. Bacteria does not grow freely in acidic urine. Increasing intake of meats is not associated with urinary tract infections, so answer A is incorrect. The client does not have to avoid citrus fruits and peri care should be done, but hydrogen peroxide is drying, so answers B and C are incorrect.

25. Answer: C. "I will eat a snack around three o'clock each afternoon."

NPH insulin peaks in 8–12 hours, so a snack should be offered at that time. NPH insulin onsets in 90–120 minutes, so answer A is incorrect. Answer B is untrue because NPH insulin is time released and does not usually cause sudden hypoglycemia. Answer D is incorrect, but the client should eat a bedtime snack.

26. Answer: B. Chest tubes serve as a method of draining blood and serous fluid and assist in reinflating the lungs.

Chest tubes work to reinflate the lung and drain serous fluid. The tube does not equalize expansion of the lungs. Pain is associated with collapse of the lung, and insertion of chest tubes is painful, so answers A and C are incorrect. Answer D is true, but this is not the primary rationale for performing chest tube insertion.

27. Answer: D. Mother's desire to breastfeed

Success with breastfeeding depends on many factors, but the most dependable reason for success is desire and willingness to continue the breastfeeding until the infant and mother have time to adapt. The educational level, the infant's birth weight, and the size of the mother's breast have nothing to do with success, so answers A, B, and C are incorrect.

28. Answer: C. The presence of green-tinged amniotic fluid

Green-tinged amniotic fluid is indicative of meconium staining. This finding indicates fetal distress. The presence of scant bloody discharge is normal, as are frequent urination and moderate uterine contractions, making answers A, B, and D incorrect.

29. Answer: C. Duration is measured by timing from the beginning of one contraction to the end of the same contraction.

Duration is measured from the beginning of one contraction to the end of the same contraction. Answer A refers to frequency. Answer B is incorrect because we do not measure from the end of one contraction to the beginning of the next contraction. Duration is not measured from the peak of the contraction to the end, as stated in D.

30. Answer: B. Fetal bradycardia

The client receiving Pitocin should be monitored for decelerations. There is no association with Pitocin use and hypoglycemia, maternal hyperreflexia, or fetal movement; therefore, answers A, C, and D are incorrect.

31. Answer: D. Fetal development depends on adequate insulin regulation.

Fetal development depends on adequate nutrition and insulin regulation. Insulin needs increase during the second and third trimesters, insulin requirements do not moderate as the pregnancy progresses, and elevated human chorionic gonadotrophin elevates insulin needs, not decreases them; therefore, answers A, B, and C are incorrect.

32. Answer: A. Providing a calm environment

A calm environment is needed to prevent seizure activity. Any stimulation can precipitate seizures. Obtaining a diet history should be done later, and administering an analgesic is not indicated because there is no data in the stem to indicate pain. Therefore, answers B and C are incorrect. Assessing the fetal heart tones is important, but this is not the highest priority in this situation as stated in answer D.

33. Answer: A. Down syndrome

The client who is age 42 is at risk for fetal anomalies such as Down syndrome and other chromosomal aberrations. Answers B, C, and D are incorrect because the client is not at higher risk for respiratory distress syndrome or pathological jaundice, and Turner's syndrome is a genetic disorder.

34. Answer: C. Dinoprostone (Prostin E.)

The client with a missed abortion will have induction of labor. Prostin E. is a form of prostaglandin used to soften the cervix. Magnesium sulfate is used for preterm labor and preeclampsia, calcium gluconate is the antidote for magnesium sulfate, and Pardel is a dopamine receptor stimulant used to treat Parkinson's disease; therefore, answers A, B, and D are incorrect. Pardel was used at one time to dry breast milk.

35. Answer: A. Continue the infusion of magnesium sulfate while monitoring the client's blood pressure

The client's blood pressure and urinary output are within normal limits. The only alteration from normal is the decreased deep tendon reflexes. The nurse should continue to monitor the blood pressure and check the magnesium level. The therapeutic level is 4.8–9.6mg/dL. Answers B, C, and D are incorrect. There is no need to stop the infusion at this time or slow the rate. Calcium gluconate is the antidote for magnesium sulfate, but there is no data to indicate toxicity.

36. Answer: C. Affected parents have a one in four chance of passing on the defective gene.

Autosomal recessive disorders can be passed from the parents to the infant. If both parents pass the trait, the child will get two abnormal genes and the disease results. Parents can also pass the trait to the infant. Answer A is incorrect because, to have an affected newborn, the parents must be carriers. Answer B is incorrect because both parents must be carriers. Answer D is incorrect because the parents might have affected children.

37. Answer: D. To detect neurological defects

Alpha fetoprotein is a screening test done to detect neural tube defects such as spina bifida. The test is not mandatory, as stated in answer A. It does not indicate cardiovascular defects, and the mother's age has no bearing on the need for the test, so answers B and C are incorrect.

38. Answer: B. Regulation of thyroid medication is more difficult because the thyroid gland increases in size during pregnancy.

During pregnancy, the thyroid gland triples in size. This makes it more difficult to regulate thyroid medication. Answer A is incorrect because there could be a need for thyroid medication during pregnancy. Answer C is incorrect because the thyroid function does not slow. Fetal growth is not arrested if thyroid medication is continued, so answer D is incorrect.

39. Answer: C. Cyanosis of the feet and hands

Cyanosis of the feet and hands is acrocyanosis. This is a normal finding 1 minute after birth. An apical pulse should be 120–160, and the baby should have muscle tone, making answers A and B incorrect. Jaundice immediately after birth is pathological jaundice and is abnormal, so answer D is incorrect.

40. Answer: A. Supplemental oxygen

Clients with sickle cell crises are treated with heat, hydration, oxygen, and pain relief. Fluids are increased, not decreased. Blood transfusions are usually not required, and the client can be delivered vaginally; thus, answers B, C, and D are incorrect.

41. Answer: A. Increasing fluid intake

Before ultrasonography, the client should be taught to drink plenty of fluids and not void. The client may ambulate, an enema is not needed, and there is no need to withhold food for 8 hours. Therefore, answers B, C, and D are incorrect.

42. Answer: D. 24 pounds

By 1 year of age, the infant is expected to triple his birth weight. Answers A, B, and C are incorrect because they are too low.

43. Answer: B. Measures the activity of the fetus

A nonstress test is done to evaluate periodic movement of the fetus. It is not done to evaluate lung maturity as in answer A. An oxytocin challenge test shows the effect of contractions on fetal heart rate and a nonstress test does not measure neurological well-being of the fetus, so answers C and D are incorrect.

44. Answer: D. The urethral meatus opens on the underside of the penis.

Hypospadias is a congenital abnormality in which the urethral meatus is on the underside of the penis.

45. Answer: A. Alteration in coping related to pain

Transition is the time during labor when the client loses concentration due to intense contractions. Potential for injury related to precipitate delivery has nothing to do with the dilation of the cervix, so answer B is incorrect. There is no data to indicate that the client has had anesthesia or fluid volume deficit, making answers C and D incorrect.

46. Answer: C. Antivirals

Varicella is chicken pox. This herpes virus is treated with antiviral medications. The client is not treated with antibiotics or anticoagulants as stated in answers A and D. The client might have a fever before the rash appears, but when the rash appears, the temperature is usually gone, so answer B is incorrect.

47. Answer: B. Ampicillin

Clients with chest pain can be treated with nitroglycerin, a beta blocker such aspropranolol, or Verapamil. There is no indication for an antibiotic such as Ampicillin, so answers A, C, and D are incorrect.

48. Answer: B. Take prescribed anti-inflammatory medications with meals.

Anti-inflammatory drugs should be taken with meals to avoid stomach upset. Answers A, C, and D are incorrect. Clients with rheumatoid arthritis should exercise, but not to the point of pain. Alternating hot and cold is not necessary, especially because warm, moist soaks are more useful in decreasing pain. Weight-bearing activities such as walking are useful but is not the best answer for the stem.

49. Answer: D. Morphine 8 mg IM q 4 hours PRN pain

Morphine is contraindicated in clients with gallbladder disease and pancreatitis becausemorphine causes spasms of the Sphincter of Oddi. Meperidine, Mylanta, and Cimetidine are ordered for pancreatitis, making answers A, B, and C incorrect.

50. Answer: B. Hallucinogenic drugs induce a state of altered perception.

Hallucinogenic drugs can cause hallucinations. Continuous observation is ordered to prevent the client from harming himself during withdrawal. Answers A, C, and D are incorrect because hallucinogenic drugs don't create both stimulant and depressant.

1. A patient arrives at the emergency department complaining of midsternal chest pain. Which of the following nursing action should take priority?

A. A complete history with emphasis on preceding events.
B. An electrocardiogram.

C. Careful assessment of vital signs.
D. Chest exam with auscultation.

2. A patient has been hospitalized with pneumonia and is about to be discharged. A nurse provides discharge instructions to a patient and his family. Which misunderstanding by the family indicates the need for more detailed information?

A. The patient may resume normal home activities as tolerated but should avoid physical exertion and get adequate rest.
B. The patient should resume a normal diet with emphasis on nutritious, healthy foods.
C. The patient may discontinue the prescribed course of oral antibiotics once the symptoms have completely resolved.
D. The patient should continue use of the incentive spirometer to keep airways open and free of secretions.

3. A nurse is caring for an elderly Vietnamese patient in the terminal stages of lung cancer. Many family members are in the room around the clock performing unusual rituals and bringing ethnic foods. Which of the following actions should the nurse take?

A. Restrict visiting hours and ask the family to limit visitors to two at a time.
B. Notify visitors with a sign on the door that the patient is limited to clear fluids only with no solid food allowed.
C. If possible, keep the other bed in the room unassigned to provide privacy and comfort to the family.
D. Contact the physician to report the unusual rituals and activities.

4. The charge nurse on the cardiac unit is planning assignments for the day. Which of the following is the most appropriate assignment for the float nurse that has been reassigned from labor and delivery?

A. A one-week postoperative coronary bypass patient, who is being evaluated for placement of a pacemaker prior to discharge.
B. A suspected myocardial infarction patient on telemetry, just admitted from the Emergency Department and scheduled for an angiogram.
C. A patient with unstable angina being closely monitored for pain and medication titration.
D. A postoperative valve replacement patient who was recently admitted to the unit because all surgical beds were filled.

5. A newly diagnosed 8-year-old child with type I diabetes mellitus and his mother are receiving diabetes education prior to discharge. The physician has prescribed Glucagon for emergency use. The mother asks the purpose of this medication. Which of the following statements by the nurse is correct?
A. Glucagon enhances the effect of insulin in case the blood sugar remains high one hour after injection.
B. Glucagon treats hypoglycemia resulting from insulin overdose.

C. Glucagon treats lipoatrophy from insulin injections.
D. Glucagon prolongs the effect of insulin, allowing fewer injections.

6. An infant with congestive heart failure is receiving diuretic therapy at home. Which of the following symptoms would indicate that the dosage may need to be increased?

A. Sudden weight gain.
B. Decreased blood pressure.
C. Slow, shallow breathing.
D. Bradycardia.

7. A patient taking Dilantin (phenytoin) for a seizure disorder is experiencing breakthrough seizures. A blood sample is taken to determine the serum drug level. Which of the following would indicate a sub-therapeutic level?

A. 15 mcg/mL.
B. 4 mcg/mL.
C. 10 mcg/dL.
D. 5 mcg/dL.

8. A patient arrives at the emergency department complaining of back pain. He reports taking at least 3 acetaminophen tablets every three hours for the past week without relief. Which of the following symptoms suggests acetaminophen toxicity?

A. Tinnitus.
B. Diarrhea.
C. Hypertension.
D. Hepatic damage.

9. A nurse is caring for a cancer patient receiving subcutaneous morphine sulfate for pain. Which of the following nursing actions is most important in the care of this patient?

A. Monitor urine output.
B. Monitor respiratory rate.
C. Monitor heart rate.
D. Monitor temperature.

10. A patient arrives at the emergency department with severe lower leg pain after a fall in a touch football game. Following routine triage, which of the following is the appropriate next step in assessment and treatment?

A. Apply heat to the painful area.
B. Apply an elastic bandage to the leg.
C. X-ray the leg.
D. Give pain medication.

11. A nurse caring for several patients on the cardiac unit is told that one is scheduled for implantation of an automatic internal cardioverter-defibrillator. Which of the following patients is most likely to have this procedure?

A. A patient admitted for myocardial infarction without cardiac muscle damage.
B. A post-operative coronary bypass patient, recovering on schedule.
C. A patient with a history of ventricular tachycardia and syncopal episodes.
D. A patient with a history of atrial tachycardia and fatigue.

12. A patient is scheduled for a magnetic resonance imaging (MRI) scan for suspected lung cancer. Which of the following is a contraindication to the study for this patient?

A. The patient is allergic to shellfish.
B. The patient has a pacemaker.
C. The patient suffers from claustrophobia.
D. The patient takes antipsychotic medication.

13. A nurse calls a physician with the concern that a patient has developed a pulmonary embolism. Which of the following symptoms has the nurse most likely observed?

A. The patient is somnolent with decreased response to the family.
B. The patient suddenly complains of chest pain and shortness of breath.
C. The patient has developed a wet cough and the nurse hears crackles on auscultation of the lungs.
D. The patient has a fever, chills, and loss of appetite.

14. A patient comes to the emergency department with abdominal pain. Work-up reveals the presence of a rapidly enlarging abdominal aortic aneurysm. Which of the following actions should the nurse expect?

A. The patient will be admitted to the medicine unit for observation and medication.
B. The patient will be admitted to the day surgery unit for sclerotherapy.
C. The patient will be admitted to the surgical unit and resection will be scheduled.
D. The patient will be discharged home to follow-up with his cardiologist in 24 hours.

15. A patient with leukemia is receiving chemotherapy that is known to depress bone marrow. A CBC (complete blood count) reveals a platelet count of 25,000/microliter. Which of the following actions related specifically to the platelet count should be included on the nursing care plan?

A. Monitor for fever every 4 hours.
B. Require visitors to wear respiratory masks and protective clothing.
C. Consider transfusion of packed red blood cells.
D. Check for signs of bleeding, including examination of urine and stool for blood.

16. A patient is undergoing the induction stage of treatment for leukemia. The nurse teaches family members about infectious precautions. Which of the

following statements by family members indicates that the family needs more education?

A. We will bring in books and magazines for entertainment.
B. We will bring in personal care items for comfort.
C. We will bring in fresh flowers to brighten the room.
D. We will bring in family pictures and get well cards.

17. A nurse is caring for a patient with acute lymphoblastic leukemia (ALL). Which of the following is the most likely age range of the patient?

A. 3-10 years.
B. 25-35 years.
C. 45-55 years.
D. over 60 years.

18. A patient is admitted to the oncology unit for diagnosis of suspected Hodgkin's disease. Which of the following symptoms is typical of Hodgkin's disease?

A. Painful cervical lymph nodes.
B. Night sweats and fatigue.
C. Nausea and vomiting.
D. Weight gain.

19. The Hodgkin's disease patient described in the question above undergoes a lymph node biopsy for definitive diagnosis. If the diagnosis of Hodgkin's disease were correct, which of the following cells would the pathologist expect to find?

A. Reed-Sternberg cells.
B. Lymphoblastic cells.
C. Gaucher's cells.
D. Rieder's cells

20. A patient is about to undergo bone marrow aspiration and biopsy and expresses fear and anxiety about the procedure. Which of the following is the most effective nursing response?

A. Warn the patient to stay very still because the smallest movement will increase her pain.
B. Encourage the family to stay in the room for the procedure.
C. Stay with the patient and focus on slow, deep breathing for relaxation.
D. Delay the procedure to allow the patient to deal with her feelings.

Answers and Rationale

1. Answer: C. Careful assessment of vital signs.

The priority nursing action for a patient arriving at the ED in distress is always assessment of vital signs. This indicates the extent of physical compromise and provides a baseline by which to plan further assessment and treatment. A thorough medical history, including onset of symptoms, will be necessary and it is likely that an electrocardiogram will be performed as well, but these are not the first priority. Similarly, chest exam with auscultation may offer useful information after vital signs are assessed.

2. Answer: C. The patient may discontinue the prescribed course of oral antibiotics once the symptoms have completely resolved.

It is always critical that patients being discharged from the hospital take prescribed medications as instructed. In the case of antibiotics, a full course must be completed even after symptoms have resolved to prevent incomplete eradication of the organism and recurrence of infection. The patient should resume normal activities as tolerated, as well as a nutritious diet. Continued use of the incentive spirometer after discharge will speed recovery and improve lung function.

3. Answer: C. If possible, keep the other bed in the room unassigned to provide privacy and comfort to the family.

When a family member is dying, it is most helpful for nursing staff to provide a culturally sensitive environment to the degree possible within the hospital routine. In the Vietnamese culture, it is important that the dying be surrounded by loved ones and not left alone. Traditional rituals and foods are thought to ease the transition to the next life. When possible, allowing the family privacy for this traditional behavior is best for them and the patient. Answers A, B, and D are incorrect because they create unnecessary conflict with the patient and family.

4. Answer: A. A one-week postoperative coronary bypass patient, who is being evaluated for placement of a pacemaker prior to discharge.

The charge nurse planning assignments must consider the skills of the staff and the needs of the patients. The labor and delivery nurse who is not experienced with the needs of cardiac patients should be assigned to those with the least acute needs. The patient who is one-week post-operative and nearing discharge is likely to require routine care. A new patient admitted with suspected MI and scheduled for angiography would require continuous assessment as well as coordination of care that is best carried out by experienced staff. The unstable patient requires staff that can immediately identify symptoms and respond appropriately. A postoperative patient also requires close monitoring and cardiac experience.

5. Answer: B. Glucagon treats hypoglycemia resulting from insulin overdose.

Glucagon is given to treat insulin overdose in an unresponsive patient. Following Glucagon administration, the patient should respond within 15-20 minutes at which time oral carbohydrates should be given. Glucagon reverses rather than enhances or prolongs the effects of insulin. Lipoatrophy refers to the effect of repeated insulin injections on subcutaneous fat.

6. Answer: A. Sudden weight gain.

Weight gain is an early symptom of congestive heart failure due to accumulation of fluid. When diuretic therapy is inadequate, one would expect an increase in blood pressure, tachypnea, and tachycardia to result.

7. Answer: B. 4 mcg/mL.

The therapeutic serum level for Dilantin is 10 – 20 mcg/mL. A level of 4 mcg/mL is subtherapeutic and may be caused by patient non-compliance or increased metabolism

of the drug. A level of 15 mcg/mL is therapeutic. Choices C and D are expressed in mcg/dL, which is the incorrect unit of measurement.

8. Answer: D. Hepatic damage.

Acetaminophen in even moderately large doses can cause serious liver damage that may result in death. Immediate evaluation of liver function is indicated with consideration of N-acetylcysteine administration as an antidote. Tinnitus is associated with aspirin overdose, not acetaminophen. Diarrhea and hypertension are not associated with acetaminophen.

9. Answer: B. Monitor respiratory rate.

Morphine sulfate can suppress respiration and respiratory reflexes, such as cough. Patients should be monitored regularly for these effects to avoid respiratory compromise.Morphine sulfate does not significantly affect urine output, heart rate, or body temperature.

10. Answer: C. X-ray the leg.

Following triage, an x-ray should be performed to rule out fracture. Ice, not heat, should be applied to a recent sports injury. An elastic bandage may be applied and pain medication given once fracture has been excluded.

11. Answer: C. A patient with a history of ventricular tachycardia and syncopal episodes.

An automatic internal cardioverter-defibrillator delivers an electric shock to the heart to terminate episodes of ventricular tachycardia and ventricular fibrillation. This is necessary in a patient with significant ventricular symptoms, such as tachycardia resulting in syncope. A patient with myocardial infarction that resolved with no permanent cardiac damage would not be a candidate. A patient recovering well from coronary bypass would not need the device. Atrial tachycardia is less serious and is treated conservatively with medication and cardioversion as a last resort.

12. Answer: B. The patient has a pacemaker.

The implanted pacemaker will interfere with the magnetic fields of the MRI scanner and may be deactivated by them. Shellfish/iodine allergy is not a contraindication because the contrast used in MRI scanning is not iodine-based. Open MRI scanners and anti-anxiety medications are available for patients with claustrophobia. Psychiatric medication is not a contraindication to MRI scanning.

13. Answer: B. The patient suddenly complains of chest pain and shortness of breath.

Typical symptoms of pulmonary embolism include chest pain, shortness of breath, and severe anxiety. The physician should be notified immediately. A patient with pulmonary embolism will not be sleepy or have a cough with crackles on exam. A patient with fever, chills and loss of appetite may be developing pneumonia.

14. Answer: C. The patient will be admitted to the surgical unit and resection will be scheduled.

A rapidly enlarging abdominal aortic aneurysm is at significant risk of rupture and should be resected as soon as possible. No other appropriate treatment options currently exist.

15. Answer: D. Check for signs of bleeding, including examination of urine and stool for blood.

A platelet count of 25,000/microliter is severely thrombocytopenic and should prompt the initiation of bleeding precautions, including monitoring urine and stool for evidence of bleeding. Monitoring for fever and requiring protective clothing are indicated to prevent infection if white blood cells are decreased. Transfusion of red cells is indicated for severe anemia.

16. Answer: C. We will bring in fresh flowers to brighten the room.

During induction chemotherapy, the leukemia patient is severely immunocompromised and at risk of serious infection. Fresh flowers, fruit, and plants can carry microbes and should be avoided. Books, pictures, and other personal items can be cleaned with antimicrobials before being brought into the room to minimize the risk of contamination.

17. Answer: A. 3-10 years.

The peak incidence of ALL is at 4 years (range 3-10). It is uncommon after the mid-teen years. The peak incidence of chronic myelogenous leukemia (CML) is 45-55 years. The peak incidence of acute myelogenous leukemia (AML) occurs at 60 years. Two-thirds of cases of chronic lymphocytic leukemia (CLL) occur after 60 years.

18. Answer: B. Night sweats and fatigue.

Symptoms of Hodgkin's disease include night sweats, fatigue, weakness, and tachycardia. The disease is characterized by painless, enlarged cervical lymph nodes. Weight loss occurs early in the disease. Nausea and vomiting are not typically symptoms of Hodgkin's disease.

19. Answer: A. Reed-Sternberg cells.

A definitive diagnosis of Hodgkin's disease is made if Reed-Sternberg cells are found on pathologic examination of the excised lymph node. Lymphoblasts are immature cells found in the bone marrow of patients with acute lymphoblastic leukemia. Gaucher's cells are large storage cells found in patients with Gaucher's disease. Rieder's cells are myeloblasts found in patients with acute myelogenous leukemia.

20. Answer: C. Stay with the patient and focus on slow, deep breathing for relaxation.

Slow, deep breathing is the most effective method of reducing anxiety and stress. It reduces the level of carbon dioxide in the brain to increase calm and relaxation. Warning the patient to remain still will likely increase her anxiety. Encouraging family members to stay with the patient may make her worry about their anxiety as well as her own. Delaying the procedure is unlikely to allay her fears.

1. A mother complains to the clinic nurse that her 2 ½-year-old son is not yet toilet trained. She is particularly concerned that, although he reliably uses the potty seat for bowel movements, he isn't able to hold his urine for long periods. Which of the following statements by the nurse is correct?

A. The child should have been trained by age 2 and may have a psychological problem that is responsible for his "accidents."
B. Bladder control is usually achieved before bowel control, and the child should be required to sit on the potty seat until he passes urine.
C. Bowel control is usually achieved before bladder control, and the average age for completion of toilet training varies widely from 24 to 36 months.
D. The child should be told "no" each time he wets so that he learns the behavior is unacceptable.

2. The mother of a 14-month-old child reports to the nurse that her child will not fall asleep at night without a bottle of milk in the crib and often wakes during the night asking for another. Which of the following instructions by the nurse is correct?

A. Allow the child to have the bottle at bedtime, but withhold the one later in the night.
B. Put juice in the bottle instead of milk.
C. Give only a bottle of water at bedtime.
D. Do not allow bottles in the crib.

3. Which of the following actions is NOT appropriate in the care of a 2-month-old infant?

A. Place the infant on her back for naps and bedtime.
B. Allow the infant to cry for 5 minutes before responding if she wakes during the night as she may fall back asleep.
C. Talk to the infant frequently and make eye contact to encourage language development.
D. Wait until at least 4 months to add infant cereals and strained fruits to the diet.

4. An older patient asks a nurse to recommend strategies to prevent constipation. Which of the following suggestions would be helpful? Note: More than one answer may be correct.

A. Get moderate exercise for at least 30 minutes each day.
B. Drink 6-8 glasses of water each day.
C. Eat a diet high in fiber.
D. Take a mild laxative if you don't have a bowel movement every day.

5. A child is admitted to the hospital with suspected rheumatic fever. Which of the following observations is NOT confirming of the diagnosis?

A. A reddened rash visible over the trunk and extremities.
B. A history of sore throat that was self-limited in the past month.
C. A negative antistreptolysin O titer.
D. An unexplained fever.

6. A patient with a history of congestive heart failure arrives at the clinic complaining of dyspnea. Which of the following actions is the first the nurse should perform?

A. Ask the patient to lie down on the exam table.
B. Draw blood for chemistry panel and arterial blood gas (ABG).
C. Send the patient for a chest x-ray.
D. Check blood pressure.

7. A clinic patient has recently been prescribed nitroglycerin for treatment of angina. He calls the nurse complaining of frequent headaches. Which of the following responses to the patient is correct?

A. "Stop taking the nitroglycerin and see if the headaches improve."
B. "Go to the emergency department to be checked because nitroglycerin can cause bleeding in the brain."
C. "Headaches are a frequent side effect of nitroglycerine because it causes vasodilation."
D. "The headaches are unlikely to be related to the nitroglycerin, so you should see your doctor for further investigation."

8. A patient received surgery and chemotherapy for colon cancer, completing therapy 3 months previously, and she is now in remission. At a follow-up appointment, she complains of fatigue following activity and difficulty with concentration at her weekly bridge games. Which of the following explanations could account for her symptoms?

A. The symptoms may be the result of anemia caused by chemotherapy.
B. The patient may be immunosuppressed.
C. The patient may be depressed.
D. The patient may be dehydrated.

9. A clinic patient has a hemoglobin concentration of 10.8 g/dL and reports sticking to a strict vegetarian diet. Which of the follow nutritional advice is appropriate?

A. The diet is providing adequate sources of iron and requires no changes.
B. The patient should add meat to her diet; a vegetarian diet is not advised.
C. The patient should use iron cookware to prepare foods, such as dark green, leafy vegetables and legumes, which are high in iron.
D. A cup of coffee or tea should be added to every meal.

10. A hospitalized patient is receiving packed red blood cells (PRBCs) for treatment of severe anemia. Which of the following is the most accurate statement?

A. Transfusion reaction is most likely immediately after the infusion is completed.
B. PRBCs are best infused slowly through a 20g. IV catheter.
C. PRBCs should be flushed with a 5% dextrose solution.
D. A nurse should remain in the room during the first 15 minutes of infusion.

11. Emergency department triage is an important nursing function. A nurse working the evening shift is presented with four patients at the same time. Which of the following patients should be assigned the highest priority?

A. A patient with low-grade fever, headache, and myalgias for the past 72 hours.
B. A patient who is unable to bear weight on the left foot, with swelling and bruising

following a running accident.
C. A patient with abdominal and chest pain following a large, spicy meal.
D. A child with a one-inch bleeding laceration on the chin but otherwise well after falling while jumping on his bed.

12. A patient is admitted to the hospital with a calcium level of 6.0 mg/dL. Which of the following symptoms would you NOT expect to see in this patient?

A. Numbness in hands and feet.
B. Muscle cramping.
C. Hypoactive bowel sounds.
D. Positive Chvostek's sign.

13. A nurse cares for a patient who has a nasogastric tube attached to low suction because of a suspected bowel obstruction. Which of the following arterial blood gas results might be expected in this patient?

A. pH 7.52, PCO2 54 mmHg.
B. pH 7.42, PCO2 40 mmHg.
C. pH 7.25, PCO2 25 mmHg.
D. pH 7.38, PCO2 36 mmHg.

14. A patient is admitted to the hospital for routine elective surgery. Included in the list of current medications is warfarin at a high dose. Concerned about the possible effects of the drug, particularly in a patient scheduled for surgery, the nurse anticipates which of the following actions?

A. Draw a blood sample for prothrombin (PT) and international normalized ratio (INR) level.
B. Administer vitamin K.
C. Draw a blood sample for type and crossmatch and request blood from the blood bank.
D. Cancel the surgery after the patient reports stopping the warfarin one week previously.

15. The follow lab results are received for a patient. Which of the following results are abnormal? Note: More than one answer may be correct.

A. Hemoglobin 10.4 g/dL.
B. Total cholesterol 340 mg/dL.
C. Total serum protein 7.0 g/dL.
D. Glycosylated hemoglobin A1C 5.4%.

16. A nurse is assigned to the pediatric rheumatology clinic and is assessing a child who has just been diagnosed with juvenile idiopathic arthritis. Which of the following statements about the disease is most accurate?
A. The child has a poor chance of recovery without joint deformity.
B. Most children progress to adult rheumatoid arthritis.
C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.
D. Physical activity should be minimized.

17. A child is admitted to the hospital several days after stepping on a sharp object that punctured her athletic shoe and entered the flesh of her foot. The physician is concerned about osteomyelitis and has ordered parenteral antibiotics. Which of the following actions is done immediately before the antibiotic is started?

A. The admission orders are written.
B. A blood culture is drawn.
C. A complete blood count with differential is drawn.
D. The parents arrive.

18. A two-year-old child has sustained an injury to the leg and refuses to walk. The nurse in the emergency department documents swelling of the lower affected leg. Which of the following does the nurse suspect is the cause of the child's symptoms?

A. Possible fracture of the tibia.
B. Bruising of the gastrocnemius muscle.
C. Possible fracture of the radius.
D. No anatomic injury, the child wants his mother to carry him.

19. A toddler has recently been diagnosed with cerebral palsy. Which of the following information should the nurse provide to the parents? Note: More than one answer may be correct.

A. Regular developmental screening is important to avoid secondary developmental delays.
B. Cerebral palsy is caused by injury to the upper motor neurons and results in motor dysfunction, as well as possible ocular and speech difficulties.
C. Developmental milestones may be slightly delayed but usually will require no additional intervention.
D. Parent support groups are helpful for sharing strategies and managing health care issues.

20. A child has recently been diagnosed with Duchenne's muscular dystrophy. The parents are receiving genetic counseling prior to planning another pregnancy. Which of the following statements includes the most accurate information?

A. Duchenne's is an X-linked recessive disorder, so daughters have a 50% chance of being carriers and sons a 50% chance of developing the disease.
B. Duchenne's is an X-linked recessive disorder, so both daughters and sons have a 50% chance of developing the disease.
C. Each child has a 1 in 4 (25%) chance of developing the disorder.
D. Sons only have a 1 in 4 (25%) chance of developing the disorder.

Answers and Rationale

1. Answer: C. Bowel control is usually achieved before bladder control, and the average age for completion of toilet training varies widely from 24 to 36 months.

Toddlers typically learn bowel control before bladder control, with boys often taking longer to complete toilet training than girls. Many children are not trained until 36

months and this should not cause concern. Later training is rarely caused by psychological factors and is much more commonly related to individual developmental maturity. Reprimanding the child will not speed the process and may be confusing.

2. Answer: C. Give only a bottle of water at bedtime.

Babies and toddlers should not fall asleep with bottles containing liquid other than plain water due to the risk of dental decay. Sugars in milk or juice remain in the mouth during sleep and cause caries, even in teeth that have not yet erupted. When water is substituted for milk or juice, babies will often lose interest in the bottle at night.

3. Answer: B. Allow the infant to cry for 5 minutes before responding if she wakes during the night as she may fall back asleep.

Infants under 6 months may not be able to sleep for long periods because their stomachs are too small to hold adequate nourishment to take them through the night. After 6 months, it may be helpful to let babies put themselves back to sleep after waking during the night, but not prior to 6 months. Infants should always be placed on their backs to sleep. Research has shown a dramatic decrease in sudden infant death syndrome (SIDS) with back sleeping. Eye contact and verbal engagement with infants are important to language development. The best diet for infants under 4 months of age is breast milk or infant formula.

4. Answers: A, B, and C

A daily bowel movement is not necessary if the patient is comfortable and the bowels move regularly. Moderate exercise, such as walking, encourages bowel health, as does generous water intake. A diet high in fiber is also helpful. Laxatives should be used as a last resort and should not be taken regularly. Over time, laxatives can desensitize the bowel and worsen constipation.

5. Answer: C. A negative antistreptolysin O titer.

Rheumatic fever is caused by an untreated group A B hemolytic Streptococcus infection in the previous 2-6 weeks, confirmed by a positive antistreptolysin O titer. Rheumatic fever is characterized by a red rash over the trunk and extremities as well as fever and other symptoms.

6. Answer: D. Check blood pressure.

A patient with congestive heart failure and dyspnea may have pulmonary edema, which can cause severe hypertension. Therefore, taking the patient's blood pressure should be the first action. Lying flat on the exam table would likely worsen the dyspnea, and the patient may not tolerate it. Blood draws for chemistry and ABG will be required, but not prior to the blood pressure assessment.

7. Answer: C. "Headaches are a frequent side effect of nitroglycerine because it causes vasodilation."

Nitroglycerin is a potent vasodilator and often produces unwanted effects such as headache, dizziness, and hypotension. Patients should be counseled, and the dose

titrated, to minimize these effects. In spite of the side effects, nitroglycerine is effective at reducing myocardial oxygen consumption and increasing blood flow. The patient should not stop the medication. Nitroglycerine does not cause bleeding in the brain.

8. Answer: A. The symptoms may be the result of anemia caused by chemotherapy.

Three months after surgery and chemotherapy the patient is likely to be feeling the after-effects, which often includes anemia because of bone-marrow suppression. There is no evidence that the patient is immunosuppressed, and fatigue is not a typical symptom of immunosuppression. The information given does not indicate that depression or dehydration is a cause of her symptoms.

9. Answer: C. The patient should use iron cookware to prepare foods, such as dark green, leafy vegetables and legumes, which are high in iron.

Normal hemoglobin values range from 11.5-15.0. This vegetarian patient is mildly anemic. When food is prepared in iron cookware its iron content is increased. In addition, dark green leafy vegetables, such as spinach and kale, and legumes are high in iron. Mild anemia does not require that animal sources of iron be added to the diet. Many non-animal sources are available. Coffee and tea increase gastrointestinal activity and inhibit absorption of iron.

10. Answer: D. A nurse should remain in the room during the first 15 minutes of infusion.

Transfusion reaction is most likely during the first 15 minutes of infusion, and a nurse should be present during this period. PRBCs should be infused through a 19g or larger IV catheter to avoid slow flow, which can cause clotting. PRBCs must be flushed with 0.45% normal saline solution. Other intravenous solutions will hemolyze the cells.

11. Answer: C. A patient with abdominal and chest pain following a large, spicy meal.

Emergency triage involves quick patient assessment to prioritize the need for further evaluation and care. Patients with trauma, chest pain, respiratory distress, or acute neurological changes are always classified number one priority. Though the patient with chest pain presented in the question recently ate a spicy meal and may be suffering from heartburn, he also may be having an acute myocardial infarction and require urgent attention. The patient with fever, headache and muscle aches (classic flu symptoms) should be classified as non-urgent. The patient with the foot injury may have sustained a sprain or fracture, and the limb should be x-rayed as soon as is practical, but the damage is unlikely to worsen if there is a delay. The child's chin laceration may need to be sutured but is also non-urgent.

12. Answer: C. Hypoactive bowel sounds.

Normal serum calcium is 8.5 – 10 mg/dL. The patient is hypocalcemic. Increased gastric motility, resulting in hyperactive (not hypoactive) bowel sounds, abdominal cramping and diarrhea is an indication of hypocalcemia. Numbness in hands and feet and muscle

cramps are also signs of hypocalcemia. Positive Chvostek's sign refers to the sustained twitching of facial muscles following tapping in the area of the cheekbone and is a hallmark of hypocalcemia.

13. Answer: A. pH 7.52, PCO2 54 mmHg.

A patient on nasogastric suction is at risk of metabolic alkalosis as a result of loss of hydrochloric acid in gastric fluid. Of the answers given, only answer A (pH 7.52, PCO2 54 mm Hg) represents alkalosis. Answer B is a normal blood gas. Answer C represents respiratory acidosis. Answer D is borderline normal with slightly low PCO2.

14. Answer: A. Draw a blood sample for prothrombin (PT) and international normalized ratio (INR) level.

The effect of (**warfarin**)Coumadin is to inhibit clotting. The next step is to check the PT and INR to determine the patient's anticoagulation status and risk of bleeding. Vitamin K is an antidote to Coumadin and may be used in a patient who is at imminent risk of dangerous bleeding. Preparation for transfusion, as described in option C, is only indicated in the case of significant blood loss. If lab results indicate an anticoagulation level that would place the patient at risk of excessive bleeding, the surgeon may choose to delay surgery and discontinue the medication.

15. Answer: A and B

Normal hemoglobin in adults is 12 – 16 g/dL. Total cholesterol levels of 200 mg/dL or below are considered normal. Total serum protein of 7.0-g/dL and glycosylated hemoglobin A1c of 5.4% are both normal levels.

16. Answer: C. Nonsteroidal anti-inflammatory drugs are the first choice in treatment.

Nonsteroidal anti-inflammatory drugs are important first line treatment for juvenile idiopathic arthritis (formerly known as juvenile rheumatoid arthritis). NSAIDs require 3-4 weeks for the therapeutic anti-inflammatory effects to be realized. Half of children with the disorder recover without joint deformity, and about a third will continue with symptoms into adulthood. Physical activity is an integral part of therapy.

17. Answer: B. A blood culture is drawn.

Antibiotics must be started after the blood culture is drawn, as they may interfere with the identification of the causative organism. The blood count will reveal the presence of infection but does not help identify an organism or guide antibiotic treatment. Parental presence is important for the adjustment of the child but not for the administration of medication.

18. Answer: A. Possible fracture of the tibia.

The child's refusal to walk, combined with swelling of the limb is suspicious for fracture. Toddlers will often continue to walk on a muscle that is bruised or strained. The radius is found in the lower arm and is not relevant to this question. Toddlers rarely feign injury to be carried, and swelling indicates a physical injury.

19. Answers: A, B and D.

Delayed developmental milestones are characteristic of cerebral palsy, so regular screening and intervention is essential. Because of injury to upper motor neurons, children may have ocular and speech difficulties. Parent support groups help families to share and cope. Physical therapy and other interventions can minimize the extent of the delay in developmental milestones.

20. Answer: A. Duchenne's is an X-linked recessive disorder, so daughters have a 50% chance of being carriers and sons a 50% chance of developing the disease.

The recessive Duchenne gene is located on one of the two X chromosomes of a female carrier. If her son receives the X bearing the gene he will be affected. Thus, there is a 50% chance of a son being affected. Daughters are not affected, but 50% are carriers because they inherit one copy of the defective gene from the mother. The other X chromosome comes from the father, who cannot be a carrier.

1. A patient is admitted to the hospital with a diagnosis of primary hyperparathyroidism. A nurse checking the patient's lab results would expect which of the following changes in laboratory findings?

A. Elevated serum calcium.
B. Low serum parathyroid hormone (PTH).
C. Elevated serum vitamin D.
D. Low urine calcium.

2. A patient with Addison's disease asks a nurse for nutrition and diet advice. Which of the following diet modifications is NOT recommended?

A. A diet high in grains.
B. A diet with adequate caloric intake.
C. A high protein diet.
D. A restricted sodium diet.

3. A patient with a history of diabetes mellitus is in the second post-operative day following cholecystectomy. She has complained of nausea and isn't able to eat solid foods. The nurse enters the room to find the patient confused and shaky. Which of the following is the most likely explanation for the patient's symptoms?

A. Anesthesia reaction.
B. Hyperglycemia.
C. Hypoglycemia.
D. Diabetic ketoacidosis.

4. A nurse assigned to the emergency department evaluates a patient who underwent fiberoptic colonoscopy 18 hours previously. The patient reports increasing abdominal pain, fever, and chills. Which of the following conditions poses the most immediate concern?

A. Bowel perforation.
B. Viral gastroenteritis.
C. Colon cancer.
D. Diverticulitis.

5. A patient is admitted to the same day surgery unit for liver biopsy. Which of the following laboratory tests assesses coagulation? Select all that apply.

A. Partial thromboplastin time.
B. Prothrombin time.
C. Platelet count.
D. Hemoglobin
E. Complete Blood Count
F. White Blood Cell Count

6. A patient on the cardiac telemetry unit unexpectedly goes into ventricular fibrillation. The advanced cardiac life support team prepares to defibrillate. Which of the following choices indicates the correct placement of the conductive gel pads?

A. The left clavicle and right lower sternum.
B. Right of midline below the bottom rib and the left shoulder.
C. The upper and lower halves of the sternum.
D. The right side of the sternum just below the clavicle and left of the precordium.

7. The nurse performs an initial abdominal assessment on a patient newly admitted for abdominal pain. The nurse hears what she describes as "clicks and gurgles in all four quadrants" as well as "swishing or buzzing sound heard in one or two quadrants." Which of the following statements is correct?

A. The frequency and intensity of bowel sounds varies depending on the phase of digestion.
B. In the presence of intestinal obstruction, bowel sounds will be louder and higher pitched.
C. A swishing or buzzing sound may represent the turbulent blood flow of a bruit and is not normal.
D. All of the above.

8. A patient arrives in the emergency department and reports splashing concentrated household cleaner in his eye. Which of the following nursing actions is a priority?

A. Irrigate the eye repeatedly with normal saline solution.
B. Place fluorescein drops in the eye.
C. Patch the eye.
D. Test visual acuity.

9. A nurse is caring for a patient who has had hip replacement. The nurse should be most concerned about which of the following findings?

A. Complaints of pain during repositioning.
B. Scant bloody discharge on the surgical dressing.
C. Complaints of pain following physical therapy.
D. Temperature of 101.8 F (38.7 C).

10. A child is admitted to the hospital with an uncontrolled seizure disorder. The admitting physician writes orders for actions to be taken in the event of a seizure. Which of the following actions would NOT be included?

A. Notify the physician.
B. Restrain the patient's limbs.
C. Position the patient on his/her side with the head flexed forward.
D. Administer rectal diazepam.

11. A patient who has received chemotherapy for cancer treatment is given an injection of Epoetin. Which of the following should reflect the findings in a complete blood count (CBC) drawn several days later?

A. An increase in neutrophil count.
B. An increase in hematocrit.
C. An increase in platelet count.
D. An increase in serum iron.

12. A patient is admitted to the hospital with suspected polycythemia vera. Which of the following symptoms is consistent with the diagnosis? Select all that apply.

A. Weight loss.
B. Increased clotting time.
C. Hypertension.
D. Headaches.

13. A nurse is caring for a patient with a platelet count of 20,000/microliter. Which of the following is an important intervention?

A. Observe for evidence of spontaneous bleeding.
B. Limit visitors to family only.
C. Give aspirin in case of headaches.
D. Impose immune precautions.

14. A nurse in the emergency department assesses a patient who has been taking long-term corticosteroids to treat renal disease. Which of the following is a typical side effect of corticosteroid treatment? Note: More than one answer may be correct.

A. Hypertension.
B. Cushingoid features.
C. Hyponatremia.
D. Low serum albumin.

15. A nurse is caring for patients in the oncology unit. Which of the following is the most important nursing action when caring for a neutropenic patient?

A. Change the disposable mask immediately after use.
B. Change gloves immediately after use.
C. Minimize patient contact.
D. Minimize conversation with the patient.

16. A nurse is counseling patients at a health clinic on the importance of immunizations. Which of the following information is the most accurate regarding immunizations?

A. All infectious diseases can be prevented with proper immunization.
B. Immunizations provide natural immunity from disease.
C. Immunizations are risk-free and should be universally administered.
D. Immunization provides acquired immunity from some specific diseases.

17. A patient is brought to the emergency department after a bee sting. The family reports a history of severe allergic reaction, and the patient appears to have some oral swelling. Which of the following is the most urgent nursing action?

A. Consult a physician.
B. Maintain a patent airway.
C. Administer epinephrine subcutaneously.
D. Administer diphenhydramine (Benadryl) orally.

18. A mother calls the clinic to report that her son has recently started medication to treat attention deficit/hyperactivity disorder (ADHD). The mother fears her son is experiencing side effects of the medicine. Which of the following side effects are typically related to medications used for ADHD? Note: More than one answer may be correct:

A. Poor appetite.
B. Insomnia.
C. Sleepiness.
D. Agitation.

19. A patient at a mental health clinic is taking Haldol (haloperidol) for treatment of schizophrenia. She calls the clinic to report abnormal movements of her face and tongue. The nurse concludes that the patient is experiencing which of the following symptoms:

A. Co-morbid depression.
B. Psychotic hallucinations.
C. Negative symptoms of schizophrenia.
D. Tardive dyskinesia.

20. A patient with newly diagnosed diabetes mellitus is learning to recognize the symptoms of hypoglycemia. Which of the following symptoms is indicative of hypoglycemia?

A. Polydipsia.
B. Confusion.
C. Blurred vision.
D. Polyphagia.

Answers and Rationale

1. Answer: A. Elevated serum calcium.

The parathyroid glands regulate the calcium level in the blood. In hyperparathyroidism, the serum calcium level will be elevated. Parathyroid hormone levels may be high or normal but not low. The body will lower the level of vitamin D in an attempt to lower calcium. Urine calcium may be elevated, with calcium spilling over from elevated serum levels. This may cause renal stones.

2. Answer: D. A restricted sodium diet.

A patient with Addison's disease requires normal dietary sodium to prevent excess fluid loss. Adequate caloric intake is recommended with a diet high in protein and complex carbohydrates, including grains.

3. Answer: C. Hypoglycemia.

A postoperative diabetic patient who is unable to eat is likely to be suffering from hypoglycemia. Confusion and shakiness are common symptoms. An anesthesia reaction would not occur on the second post-operative day. Hyperglycemia and ketoacidosis do not cause confusion and shakiness.

4. Answer: A. Bowel perforation.

Bowel perforation is the most serious complication of fiberoptic colonoscopy. Important signs include progressive abdominal pain, fever, chills, and tachycardia, which indicate advancing peritonitis. Viral gastroenteritis and colon cancer do not cause these symptoms. Diverticulitis may cause pain, fever, and chills, but is far less serious than perforation and peritonitis.

5. Answer: A, B, and C

Prothrombin time, partial thromboplastin time, and platelet count are all included in coagulation studies. The hemoglobin level, though important information prior to an invasive procedure like liver biopsy, does not assess coagulation.

6. Answer: D. The right side of the sternum just below the clavicle and left of the precordium.

One gel pad should be placed to the right of the sternum, just below the clavicle and the other just left of the precordium, as indicated by the anatomic location of the heart. To defibrillate, the paddles are placed over the pads. Options A, B, and C are not consistent with the position of the heart and are therefore incorrect responses.

7. Answer: D. All of the above.

All of the statements are true. The gurgles and clicks described in the question represent normal bowel sounds, which vary with the phase of digestion. Intestinal obstruction causes the sounds to intensify as the normal flow is blocked by the obstruction. The swishing and buzzing sound of turbulent blood flow may be heard in the abdomen in the presence of abdominal aortic aneurism, for example, and should always be considered abnormal.

8. Answer: A. Irrigate the eye repeatedly with normal saline solution.

Emergency treatment following a chemical splash to the eye includes immediate irrigation with normal saline. The irrigation should be continued for at least 10 minutes. Fluorescein drops are used to check for scratches on the cornea due to their fluorescent properties and are not part of the initial care of a chemical splash, nor is patching the eye. Following irrigation, visual acuity will be assessed.

9. Answer: D. Temperature of 101.8 F (38.7 C).

Post-surgical nursing assessment after hip replacement should be principally concerned with the risk of neurovascular complications and the development of infection. A temperature of 101.8 F (38.7 C) postoperatively is higher than the low grade that is to be expected and should raise concern. Some pain during repositioning and following physical therapy is to be expected and can be managed with analgesics. A small amount of bloody drainage on the surgical dressing is a result of normal healing.

10. Answer: B. Restrain the patient's limbs.

During a witnessed seizure, nursing actions should focus on securing the patient's safely and curtailing the seizure. Restraining the limbs is not indicated because strong muscle contractions could cause injury. A side-lying position with head flexed forward allows for drainage of secretions and prevents the tongue from falling back, blocking the airway. Rectal diazepam may be a treatment ordered by the physician, who should be notified of the seizure.

11. Answer: B. An increase in hematocrit.

Epoetin is a form of erythropoietin, which stimulates the production of red blood cells, causing an increase in hematocrit. Epoetin is given to patients who are anemic, often as a result of chemotherapy treatment. Epoetin has no effect on neutrophils, platelets, or serum iron.

12. Answer: B, C, and D

Polycythemia vera is a condition in which the bone marrow produces too many red blood cells. This causes an increase in hematocrit and viscosity of the blood. Patients can experience headaches, dizziness, and visual disturbances. Cardiovascular effects include increased blood pressure and delayed clotting time. Weight loss is not a manifestation of polycythemia vera.

13. Answer: A. Observe for evidence of spontaneous bleeding.

Platelet counts under 30,000/microliter may cause spontaneous petechiae and bruising, particularly in the extremities. When the count falls below 15,000, spontaneous bleeding into the brain and internal organs may occur. Headaches may be a sign and should be watched for. Aspirin disables platelets and should never be used in the presence of thrombocytopenia. Thrombocytopenia does not compromise immunity, and there is no reason to limit visitors as long as any physical trauma is prevented.

14. Answers: A, B, and D

Side effects of corticosteroids include weight gain, fluid retention with hypertension, Cushingoid features, a low serum albumin, and suppressed inflammatory response. Patients are encouraged to eat a diet high in protein, vitamins, and minerals and low in sodium. Corticosteroids cause hypernatremia, not hyponatremia.

15. Answer: B. Change gloves immediately after use.

The neutropenic patient is at risk of infection. Changing gloves immediately after use protects patients from contamination with organisms picked up on hospital surfaces. This contamination can have serious consequences for an immunocompromised

patient. Changing the respiratory mask is desirable, but not nearly as urgent as changing gloves. Minimizing contact and conversation are not necessary and may cause nursing staff to miss changes in the patient's symptoms or condition.

16. Answer: D. Immunization provides acquired immunity from some specific diseases.

Immunization is available for the prevention of some, but not all, specific diseases. This type of immunity is "acquired" by causing antibodies to form in response to a specific pathogen. Natural immunity is present at birth because the infant acquires maternal antibodies Immunization, like all medication, cannot be risk-free and should be considered based on the risk of the disease in question.

17. Answer: B. Maintain a patent airway.

The patient may be experiencing an anaphylactic reaction. The most urgent action is to maintain an airway, particularly with visible oral swelling, followed by the administration of epinephrine by subcutaneous injection. The physician will see the patient as soon as possible with the above actions underway. Oral diphenhydramine is indicated for mild allergic reactions and is not appropriate for anaphylaxis.

18. Answers: A, B, and D

ADHD in children is frequently treated with CNS stimulant medications, which increase focus and improve concentration. Children often experience insomnia, agitation, and decreased appetite. Sleepiness is not a side effect of stimulants.

19. Answer: D. Tardive dyskinesia.

Abnormal facial movements and tongue protrusion in a patient taking haloperidol is most likely due to tardive dyskinesia, an adverse reaction to the antipsychotic. Depression may occur along with schizophrenia and would be characterized by such symptoms as loss of affect, appetite and/or sleep changes, and anhedonia. These depressive changes and lack of volition are part of the negative symptoms of schizophrenia. Psychotic hallucinations may be visual or auditory but do not include abnormal movements.

20. Answer: B. Confusion.

Hypoglycemia in diabetes mellitus causes confusion, indicating the need for carbohydrates. Polydipsia, blurred vision, and polyphagia are symptoms of hyperglycemia.

1. A child is admitted to the hospital with a diagnosis of Wilms tumor, stage II. Which of the following statements most accurately describes this stage?

A. The tumor is less than 3 cm. in size and requires no chemotherapy.
B. The tumor did not extend beyond the kidney and was completely resected.
C. The tumor extended beyond the kidney but was completely resected.
D. The tumor has spread into the abdominal cavity and cannot be resected.

2. A teen patient is admitted to the hospital by his physician who suspects a diagnosis of acute glomerulonephritis. Which of the following findings is consistent with this diagnosis? Note: More than one answer may be correct.

A. Urine specific gravity of 1.040.
B. Urine output of 350 ml in 24 hours.
C. Brown ("tea-colored") urine.
D. Generalized edema.

3. Which of the following conditions most commonly causes acute glomerulonephritis?

A. A congenital condition leading to renal dysfunction.
B. Prior infection with group A Streptococcus within the past 10-14 days.
C. Viral infection of the glomeruli.
D. Nephrotic syndrome.

4. An infant with hydrocele is seen in the clinic for a follow-up visit at 1 month of age. The scrotum is smaller than it was at birth, but fluid is still visible on illumination. Which of the following actions is the physician likely to recommend?

A. Massaging the groin area twice a day until the fluid is gone.
B. Referral to a surgeon for repair.
C. No treatment is necessary; the fluid is reabsorbing normally.
D. Keeping the infant in a flat, supine position until the fluid is gone.

5. A nurse is caring for a patient with peripheral vascular disease (PVD). The patient complains of burning and tingling of the hands and feet and cannot tolerate touch of any kind. Which of the following is the most likely explanation for these symptoms?

A. Inadequate tissue perfusion leading to nerve damage.
B. Fluid overload leading to compression of nerve tissue.
C. Sensation distortion due to psychiatric disturbance.
D. Inflammation of the skin on the hands and feet.

6. A nurse is assessing a clinic patient with a diagnosis of hepatitis A. Which of the following is the most likely route of transmission?

A. Sexual contact with an infected partner.
B. Contaminated food.
C. Blood transfusion.
D. Illegal drug use.

7. A leukemia patient has a relative who wants to donate blood for transfusion. Which of the following donor medical conditions would prevent this?

A. A history of hepatitis C five years previously.
B. Cholecystitis requiring cholecystectomy one year previously.
C. Asymptomatic diverticulosis.
D. Crohn's disease in remission.

8. A physician has diagnosed acute gastritis in a clinic patient. Which of the following medications would be contraindicated for this patient?

A. Naproxen sodium (Naprosyn).
B. Calcium carbonate.
C. Clarithromycin (Biaxin).
D. Furosemide (Lasix).

9. The nurse is conducting nutrition counseling for a patient with cholecystitis. Which of the following information is important to communicate?

A. The patient must maintain a low calorie diet.
B. The patient must maintain a high protein/low carbohydrate diet.
C. The patient should limit sweets and sugary drinks.
D. The patient should limit fatty foods.

10. A patient admitted to the hospital with myocardial infarction develops severe pulmonary edema. Which of the following symptoms should the nurse expect the patient to exhibit?

A. Slow, deep respirations.
B. Stridor.
C. Bradycardia.
D. Air hunger.

11. A nurse is evaluating a postoperative patient and notes a moderate amount of serous drainage on the dressing 24 hours after surgery. Which of the following is the appropriate nursing action?

A. Notify the surgeon about evidence of infection immediately.
B. Leave the dressing intact to avoid disturbing the wound site.
C. Remove the dressing and leave the wound site open to air.
D. Change the dressing and document the clean appearance of the wound site.

12. A patient returns to the emergency department less than 24 hours after having a fiberglass cast applied for a fractured right radius. Which of the following patient complaints would cause the nurse to be concerned about impaired perfusion to the limb?

A. Severe itching under the cast.
B. Severe pain in the right shoulder.
C. Severe pain in the right lower arm.
D. Increased warmth in the fingers.

13. An older patient with osteoarthritis is preparing for discharge. Which of the following information is correct.

A. Increased physical activity and daily exercise will help decrease discomfort associated with the condition.
B. Joint pain will diminish after a full night of rest.
C. Nonsteroidal anti-inflammatory medications should be taken on an empty stomach.
D. Acetaminophen (Tylenol) is a more effective anti-inflammatory than ibuprofen.

14. Which patient should NOT be prescribed alendronate (Fosamax) for osteoporosis?

A. A female patient being treated for high blood pressure with an ACE inhibitor.
B. A patient who is allergic to iodine/shellfish.
C. A patient on a calorie restricted diet.
D. A patient on bed rest who must maintain a supine position.

15. Which of the following strategies is NOT effective for prevention of Lyme disease?

A. Insect repellant on the skin and clothes when in a Lyme endemic area.
B. Long sleeved shirts and long pants.
C. Prophylactic antibiotic therapy prior to anticipated exposure to ticks.
D. Careful examination of skin and hair for ticks following anticipated exposure.

16. A nurse is performing routine assessment of an IV site in a patient receiving both IV fluids and medications through the line. Which of the following would indicate the need for discontinuation of the IV line as the next nursing action?

A. The patient complains of pain on movement.
B. The area proximal to the insertion site is reddened, warm, and painful.
C. The IV solution is infusing too slowly, particularly when the limb is elevated.
D. A hematoma is visible in the area of the IV insertion site.

17. A hospitalized patient has received transfusions of 2 units of blood over the past few hours. A nurse enters the room to find the patient sitting up in bed, dyspneic and uncomfortable. On assessment, crackles are heard in the bases of both lungs, probably indicating that the patient is experiencing a complication of transfusion. Which of the following complications is most likely the cause of the patient's symptoms?

A. Febrile non-hemolytic reaction.
B. Allergic transfusion reaction.
C. Acute hemolytic reaction.
D. Fluid overload.

18. A patient in labor and delivery has just received an amniotomy. Which of the following is correct? Note: More than one answer may be correct.

A. Frequent checks for cervical dilation will be needed after the procedure.
B. Contractions may rapidly become stronger and closer together after the procedure.

C. The FHR (fetal heart rate) will be followed closely after the procedure due to the possibility of cord compression.
D. The procedure is usually painless and is followed by a gush of amniotic fluid.

19. A nurse is counseling the mother of a newborn infant with hyperbilirubinemia. Which of the following instructions by the nurse is NOT correct?

A. Continue to breastfeed frequently, at least every 2-4 hours.
B. Follow up with the infant's physician within 72 hours of discharge for a recheck of the serum bilirubin and exam.
C. Watch for signs of dehydration, including decreased urinary output and changes in skin turgor.
D. Keep the baby quiet and swaddled, and place the bassinet in a dimly lit area.

20. A nurse is giving discharge instructions to the parents of a healthy newborn. Which of the following instructions should the nurse provide regarding car safety and the trip home from the hospital?

A. The infant should be restrained in an infant car seat, properly secured in the back seat in a rear-facing position.
B. The infant should be restrained in an infant car seat, properly secured in the front passenger seat.
C. The infant should be restrained in an infant car seat facing forward or rearward in the back seat.
D. For the trip home from the hospital, the parent may sit in the back seat and hold the newborn.

Answers and Rationale

1. Answer: C. The tumor extended beyond the kidney but was completely resected.

The staging of Wilms tumor is confirmed at surgery as follows: Stage I, the tumor is limited to the kidney and completely resected; stage II, the tumor extends beyond the

kidney but is completely resected; stage III, residual non hematogenous tumor is confined to the abdomen; stage IV, hematogenous metastasis has occurred with spread beyond the abdomen; and stage V, bilateral renal involvement is present at diagnosis.

2. Answers: A, B, and C

Acute glomerulonephritis is characterized by high urine specific gravity related to oliguria as well as dark "tea colored" urine caused by large amounts of red blood cells. There is periorbital edema, but generalized edema is seen in nephrotic syndrome, not acute glomerulonephritis.

3. Answer: B. Prior infection with group A Streptococcus within the past 10-14 days.

Acute glomerulonephritis is most commonly caused by the immune response to a prior upper respiratory infection with group A Streptococcus. Glomerular inflammation occurs about 10-14 days after the infection, resulting in scant, dark urine and retention of body fluid. Periorbital edema and hypertension are common signs at diagnosis.

4. Answer: C. No treatment is necessary; the fluid is reabsorbing normally.

A hydrocele is a collection of fluid in the scrotum that results from a patent tunica vaginalis. Illumination of the scrotum with a pocket light demonstrates the clear fluid. In most cases the fluid reabsorbs within the first few months of life and no treatment is necessary. Massaging the area or placing the infant in a supine position would have no effect. Surgery is not indicated.

5. Answer: A. Inadequate tissue perfusion leading to nerve damage.

Patients with peripheral vascular disease often sustain nerve damage as a result of inadequate tissue perfusion. Fluid overload is not characteristic of PVD. There is nothing to indicate psychiatric disturbance in the patient. Skin changes in PVD are secondary to decreased tissue perfusion rather than primary inflammation.

6. Answer: B. Contaminated food.

Hepatitis A is the only type that is transmitted by the fecal-oral route through contaminated food. Hepatitis B, C, and D are transmitted through infected bodily fluids.

7. Answer: A. A history of hepatitis C five years previously.

Hepatitis C is a viral infection transmitted through bodily fluids, such as blood, causing inflammation of the liver. Patients with hepatitis C may not donate blood for transfusion due to the high risk of infection in the recipient. Cholecystitis (gallbladder disease), diverticulosis, and history of Crohn's disease do not preclude blood donation.

8. Answer: A. Naproxen sodium (Naprosyn).

Naproxen sodium is a nonsteroidal anti-inflammatory drug that can cause inflammation of the upper GI tract. For this reason, it is contraindicated in a patient with gastritis. Calcium carbonate is used as an antacid for the relief of indigestion and is not contraindicated. Clarithromycin is an antibacterial often used for the treatment of Helicobacter pylori in gastritis. Furosemide is a loop diuretic and is contraindicated in a patient with gastritis.

9. Answer: D. The patient should limit fatty foods.

Cholecystitis, inflammation of the gallbladder, is most commonly caused by the presence of gallstones, which may block bile (necessary for fat absorption) from

entering the intestines. Patients should decrease dietary fat by limiting foods like fatty meats, fried foods, and creamy desserts to avoid irritation of the gallbladder.

10. Answer: D. Air hunger.

Patients with pulmonary edema experience air hunger, anxiety, and agitation. Respiration is fast and shallow and heart rate increases. Stridor is noisy breathing caused by laryngeal swelling or spasm and is not associated with pulmonary edema.

11. Answer: D. Change the dressing and document the clean appearance of the wound site.

A moderate amount of serous drainage from a recent surgical site is a sign of normal healing. Purulent drainage would indicate the presence of infection. A soiled dressing should be changed to avoid bacterial growth and to examine the appearance of the wound. The surgical site is typically covered by gauze dressings for a minimum of 48-72 hours to ensure that initial healing has begun.

12. Answer: C. Severe pain in the right lower arm.

Impaired perfusion to the right lower arm as a result of a closed cast may cause neurovascular compromise and severe pain, requiring immediate cast removal. Itching under the cast is common and fairly benign. Neurovascular compromise in the arm would not cause pain in the shoulder, as perfusion there would not be affected. Impaired perfusion would cause the fingers to be cool and pale. Increased warmth would indicate increased blood flow or infection.

13. Answer: A. Increased physical activity and daily exercise will help decrease discomfort associated with the condition.

Physical activity and daily exercise can help to improve movement and decrease pain in osteoarthritis. Joint pain and stiffness are often at their worst during the early morning after several hours of decreased movement. Acetaminophen is a pain reliever, but does not have anti-inflammatory activity. Ibuprofen is a strong anti-inflammatory, but should always be taken with food to avoid GI distress.

14. Answer: D. A patient on bed rest who must maintain a supine position.

Alendronate can cause significant gastrointestinal side effects, such as esophageal irritation, so it should not be taken if a patient must stay in supine position. It should be taken upon rising in the morning with 8 ounces of water on an empty stomach to increase absorption. The patient should not eat or drink for 30 minutes after administration and should not lie down. ACE inhibitors are not contraindicated with alendronate and there is no iodine allergy relationship.

15. Answer: C. Prophylactic antibiotic therapy prior to anticipated exposure to ticks.

Prophylactic use of antibiotics is not indicated to prevent Lyme disease. Antibiotics are used only when symptoms develop following a tick bite. Insect repellant should be used on skin and clothing when exposure is anticipated. Clothing should be designed to cover as much exposed area as possible to provide an effective barrier. Close examination of skin and hair can reveal the presence of a tick before a bite occurs.

16. Answer: B. The area proximal to the insertion site is reddened, warm, and painful.

An IV site that is red, warm, painful and swollen indicates that phlebitis has developed and the line should be discontinued and restarted at another site. Pain on movement should be managed by maneuvers such as splinting the limb with an IV board or gently shifting the position of the catheter before making a decision to remove the line. An IV line that is running slowly may simply need flushing or repositioning. A hematoma at the site is likely a result of minor bleeding at the time of insertion and does not require discontinuation of the line.

17. Answer: D. Fluid overload.

Fluid overload occurs when then the fluid volume infused over a short period is too great for the vascular system, causing fluid leak into the lungs. Symptoms include dyspnea, rapid respirations, and discomfort as in the patient described. Febrile non-hemolytic reaction results in fever. Symptoms of allergic transfusion reaction would include flushing, itching, and a generalized rash. Acute hemolytic reaction may occur when a patient receives blood that is incompatible with his blood type. It is the most serious adverse transfusion reaction and can cause shock and death.

18. Answer: B, C, and D

Uterine contractions typically become stronger and occur more closely together following amniotomy. The FHR is assessed immediately after the procedure and followed closely to detect changes that may indicate cord compression. The procedure itself is painless and results in the quick expulsion of amniotic fluid. Following amniotomy, cervical checks are minimized because of the risk of infection

19. Answer: D. Keep the baby quiet and swaddled, and place the bassinet in a dimly lit area.

An infant discharged home with hyperbilirubinemia (newborn jaundice) should be placed in a sunny rather than dimly lit area with skin exposed to help process the bilirubin. Frequent feedings will help to metabolize the bilirubin. A recheck of the serum bilirubin and a physical exam within 72 hours will confirm that the level is falling and the infant is thriving and is well hydrated. Signs of dehydration, including decreased urine output and skin changes, indicate inadequate fluid intake and will worsen the hyperbilirubinemia.

20. Answer: A. The infant should be restrained in an infant car seat, properly secured in the back seat in a rear-facing position.

All infants under 1 year of age weighing less than 20 lbs. should be placed in a rear-facing infant car seat secured properly in the back seat. Infant car seats should never be placed in the front passenger seat. Infants should always be placed in an approved car seat during travel, even on that first ride home from the hospital.

1. A nurse is administering IV furosemide to a patient admitted with congestive heart failure. After the infusion, which of the following symptoms is NOT expected?

A. Increased urinary output.
B. Decreased edema.
C. Decreased pain.
D. Decreased blood pressure.

2. There are a number of risk factors associated with coronary artery disease. Which of the following is a modifiable risk factor?

A. Obesity.
B. Heredity.
C. Gender.
D. Age.

3. Tissue plasminogen activator (t-PA) is considered for treatment of a patient who arrives in the emergency department following onset of symptoms of myocardial infarction. Which of the following is a contraindication for treatment with t-PA?

A. Worsening chest pain that began earlier in the evening.
B. History of cerebral hemorrhage.
C. History of prior myocardial infarction.
D. Hypertension.

4. Following myocardial infarction, a hospitalized patient is encouraged to practice frequent leg exercises and ambulate in the hallway as directed by his physician. Which of the following choices reflects the purpose of exercise for this patient?

A. Increases fitness and prevents future heart attacks.
B. Prevents bedsores.
C. Prevents DVT (deep vein thrombosis).
D. Prevent constipations.

5. A patient arrives in the emergency department with symptoms of myocardial infarction, progressing to cardiogenic shock. Which of the following symptoms should the nurse expect the patient to exhibit with cardiogenic shock?

A. Hypertension.
B. Bradycardia.
C. Bounding pulse.
D. Confusion.

6. A patient in the cardiac unit is concerned about the risk factors associated with atherosclerosis. Which of the following are hereditary risk factors for developing atherosclerosis?

A. Family history of heart disease.
B. Overweight.
C. Smoking.
D. Age.

7. Claudication is a well-known effect of peripheral vascular disease. Which of the following facts about claudication is correct? More than one answer may be correct.

A. It results when oxygen demand is greater than oxygen supply.
B. It is characterized by pain that often occurs during rest.
C. It is a result of tissue hypoxia.
D. It is characterized by cramping and weakness.

8. A nurse is providing discharge information to a patient with peripheral vascular disease. Which of the following information should be included in instructions?

A. Walk barefoot whenever possible.
B. Use a heating pad to keep feet warm.
C. Avoid crossing the legs.
D. Use antibacterial ointment to treat skin lesions at risk of infection.

9. A patient who has been diagnosed with vasospastic disorder (Raynaud's disease) complains of cold and stiffness in the fingers. Which of the following descriptions is most likely to fit the patient?

A. An adolescent male.
B. An elderly woman.
C. A young woman.
D. An elderly man.

10. A 23 year old patient in the 27th week of pregnancy has been hospitalized on complete bed rest for 6 days. She experiences sudden shortness of breath, accompanied by chest pain. Which of the following conditions is the most likely cause of her symptoms?

A. Myocardial infarction due to a history of atherosclerosis.
B. Pulmonary embolism due to deep vein thrombosis (DVT).
C. Anxiety attack due to worries about her baby's health.
D. Congestive heart failure due to fluid overload.

11. Thrombolytic therapy is frequently used in the treatment of suspected stroke. Which of the following is a significant complication associated with thrombolytic therapy?

A. Air embolus.
B. Cerebral hemorrhage.
C. Expansion of the clot.
D. Resolution of the clot.

12. An infant is brought to the clinic by his mother, who has noticed that he holds his head in an unusual position and always faces to one side. Which of the following is the most likely explanation?

A. Torticollis, with shortening of the sternocleidomastoid muscle.
B. Craniosynostosis, with premature closure of the cranial sutures.
C. Plagiocephaly, with flattening of one side of the head.
D. Hydrocephalus, with increased head size.

13. An adolescent brings a physician's note to school stating that he is not to participate in sports due to a diagnosis of Osgood-Schlatter disease. Which of the following statements about the disease is correct?

A. The condition was caused by the student's competitive swimming schedule.
B. The student will most likely require surgical intervention.
C. The student experiences pain in the inferior aspect of the knee.
D. The student is trying to avoid participation in physical education.

14. The clinic nurse asks a 13-year-old female to bend forward at the waist with arms hanging freely. Which of the following assessments is the nurse most likely conducting?

A. Spinal flexibility.
B. Leg length disparity.
C. Hypostatic blood pressure.
D. Scoliosis.

15. A clinic nurse interviews a parent who is suspected of abusing her child. Which of the following characteristics is the nurse LEAST likely to find in an abusing parent?

A. Low self-esteem.
B. Unemployment.
C. Self-blame for the injury to the child.
D. Single status.

16. A nurse in the emergency department is observing a 4-year-old child for signs of increased intracranial pressure after a fall from a bicycle, resulting in head trauma. Which of the following signs or symptoms would be cause for concern?

A. Bulging anterior fontanel.
B. Repeated vomiting.
C. Signs of sleepiness at 10 PM.
D. Inability to read short words from a distance of 18 inches.

17. A nonimmunized child appears at the clinic with a visible rash. Which of the following observations indicates the child may have rubeola (measles)?

A. Small blue-white spots are visible on the oral mucosa.
B. The rash begins on the trunk and spreads outward.

C. There is low-grade fever.
D. The lesions have a “teardrop on a rose petal” appearance.

18. A child is seen in the emergency department for scarlet fever. Which of the following descriptions of scarlet fever is NOT correct?

A. Scarlet fever is caused by infection with group A Streptococcus bacteria.
B. “Strawberry tongue” is a characteristic sign.
C. Petechiae occur on the soft palate.
D. The pharynx is red and swollen.

19. A child weighing 30 kg arrives at the clinic with diffuse itching as the result of an allergic reaction to an insect bite. Diphenhydramine (Benadryl) 25 mg 3 times a day is prescribed. The correct pediatric dose is 5 mg/kg/day. Which of the following best describes the prescribed drug dose?

A. It is the correct dose.
B. The dose is too low.
C. The dose is too high.
D. The dose should be increased or decreased, depending on the symptoms.

20. The mother of a 2-month-old infant brings the child to the clinic for a well baby check. She is concerned because she feels only one testis in the scrotal sac. Which of the following statements about the undescended testis is the most accurate?

A. Normally, the testes are descended by birth.
B. The infant will likely require surgical intervention.
C. The infant probably has with only one testis.
D. Normally, the testes descend by one year of age.

Answers and Rationale

1. Answer: C. Decreased pain.

Furosemide, a loop diuretic, does not alter pain. Furosemide acts on the kidneys to increase urinary output. Fluid may move from the periphery, decreasing edema. Fluid load is reduced, lowering blood pressure.

2. Answer: A. Obesity.

Obesity is an important risk factor for coronary artery disease that can be modified by improved diet and weight loss. Family history of coronary artery disease, male gender, and advancing age increase risk but cannot be modified.

3. Answer: B. History of cerebral hemorrhage.

A history of cerebral hemorrhage is a contraindication to tPA because it may increase the risk of bleeding. TPA acts by dissolving the clot blocking the coronary artery and works best when administered within 6 hours of onset of symptoms. Prior MI is not a contraindication to tPA. Patients receiving tPA should be observed for changes in blood pressure, as tPA may cause hypotension.

4. Answer: C. Prevents DVT (deep vein thrombosis).

Exercise is important for all hospitalized patients to prevent deep vein thrombosis. Muscular contraction promotes venous return and prevents hemostasis in the lower extremities. This exercise is not sufficiently vigorous to increase physical fitness, nor is it intended to prevent bedsores or constipation.

5. Answer: D. Confusion.

Cardiogenic shock severely impairs the pumping function of the heart muscle, causing diminished blood flow to the organs of the body. This results in diminished brain function and confusion, as well as hypotension, tachycardia, and weak pulse. Cardiogenic shock is a serious complication of myocardial infarction with a high mortality rate.

6. Answer: A. Family history of heart disease.

Family history of heart disease is an inherited risk factor that is not subject to lifestyle change. Having a first degree relative with heart disease has been shown to significantly increase risk. Overweight and smoking are risk factors that are subject to lifestyle change and can reduce risk significantly. Advancing age increases risk of atherosclerosis but is not a hereditary factor.

7. Answers: A, C, and D

Claudication describes the pain experienced by a patient with peripheral vascular disease when oxygen demand in the leg muscles exceeds the oxygen supply. This most often occurs during activity when demand increases in muscle tissue. The tissue becomes hypoxic, causing cramping, weakness, and discomfort.

8. Answer: C. Avoid crossing the legs.

Patients with peripheral vascular disease should avoid crossing the legs because this can impede blood flow. Walking barefoot is not advised, as foot protection is important to avoid trauma that may lead to serious infection. Heating pads can cause injury, which can also increase the risk of infection. Skin lesions at risk for infection should be examined and treated by a physician.

9. Answer: C. A young woman.

Raynaud's disease is most common in young women and is frequently associated with rheumatologic disorders, such as lupus and rheumatoid arthritis.

10. Answer: B. Pulmonary embolism due to deep vein thrombosis (DVT).

In a hospitalized patient on prolonged bed rest, he most likely cause of sudden onset shortness of breath and chest pain is pulmonary embolism. Pregnancy and prolonged inactivity both increase the risk of clot formation in the deep veins of the legs. These clots can then break loose and travel to the lungs. Myocardial infarction and atherosclerosis are unlikely in a 27-year-old woman, as is congestive heart failure due to fluid overload. There is no reason to suspect an anxiety disorder in this patient. Though anxiety is a possible cause of her symptoms, the seriousness of pulmonary embolism demands that it be considered first.

11. Answer: B. Cerebral hemorrhage.

Cerebral hemorrhage is a significant risk when treating a stroke victim with thrombolytic therapy intended to dissolve a suspected clot. Success of the treatment demands that it be instituted as soon as possible, often before the cause of stroke has been determined. Air embolism is not a concern. Thrombolytic therapy does not lead to expansion of the clot, but to resolution, which is the intended effect.

12. Answer: A. Torticollis, with shortening of the sternocleidomastoid muscle.

In torticollis, the sternocleidomastoid muscle is contracted, limiting range of motion of the neck and causing the chin to point to the opposing side. In craniosynostosis one of the cranial sutures, often the sagittal, closes prematurely, causing the head to grow in an abnormal shape. Plagiocephaly refers to the flattening of one side of the head, caused by the infant being placed supine in the same position over time. Hydrocephalus is caused by a build-up of cerebrospinal fluid in the brain resulting in large head size.

13. Answer: C. The student experiences pain in the inferior aspect of the knee.

Osgood-Schlatter disease occurs in adolescents in rapid growth phase when the infrapatellar ligament of the quadriceps muscle pulls on the tibial tubercle, causing pain and swelling in the inferior aspect of the knee. Osgood-Schlatter disease is commonly caused by activities that require repeated use of the quadriceps, including track and soccer. Swimming is not a likely cause. The condition is usually self-limited, responding to ice, rest, and analgesics. Continued participation will worsen the condition and the symptoms.

14. Answer: D. Scoliosis.

A check for scoliosis, a lateral deviation of the spine, is an important part of the routine adolescent exam. It is assessed by having the teen bend at the waist with arms dangling, while observing for lateral curvature and uneven rib level. Scoliosis is more common in female adolescents. Choices A, B, and C are not part of the routine adolescent exam.

15. Answer: C. Self-blame for the injury to the child.

The profile of a parent at risk of abusive behavior includes a tendency to blame the child or others for the injury sustained. These parents also have a high incidence of low self-esteem, unemployment, unstable financial situation, and single status.

16. Answer: B. Repeated vomiting.

Increased pressure caused by bleeding or swelling within the skull can damage delicate brain tissue and may become life threatening. Repeated vomiting can be an early sign of pressure as the vomit center within the medulla is stimulated. The anterior fontanel is closed in a 4-year-old child. Evidence of sleepiness at 10 PM is normal for a four year old. The average 4-year-old child cannot read yet, so this too is normal.

17. Answer: A. Small blue-white spots are visible on the oral mucosa.

Koplik's spots are small blue-white spots visible on the oral mucosa and are characteristic of measles infection. The body rash typically begins on the face and travels downward. High fever is often present. "Tear drop on a rose petal" refers to the lesions found in varicella (chicken pox).

18. Answer: C. Petechiae occur on the soft palate.

Petechiae on the soft palate are characteristic of rubella infection. Choices A, B, and D are characteristic of scarlet fever, a result of group A Streptococcus infection.

19. Answer: B. The dose is too low.

This child weighs 30 kg, and the pediatric dose of diphenhydramine is 5 mg/kg/day (5 X 30 = 150/day). Therefore, the correct dose is 150 mg/day. Divided into 3 doses per day, the child should receive 50 mg 3 times a day rather than 25 mg 3 times a day. Dosage should not be titrated based on symptoms without consulting a physician.

20. Answer: D. Normally, the testes descend by one year of age.

Normally, the testes descend by one year of age. In young infants, it is common for the testes to retract into the inguinal canal when the environment is cold or the cremasteric reflex is stimulated. Exam should be done in a warm room with warm hands. It is most likely that both testes are present and will descend by a year. If not, a full assessment will determine the appropriate treatment.

1. Which behaviors would be exhibited during the letting-go phase of maternal role adaptation. Select all that apply.

A. Emergence of family unit
B. Dependent behaviors

C. Sexual intimacy relationship continuing
D. Defining one's individual roles
E. Being talkative and excited about becoming a mother

2. While making a visit to the home of a postpartum woman 1 week after birth, the nurse should recognize that the woman would characteristically:

A. Express a strong need to review the events and her behavior during the process oflabor and birth.
B. Exhibit a reduced attention span, limiting readiness to learn.
C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn.
D. Have reestablished her role as a spouse or partner.

3. Which of the following is the most common kind of placental adherence seen in pregnant women?

A. Accreta
B. Placenta previa
C. Percreta
D. Increta

4. A 40-year-old woman with a high body mass index (BMI) is 10 weeks pregnant. Which diagnostic tool is appropriate to suggest to her at this time?

A. Biophysical profile
B. Amniocentesis
C. Maternal serum alpha-fetoprotein (MSAFP)
D. Transvaginal ultrasound

5. A nurse providing care for the antepartum woman should understand that thecontraction stress test (CST):

A. Sometimes uses vibroacoustic stimulation.
B. Is an invasive test; however, contractions are stimulated.
C. Is considered to have a negative result if no late decelerations are observed with the contractions.
D. Is more effective than nonstress test (NST) if the membranes have already been ruptured.

6. In the past, factors to determine whether a woman was likely to have a high-risk pregnancy were evaluated primarily from a medical point of view. A broader, more comprehensive approach to high-risk pregnancy has been adopted. There are now four categories based on threats to the health of the woman and the outcome of pregnancy. Which of the options listed here is not included as a category?

A. Biophysical
B. Psychosocial
C. Geographic
D. Environmental

7. A woman who is at 36 weeks of gestation is having a nonstress test. Which statement indicates her correct understanding of the test?

A. "I will need to have a full bladder for the test to be done accurately."
B. "I should have my husband drive me home after the test because I may be nauseated."
C. "This test will help to determine whether the baby has Down syndrome or a neural tube defect."
D. "This test observes for fetal activity and an acceleration of the fetal heart rate to determine the well-being of the baby."

8. What is an appropriate indicator for performing a contraction stress test?

A. Increased fetal movement and small for gestational age
B. Maternal diabetes mellitus and postmaturity
C. Adolescent pregnancy and poor prenatal care
D. History of preterm labor and intrauterine growth restriction

9. The nurse sees a woman for the first time when she is 30 weeks pregnant. The woman has smoked throughout the pregnancy, and fundal height measurements now are suggestive of growth restriction in the fetus. In addition to ultrasound to measure fetal size, what would be another tool useful in confirming the diagnosis?

A. Doppler blood flow analysis
B. Contraction stress test (CST)
C. Amniocentesis
D. Daily fetal movement counts

10. A nurse is providing instruction for an obstetrical patient to perform a daily fetal movement count (DFMC). Which instructions could be included in the plan of care? Select all that apply.

A. The fetal alarm signal is reached when there are no fetal movements noted for 5 hours.
B. The patient can monitor fetal activity once daily for a 60-minute period and note activity.
C. Monitor fetal activity two times a day either after meals or before bed for a period of 2 hours or until 10 fetal movements are noted.
D. Count all fetal movements in a 12-hour period daily until 10 fetal movements are noted.

11. A patient has undergone an amniocentesis for evaluation of fetal well-being. Which intervention would be included in the nurse's plan of care after the procedure? Select all that apply.

A. Perform ultrasound to determine fetal positioning.
B. Observe the patient for possible uterine contractions.
C. Administer RhoGAM to the patient if she is Rh negative.
D. Perform a mini catheterization to obtain a urine specimen to assess for bleeding.

12. With regard to small-for-gestational-age (SGA) infants and intrauterine growth restriction (IUGR), nurses should be aware that:

A. In the first trimester, diseases or abnormalities result in asymmetric IUGR.
B. Infants with asymmetric IUGR have the potential for normal growth and development.
C. In asymmetric IUGR, weight is slightly more than SGA, whereas length and head circumference are somewhat less than SGA.
D. Symmetric IUGR occurs in the later stages of pregnancy.

13. A client who delivered by cesarean section 24 hours ago is using a patient-controlled analgesia (PCA) pump for pain control. Her oral intake has been ice chips only since surgery. She is now complaining of nausea and bloating, and states that because she had nothing to eat, she is too weak to breastfeed her infant. Which nursing diagnosis has the highest priority?

A. Altered nutrition, less than body requirements for lactation
B. Alteration in comfort related to nausea and abdominal distention
C. Impaired bowel motility related to pain medication and immobility
D. Fatigue related to cesarean delivery and physical care demands of infant

14. The nurse is teaching care of the newborn to a childbirth preparation class and describes the need for administering antibiotic ointment into the eyes of the newborn. An expectant father asks, "What type of disease causes infections in babies that can be prevented by using this ointment?" Which response by the nurse is accurate?

A. Herpes
B. Trichomonas
C. Gonorrhea
D. Syphilis

15. A new mother is having trouble breastfeeding her newborn. The child is making frantic rooting motions and will not grasp the nipple. Which intervention should the nurse implement?

A. Encourage frequent use of a pacifier so that the infant becomes accustomed to sucking.
B. Hold the infant's head firmly against the breast until he latches onto the nipple.
C. Encourage the mother to stop feeding for a few minutes and comfort the infant.
D. Provide formula for the infant until he becomes calm, and then offer the breast again.

16. The nurse is counseling a couple who has sought information about conceiving. The couple asks the nurse to explain when ovulation usually occurs. Which statement by the nurse is correct?

A. Two weeks before menstruation
B. Immediately after menstruation
C. Immediately before menstruation
D. Three weeks before menstruation

17. The nurse instructs a laboring client to use accelerated blow breathing. The client begins to complain of tingling fingers and dizziness. Which action should the nurse take?

A. Administer oxygen by face mask.
B. Notify the health care provider of the client's symptoms.
C. Have the client breathe into her cupped hands.
D. Check the client's blood pressure and fetal heart rate.

18. When assessing a client at 12 weeks of gestation, the nurse recommends that she and her husband consider attending childbirth preparation classes. When is the best time for the couple to attend these classes?

A. At 16 weeks of gestation
B. At 20 weeks of gestation
C. At 24 weeks of gestation
D. At 30 weeks of gestation

19. One hour following a normal vaginal delivery, a newborn infant boy's axillary temperature is 96° F, his lower lip is shaking and, when the nurse assesses for aMoro reflex, the boy's hands shake. Which intervention should the nurse implement first?

A. Stimulate the infant to cry.
B. Wrap the infant in warm blankets.
C. Feed the infant formula.
D. Obtain a serum glucose level.

20. Which statement made by the client indicates that the mother understands the limitations of breastfeeding her newborn?

A. "Breastfeeding my infant consistently every 3 to 4 hours stops ovulation and my period."
B. "Breastfeeding my baby immediately after drinking alcohol is safer than waiting for the alcohol to clear my breast milk."
C. "I can start smoking cigarettes while breastfeeding because it will not affect my breast milk."
D. "When I take a warm shower after I breastfeed, it relieves the pain from being engorged between breastfeedings."

Answers and Rationale

1. Answer: A, C, and D

Emergence of family unit, sexual intimacy relationship continuing, and defining one's individual roles represent interdependent behaviors associated with the letting-go phase. Dependent behaviors are exhibited in the taking-in phase. Being talkative and excited about becoming a mother represents the taking-hold phase and is an example of dependent-independent behaviors.

2. Answer: C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn.

One week after birth the woman should exhibit behaviors characteristic of the dependent-independent or taking-hold stage. She still has needs for nurturing and acceptance by others. Wanting to discuss the events of her labor and delivery are characteristics of the taking-in stage, as are a limited readiness to learn and reduced attention span; this stage lasts from the first 24 hours until 2 days after delivery. Having reestablished her role as a spouse reflects the letting-go stage, which indicates that psychosocial recovery is complete.

3. Answer: A. Accreta

Placenta accreta is the most common kind of placental adherence seen in pregnant women and is characterized by slight penetration of myometrium. In placenta previa, theplacenta does not embed correctly and results in what is known as a low-lying placenta. It can be marginal, partial, or complete in how it covers the cervical os, and it increases the patient's risk for painless vaginal bleeding during the pregnancy and/or delivery process.Placenta percreta leads to perforation of the uterus and is the most serious and invasive of all types of accrete. Placenta increta leads to deep penetration of the myometrium.

4. Answer: D. Transvaginal ultrasound

An ultrasound is the method of biophysical assessment of the infant that is performed at this gestational age. Transvaginal ultrasound is especially useful for obese women, whose thick abdominal layers cannot be penetrated adequately with the abdominal approach. A biophysical profile is a method of biophysical assessment of fetal well-being in the third trimester. An amniocentesis is performed after the fourteenth week of pregnancy. A MSAFP test is performed from week 15 to week 22 of the gestation (weeks 16 to 18 are ideal).

5. Answer: C. Is considered to have a negative result if no late decelerations are observed with the contractions.

No late decelerations indicate a positive CST result. Vibroacoustic stimulation is sometimes used with NST. CST is invasive if stimulation is performed by IV oxytocin but not if by nipple stimulation. CST is contraindicated if the membranes have ruptured.

6. Answer: C. Geographic

The fourth category is correctly referred to as the sociodemographic risk category.

7. Answer: D. "This test observes for fetal activity and an acceleration of the fetal heart rate to determine the well-being of the baby."

The nonstress test is one of the most widely used techniques to determine fetal well-being and is accomplished by monitoring fetal heart rate in conjunction with fetal activity and movements. An ultrasound requires a full bladder. An amniocentesis is the test after which a pregnant woman should be driven home. A maternal serum alpha-

fetoprotein test is used in conjunction with unconjugated estriol levels and human chorionic gonadotropinhelps to detect Down syndrome.

8. Answer: B. Maternal diabetes mellitus and postmaturity

Decreased fetal movement is an indicator for performing a contraction stress test; the size (small for gestational age) is not an indicator. Although adolescent pregnancy and poor prenatal care are risk factors for poor fetal outcomes, they are not indicators for performing a contraction stress test. Intrauterine growth restriction is an indicator; history of a previous stillbirth, not preterm labor, is another indicator.

9. Answer: A. Doppler blood flow analysis

Doppler blood flow analysis allows the examiner to study the blood flow noninvasively in the fetus and the placenta. It is a helpful tool in the management of high-risk pregnancy due to intrauterine growth restriction (IUGR), diabetes mellitus, multiple fetuses, or preterm labor. Because of the potential risk of inducing labor and causing fetal distress, a CST is not performed in a woman whose fetus is preterm. Indications for anamniocentesis include diagnosis of genetic disorders or congenital anomalies, assessment of pulmonary maturity, and the diagnosis of fetal hemolytic disease, not IUGR. Fetal kick count monitoring is performed to monitor the fetus in pregnancies complicated by conditions that may affect fetal oxygenation. Although it may be a useful tool at some point later in this woman's pregnancy, it is not used to diagnose IUGR.

10. Answer: B, C, and D

The fetal alarm signal is reached when no fetal movements are noted for a period of 12 hours.

11. Answer: B and C

Ultrasound is used prior to the procedure as a visualization aid to assist with insertion of transabdominal needle. There is no need to assess the urine for bleeding as this is not considered to be a typical presentation or complication.

12. Answer: B. Infants with asymmetric IUGR have the potential for normal growth and development.

The infant with asymmetric IUGR has the potential for normal growth and development. IUGR is either symmetric or asymmetric. The symmetric form occurs in the first trimester, as a result of disease or abnormalities; SGA infants have reduced brain capacity. The asymmetric form occurs in the later stages of pregnancy. Weight is less than the 10th percentile, but the head circumference is greater than the 10th percentile (within normal limits).

13. Answer: C. Impaired bowel motility related to pain medication and immobility

Impaired bowel motility caused by surgical anesthesia, pain medication, and immobility (C) is the priority nursing diagnosis and addresses the potential problem of a paralytic ileus. (A and B) are both caused by impaired bowel motility. (D) is not as important as impaired motility.

14. Answer: C. Gonorrhea

Erythromycin ointment is instilled into the lower conjunctiva of each eye within 2 hours after birth to prevent ophthalmia neonatorum, an infection caused by gonorrhea (C), and inclusion conjunctivitis, an infection caused by Chlamydia. The infant may be exposed to these bacteria when passing through the birth canal. Ophthalmic ointment is not effective against (A, B, or D).

15. Answer: C. Encourage the mother to stop feeding for a few minutes and comfort the infant.

The infant is becoming frustrated and so is the mother; both need a time out. The mother should be encouraged to comfort the infant and to relax herself (C). After such a time out,breastfeeding is often more successful. (A and D) would cause nipple confusion. (B) would only cause the infant to be more resistant, resulting in the mother and infant to become more frustrated.

16. Answer: A. Two weeks before menstruation

Ovulation occurs 14 days before the first day of the menstrual period (A). Although ovulation can occur in the middle of the cycle or 2 weeks after menstruation, this is only true for a woman who has a perfect 28-day cycle. For many women, the length of themenstrual cycle varies. (B, C, and D) are incorrect.

17. Answer: C. Have the client breathe into her cupped hands.

Tingling fingers and dizziness are signs of hyperventilation (blowing off too much carbon dioxide). Hyperventilation is treated by retaining carbon dioxide. This can be facilitated by breathing into a paper bag or cupped hands (C). (A) is inappropriate because the carbon dioxide level is low, not the oxygen level. (B and D) are not specific for this situation.

18. Answer: D. At 30 weeks of gestation

Learning is facilitated by an interested pupil. The couple is most interested in childbirth toward the end of the pregnancy, when they are beginning to anticipate the onset of laborand the birth of their child. (D) is closest to the time when parents would be ready for such classes. (A, B, and C) are not the best times during a pregnancy for the couple to attendchildbirth education classes. At these times they will have other teaching needs. Early pregnancy classes often include topics such as nutrition, physiologic changes, coping with normal discomforts of pregnancy, fetal development, maternal and fetal risk factors, and evolving roles of the mother and her significant others.

19. Answer: D. Obtain a serum glucose level.

This infant is demonstrating signs of hypoglycemia, possibly secondary to a low body temperature. The nurse should first determine the serum glucose level (D). (A) is an intervention for a lethargic infant. (B) should be done based on the temperature, but first the glucose level should be obtained. (C) helps raise the blood sugar, but first the nurse should determine the glucose level.

20. Answer: A. "Breastfeeding my infant consistently every 3 to 4 hours stops ovulation and my period."

Continuous breastfeeding on a 3- to 4-hour schedule during the day will cause a release of prolactin, which will suppress ovulation and menses, but is not completely effective as a birth control method (A). (B) is incorrect because alcohol can immediately enter the breast milk. Nicotine is transferred to the infant in breast milk (C). Taking a warm shower will stimulate the production of milk, which will be more painful after breastfeedings (D).

OBG

1. A nursing instructor is conducting lecture and is reviewing the functions of the female reproductive system. She asks Mark to describe the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH). Mark accurately responds by stating that:

A. FSH and LH are released from the anterior pituitary gland.
B. FSH and LH are secreted by the corpus luteum of the ovary
C. FSH and LH are secreted by the adrenal glands
D. FSH and LH stimulate the formation of milk during pregnancy.

2. A nurse is describing the process of fetal circulation to a client during a prenatal visit. The nurse accurately tells the client that fetal circulation consists of:

A. Two umbilical veins and one umbilical artery
B. Two umbilical arteries and one umbilical vein
C. Arteries carrying oxygenated blood to the fetus
D. Veins carrying deoxygenated blood to the fetus

3. During a prenatal visit at 38 weeks, a nurse assesses the fetal heart rate. The nurse determines that the fetal heart rate is normal if which of the following is noted?

A. 80 BPM
B. 100 BPM
C. 150 BPM
D. 180 BPM

4. A client arrives at a prenatal clinic for the first prenatal assessment. The client tells a nurse that the first day of her last menstrual period was September 19th, 2013. Using Naegele's rule, the nurse determines the estimated date of confinement as:

A. July 26, 2013
B. June 12, 2014
C. June 26, 2014
D. July 12, 2014

5. A nurse is collecting data during an admission assessment of a client who is pregnant with twins. The client has a healthy 5-year old child that was delivered at 37 weeks and tells the nurse that she doesn't have any history of abortion or fetal demise. The nurse would document the GTPAL for this client as:

A. G = 3, T = 2, P = 0, A = 0, L =1
B. G = 2, T = 0, P = 1, A = 0, L =1
C. G = 1, T = 1. P = 1, A = 0, L = 1
D. G = 2, T = 0, P = 0, A = 0, L = 1

6. A nurse is performing an assessment of a primipara who is being evaluated in a clinic during her second trimester of pregnancy. Which of the following indicates an abnormal physical finding necessitating further testing?

A. Consistent increase in fundal height
B. Fetal heart rate of 180 BPM
C. Braxton hicks contractions
D. Quickening

7. A nurse is reviewing the record of a client who has just been told that a pregnancy test is positive. The physician has documented the presence of a Goodell's sign. The nurse determines this sign indicates:

A. A softening of the cervix
B. A soft blowing sound that corresponds to the maternal pulse during auscultation of the uterus.
C. The presence of hCG in the urine
D. The presence of fetal movement

8. A nursing instructor asks a nursing student who is preparing to assist with the assessment of a pregnant client to describe the process of quickening. Which of the following statements if made by the student indicates an understanding of this term?

A. "It is the irregular, painless contractions that occur throughout pregnancy."
B. "It is the soft blowing sound that can be heard when the uterus is auscultated."
C. "It is the fetal movement that is felt by the mother."
D. "It is the thinning of the lower uterine segment."

9. A nurse midwife is performing an assessment of a pregnant client and is assessing the client for the presence of ballottement. Which of the following would the nurse implement to test for the presence of ballottement?

A. Auscultating for fetal heart sounds
B. Palpating the abdomen for fetal movement
C. Assessing the cervix for thinning
D. Initiating a gentle upward tap on the cervix

10. A nurse is assisting in performing an assessment on a client who suspects that she is pregnant and is checking the client for probable signs of pregnancy. *Select all* probable signs of pregnancy.

A. Uterine enlargement
B. Fetal heart rate detected by nonelectric device
C. Outline of the fetus via radiography or ultrasound
D. Chadwick's sign
E. Braxton Hicks contractions
F. Ballottement

11. A pregnant client calls the clinic and tells a nurse that she is experiencing leg cramps and is awakened by the cramps at night. To provide relief from the leg cramps, the nurse tells the client to:

A. Dorsiflex the foot while extending the knee when the cramps occur
B. Dorsiflex the foot while flexing the knee when the cramps occur
C. Plantar flex the foot while flexing the knee when the cramps occur
D. Plantar flex the foot while extending the knee when the cramps occur.

12. A nurse is providing instructions to a client in the first trimester of pregnancy regarding measures to assist in reducing breast tenderness. The nurse tells the client to:

A. Avoid wearing a bra
B. Wash the nipples and areola area daily with soap, and massage the breasts with lotion.
C. Wear tight-fitting blouses or dresses to provide support
D. Wash the breasts with warm water and keep them dry

13. A pregnant client in the last trimester has been admitted to the hospital with a diagnosis of severe preeclampsia. A nurse monitors for complications associated with the diagnosis and assesses the client for:

A. Any bleeding, such as in the gums, petechiae, and purpura.
B. Enlargement of the breasts
C. Periods of fetal movement followed by quiet periods
D. Complaints of feeling hot when the room is cool

14. A client in the first trimester of pregnancy arrives at a health care clinic and reports that she has been experiencing vaginal bleeding. A threatened abortion is suspected, and the nurse instructs the client regarding management of care. Which statement, if made by the client, indicates a need for further education?

A. “I will maintain strict bedrest throughout the remainder of pregnancy.”
B. “I will avoid sexual intercourse until the bleeding has stopped, and for 2 weeks following the last evidence of bleeding.”
C. “I will count the number of perineal pads used on a daily basis and note the amount and color of blood on the pad.”
D. “I will watch for the evidence of the passage of tissue.”

15. A prenatal nurse is providing instructions to a group of pregnant client regarding measures to prevent toxoplasmosis. Which statement if made by one of the clients indicates a need for further instructions?

A. “I need to cook meat thoroughly.”
B. “I need to avoid touching mucous membranes of the mouth or eyes while handling raw meat.”
C. “I need to drink unpasteurized milk only.”
D. “I need to avoid contact with materials that are possibly contaminated with cat feces.”

16. A homecare nurse visits a pregnant client who has a diagnosis of mild Preeclampsia and who is being monitored for pregnancy induced hypertension (PIH). Which assessment finding indicates a worsening of the Preeclampsia and the need to notify the physician?

A. Blood pressure reading is at the prenatal baseline
B. Urinary output has increased
C. The client complains of a headache and blurred vision
D. Dependent edema has resolved

17. A nurse implements a teaching plan for a pregnant client who is newly diagnosed with gestational diabetes. Which statement if made by the client indicates a need for further education?

A. "I need to stay on the diabetic diet."
B. "I will perform glucose monitoring at home."
C. "I need to avoid exercise because of the negative effects of insulin production."
D. "I need to be aware of any infections and report signs of infection immediately to my health care provider."

18. A primigravida is receiving magnesium sulfate for the treatment of pregnancy induced hypertension (PIH). The nurse who is caring for the client is performing assessments every 30 minutes. Which assessment finding would be of most concern to the nurse?

A. Urinary output of 20 ml since the previous assessment
B. Deep tendon reflexes of 2+
C. Respiratory rate of 10 BPM
D. Fetal heart rate of 120 BPM

19. A nurse is caring for a pregnant client with Preeclampsia. The nurse prepares a plan of care for the client and documents in the plan that if the client progresses from Preeclampsia to eclampsia, the nurse's first action is to:

A. Administer magnesium sulfate intravenously
B. Assess the blood pressure and fetal heart rate
C. Clean and maintain an open airway
D. Administer oxygen by face mask

20. A nurse is monitoring a pregnant client with pregnancy induced hypertension who is at risk for Preeclampsia. The nurse checks the client for which specific signs of Preeclampsia (select all that apply)?

A. Elevated blood pressure
B. Negative urinary protein
C. Facial edema
D. Increased respirations

21. Rho (D) immune globulin (RhoGAM) is prescribed for a woman followingdelivery of a newborn infant and the nurse provides information to the woman about the purpose of the medication. The nurse determines that the woman understands the purpose of the medication if the woman states that it will protect her next baby from which of the following?

A. Being affected by Rh incompatibility
B. Having Rh positive blood
C. Developing a rubella infection
D. Developing physiological jaundice

22. A pregnant client is receiving magnesium sulfate for the management of preeclampsia. A nurse determines the client is experiencing toxicity from the medication if which of the following is noted on assessment?

A. Presence of deep tendon reflexes
B. Serum magnesium level of 6 mEq/L
C. Proteinuria of +3
D. Respirations of 10 per minute

23. A woman with preeclampsia is receiving magnesium sulfate. The nurse assigned to care for the client determines that the magnesium therapy is effective if:
A. Ankle clonus in noted
B. The blood pressure decreases
C. Seizures do not occur
D. Scotomas are present

24. A nurse is caring for a pregnant client with severe preeclampsia who is receiving IV magnesium sulfate. Select *all* nursing interventions that apply in the care for the client.
A. Monitor maternal vital signs every 2 hours
B. Notify the physician if respirations are less than 18 per minute.
C. Monitor renal function and cardiac function closely
D. Keep calcium gluconate on hand in case of a magnesium sulfate overdose
E. Monitor deep tendon reflexes hourly
F. Monitor I and O's hourly
G. Notify the physician if urinary output is less than 30 ml per hour.

25. In the 12th week of gestation, a client completely expels the products of conception. Because the client is Rh negative, the nurse must:
A. Administer RhoGAM within 72 hours
B. Make certain she receives RhoGAM on her first clinic visit
C. Not give RhoGAM, since it is not used with the birth of a stillborn
D. Make certain the client does not receive RhoGAM, since the gestation only lasted 12 weeks.

26. In a lecture on sexual functioning, the nurse plans to include the fact that ovulation occurs when the:
A. Oxytocin is too high
B. Blood level of LH is too high
C. Progesterone level is high
D. Endometrial wall is sloughed off.

27. The chief function of progesterone is the:

A. Development of the female reproductive system
B. Stimulation of the follicles for ovulation to occur
C. Preparation of the uterus to receive a fertilized egg
D. Establishment of secondary male sex characteristics

28. The developing cells are called a fetus from the:

A. Time the fetal heart is heard
B. Eighth week to the time of birth
C. Implantation of the fertilized ovum
D. End of the send week to the onset of labor

29. After the first four months of pregnancy, the chief source of estrogen andprogesterone is the:

A. Placenta
B. Adrenal cortex
C. Corpus luteum
D. Anterior hypophysis

30. The nurse recognizes that an expected change in the hematologic system that occurs during the 2nd trimester of pregnancy is:

A. A decrease in WBC's
B. In increase in hematocrit
C. An increase in blood volume
D. A decrease in sedimentation rate

31. The nurse is aware than an adaptation of pregnancy is an increased blood supply to the pelvic region that results in a purplish discoloration of the vaginal mucosa, which is known as:

A. Ladin's sign
B. Hegar's sign
C. Goodell's sign
D. Chadwick's sign

32. A pregnant client is making her first Antepartum visit. She has a two year old son born at 40 weeks, a 5 year old daughter born at 38 weeks, and 7 year old twin daughters born at 35 weeks. She had a spontaneous abortion 3 years ago at 10 weeks. Using the GTPAL format, the nurse should identify that the client is:

A. G4 T3 P2 A1 L4
B. G5 T2 P2 A1 L4
C. G5 T2 P1 A1 L4
D. G4 T3 P1 A1 L4

33. An expected cardiopulmonary adaptation experienced by most pregnant women is:

A. Tachycardia
B. Dyspnea at rest
C. Progression of dependent edema
D. Shortness of breath on exertion

34. Nutritional planning for a newly pregnant woman of average height and weighing 145 pounds should include:

A. A decrease of 200 calories a day
B. An increase of 300 calories a day
C. An increase of 500 calories a day
D. A maintenance of her present caloric intake per day

35. During a prenatal examination, the nurse draws blood from a young Rh negative client and explain that an indirect Coombs test will be performed to predict whether the fetus is at risk for:

A. Acute hemolytic disease
B. Respiratory distress syndrome
C. Protein metabolic deficiency
D. Physiologic hyperbilirubinemia

36. When involved in prenatal teaching, the nurse should advise the clients that an increase in vaginal secretions during pregnancy is called leukorrhea and is caused by increased:

A. Metabolic rates
B. Production of estrogen
C. Functioning of the Bartholin glands
D. Supply of sodium chloride to the cells of the vagina

37. A 26-year old multigravida is 14 weeks' pregnant and is scheduled for an alpha-fetoprotein test. She asks the nurse, "What does the alpha-fetoprotein test indicate?" The nurse bases a response on the knowledge that this test can detect:

A. Kidney defects
B. Cardiac defects
C. Neural tube defects
D. Urinary tract defects

38. At a prenatal visit at 36 weeks' gestation, a client complains of discomfort with irregularly occurring contractions. The nurse instructs the client to:

A. Lie down until they stop
B. Walk around until they subside
C. Time contraction for 30 minutes
D. Take 10 grains of aspirin for the discomfort

39. The nurse teaches a pregnant woman to avoid lying on her back. The nurse has based this statement on the knowledge that the supine position can:

A. Unduly prolong labor
B. Cause decreased placental perfusion
C. Lead to transient episodes of hypotension
D. Interfere with free movement of the coccyx

40. The pituitary hormone that stimulates the secretion of milk from the mammary glands is:

A. Prolactin
B. Oxytocin
C. Estrogen
D. Progesterone

41. Which of the following symptoms occurs with a hydatidiform mole?

A. Heavy, bright red bleeding every 21 days
B. Fetal cardiac motion after 6 weeks gestation
C. Benign tumors found in the smooth muscle of the uterus
D. "Snowstorm" pattern on ultrasound with no fetus or gestational sac

42. Which of the following terms applies to the tiny, blanched, slightly raised end arterioles found on the face, neck, arms, and chest during pregnancy?

A. Epulis
B. Linea nigra
C. Striae gravidarum
D. Telangiectasias

43. Which of the following conditions is common in pregnant women in the 2nd trimester of pregnancy?

A. Mastitis
B. Metabolic alkalosis
C. Physiologic anemia
D. Respiratory acidosis

44. A 21-year old client, 6 weeks' pregnant is diagnosed with hyperemesis gravidarum. This excessive vomiting during pregnancy will often result in which of the following conditions?

A. Bowel perforation
B. Electrolyte imbalance
C. Miscarriage
D. Pregnancy induced hypertension (PIH)

45. Clients with gestational diabetes are usually managed by which of the following therapies?

A. Diet
B. NPH insulin (long-acting)
C. Oral hypoglycemic drugs
D. Oral hypoglycemic drugs and insulin

46. The antagonist for magnesium sulfate should be readily available to any client receiving IV magnesium. Which of the following drugs is the antidote for magnesium toxicity?

A. Calcium gluconate
B. Hydralazine (Apresoline)
C. Narcan
D. RhoGAM

47. Which of the following answers best describes the stage of pregnancy in which maternal and fetal blood are exchanged?

A. Conception
B. 9 weeks' gestation, when the fetal heart is well developed
C. 32-34 weeks gestation
D. maternal and fetal blood are never exchanged

48. Gravida refers to which of the following descriptions?

A. A serious pregnancy
B. Number of times a female has been pregnant
C. Number of children a female has delivered
D. Number of term pregnancies a female has had.

49. A pregnant woman at 32 weeks' gestation complains of feeling dizzy and lightheaded while her fundal height is being measured. Her skin is pale and moist. The nurse's initial response would be to:

A. Assess the woman's blood pressure and pulse
B. Have the woman breathe into a paper bag
C. Raise the woman's legs
D. Turn the woman on her side.

50. A pregnant woman's last menstrual period began on April 8, 2005, and ended on April 13. Using Naegele's rule her estimated date of birth would be:

A. January 15, 2006
B. January 20, 2006
C. July 1, 2006
D. November 5, 2005

Answers and Rationale

1. Answer: A. FSH and LH are released from the anterior pituitary gland.

FSH and LH, when stimulated by gonadotropin-releasing hormone from the hypothalamus, are released from the anterior pituitary gland to stimulate follicular growth and development, growth of the graafian follicle, and production of progesterone.

2. Answer: B. Two umbilical arteries and one umbilical vein.

Blood pumped by the embryo's heart leaves the embryo through two umbilical arteries. Once oxygenated, the blood then is returned by one umbilical vein. Arteries carry deoxygenated blood and waste products from the fetus, and veins carry oxygenated blood and provide oxygen and nutrients to the fetus.

3. Answer: C. 150 BPM.

The fetal heart rate depends in gestational age and ranges from 160-170 BPM in the first trimester but slows with fetal growth to 120-160 BPM near or at term. At or near term, if the fetal heart rate is less than 120 or more than 160 BPM with the uterus at rest, the fetus may be in distress.

4. Answer: C. June 26, 2014.

Accurate use of Naegele's rule requires that the woman have a regular 28-day menstrual cycle. Add 7 days to the first day of the last menstrual period, subtract three months, and then add one year to that date.

5. Answer: B. G = 2, T = 0, P = 1, A = 0, L =1.

Pregnancy outcomes can be described with the acronym GTPAL.

- "G" is Gravidity, the number of pregnancies.
- "T" is term births, the number of born at term (38 to 41 weeks).
- "P" is preterm births, the number born before 38 weeks gestation.
- "A" is abortions or miscarriages, included in "G" if before 20 weeks gestation, included in parity if past 20 weeks AOE.
- "L" is live births, the number of births of living children.

Therefore, a woman who is pregnant with twins and has a child has a gravida of 2. Because the child was delivered at 37 weeks, the number of preterm births is 1, and the number of term births is 0. The number of abortions is 0, and the number of live births is 1.

6. Answer: B. Fetal heart rate of 180 BPM.

The normal range of the fetal heart rate depends on gestational age. The heart rate is usually 160-170 BPM in the first trimester and slows with fetal growth, near and at term, the fetal heart rate ranges from 120-160 BPM. The other options are expected.

7. Answer: A. A softening of the cervix.

In the early weeks of pregnancy the cervix becomes softer as a result of increased vascularity and hyperplasia, which causes the Goodell's sign.

8. Answer: C. "It is the fetal movement that is felt by the mother."

Quickening is fetal movement and may occur as early as the 16th and 18th week of gestation, and the mother first notices subtle fetal movements that gradually increase in intensity. Braxton Hicks contractions are irregular, painless contractions that may occur throughout the pregnancy. A thinning of the lower uterine segment occurs about the 6th week of pregnancy and is called Hegar's sign.

9. Answer: D. Initiating a gentle upward tap on the cervix.

Ballottement is a technique of palpating a floating structure by bouncing it gently and feeling it rebound. In the technique used to palpate the fetus, the examiner places a finger in the vagina and taps gently upward, causing the fetus to rise. The fetus then sinks, and the examiner feels a gentle tap on the finger.

10. Answers: A, D, E, and F.

The **probable** signs of pregnancy include:

- Uterine Enlargement
- Hegar's sign or softening and thinning of the uterine segment that occurs at week 6.
- Goodell's sign or softening of the cervix that occurs at the beginning of the 2nd month
- Chadwick's sign or bluish coloration of the mucous membranes of the cervix, vagina and vulva. Occurs at week 6.
- Ballottement or rebounding of the fetus against the examiner's fingers of palpation
- Braxton-Hicks contractions
- Positive pregnancy test measuring for hCG.

Positive signs of pregnancy include:

- Fetal Heart Rate detected by electronic device (doppler) at 10-12 weeks
- Fetal Heart rate detected by nonelectronic device (fetoscope) at 20 weeks AOG
- Active fetal movement palpable by the examiners
- Outline of the fetus via radiography or ultrasound

11. Answer: A. Dorsiflex the foot while extending the knee when the cramps occur.

Legs cramps occur when the pregnant woman stretches the leg and plantar flexes the foot. Dorsiflexion of the foot while extending the knee stretches the affected muscle, prevents the muscle from contracting, and stops the cramping.

12. Answer: D. Wash the breasts with warm water and keep them dry.

The pregnant woman should be instructed to wash the breasts with warm water and keep them dry. The woman should be instructed to avoid using soap on the nipples and areola area to prevent the drying of tissues. Wearing a supportive bra with wide adjustable straps can decrease breast tenderness. Tight-fitting blouses or dresses will cause discomfort.

13. Answer: A. Any bleeding, such as in the gums, petechiae, and purpura.

Severe Preeclampsia can trigger disseminated intravascular coagulation because of the widespread damage to vascular integrity. Bleeding is an early sign of DIC and should be reported to the M.D.

14. Answer: A. "I will maintain strict bedrest throughout the remainder of pregnancy."

Strict bed rest throughout the remainder of pregnancy is not required. The woman is advised to curtail sexual activities until the bleeding has ceased, and for 2 weeks following the last evidence of bleeding or as recommended by the physician. The woman is instructed to count the number of perineal pads used daily and to note the quantity and color of blood on the pad. The woman also should watch for the evidence of the passage of tissue.

15. Answer: C. "I need to drink unpasteurized milk only."

All pregnant women should be advised to do the following to prevent the development of toxoplasmosis. Women should be instructed to cook meats thoroughly, avoid touching mucous membranes and eyes while handling raw meat; thoroughly wash all kitchen surfaces that come into contact with uncooked meat, wash the hands thoroughly after handling raw meat; avoid uncooked eggs and unpasteurized milk; wash fruits and vegetables before consumption, and avoid contact with materials that possibly are contaminated with cat feces, such as cat litter boxes, sandboxes, and garden soil.

16. Answer: C. The client complains of a headache and blurred vision.

If the client complains of a headache and blurred vision, the physician should be notified because these are signs of worsening Preeclampsia.

17. Answer: C. "I need to avoid exercise because of the negative effects of insulin production."

Exercise is safe for the client with gestational diabetes and is helpful in lowering the blood glucose level.

18. Answer: C. Respiratory rate of 10 BPM.

Magnesium sulfate depresses the respiratory rate. If the respiratory rate is less than 12 breaths per minute, the physician or other health care provider needs to be notified, and continuation of the medication needs to be reassessed. A urinary output of 20 ml in a 30 minute period is adequate; less than 30 ml in one hour needs to be reported. Deep tendon reflexes of 2+ are normal. The fetal heart rate is WNL for a resting fetus.

19. Answer: C. Clean and maintain an open airway.

The immediate care during a seizure (eclampsia) is to ensure a patent airway. The other options are actions that follow or will be implemented after the seizure has ceased.

20. Answers: A. Elevated blood pressure and 3 Facial edema.

The three classic signs of preeclampsia are hypertension, generalized edema, and proteinuria. Increased respirations are not a sign of preeclampsia.

21. Answer: A. Being affected by Rh incompatibility.

Rh incompatibility can occur when an Rh-negative mom becomes sensitized to the Rh antigen. Sensitization may develop when an Rh-negative woman becomes pregnant with a fetus who is Rh positive. During pregnancy and at delivery, some of the baby's Rh positive blood can enter the maternal circulation, causing the woman's immune system to form antibodies against Rh positive blood. Administration of Rho(D) immune globulin prevents the woman from developing antibodies against Rh positive blood by providing passive antibody protection against the Rh antigen.

22. Answer: D. Respirations of 10 per minute.

Magnesium toxicity can occur from magnesium sulfate therapy. Signs of toxicity relate to the central nervous system depressant effects of the medication and include respiratory depression, loss of deep tendon reflexes, and a sudden drop in the fetal heart rate and maternal heart rate and blood pressure. Therapeutic levels of magnesium are 4-7 mEq/L. Proteinuria of +3 would be noted in a client with preeclampsia.

23. Answer: C. Seizures do not occur.

For a client with preeclampsia, the goal of care is directed at preventing eclampsia (seizures). Magnesium sulfate is an anticonvulsant, not an antihypertensive agent. Although a decrease in blood pressure may be noted initially, this effect is usually transient. Ankle clonus indicated hyperreflexia and may precede the onset of eclampsia. Scotomas are areas of complete or partial blindness. Visual disturbances, such as scotomas, often precede an eclamptic seizure.

24. Answers: C, D, E, F, and G.

When caring for a client receiving magnesium sulfate therapy, the nurse would monitor maternal vital signs, especially respirations, every 30-60 minutes and notify the physician if respirations are less than 12, because this would indicate respiratory depression. Calcium gluconate is kept on hand in case of magnesium sulfate overdose, because calcium gluconate is the antidote for magnesium sulfate toxicity. Deep tendon reflexes are assessed hourly. Cardiac and renal function is monitored closely. The urine output should be maintained at 30 ml per hour because the medication is eliminated through the kidneys.

25. Answer: A. Administer RhoGAM within 72 hours.

RhoGAM is given within 72 hours postpartum if the client has not been sensitized already.

26. Answer: B. Blood level of LH is too high.

It is the surge of LH secretion in mid cycle that is responsible for ovulation.

27. Answer: C. Preparation of the uterus to receive a fertilized egg.

Progesterone stimulates differentiation of the endometrium into a secretory type of tissue.

28. Answer: B. Eighth week to the time of birth.

In the first 7-14 days the ovum is known as a blastocyst; it is called an embryo until the eighth week; the developing cells are then called a fetus until birth.

29. Answer: A. Placenta.

When placental formation is complete, around the 16th week of pregnancy; it producesestrogen and progesterone.

30. Answer: C. An increase in blood volume.

The blood volume increases by approximately 40-50% during pregnancy. The peak blood volume occurs between 30 and 34 weeks of gestation. The hematocrit decreases as a result of the increased blood volume.

31. Answer: D. Chadwick's sign.

A purplish color results from the increased vascularity and blood vessel engorgement of the vagina.

32. Answer: C. G5 T2 P1 A1 L4.

5 pregnancies; 2 term births; twins count as 1; one abortion; 4 living children.

33. Answer: D. Shortness of breath on exertion.

This is an expected cardiopulmonary adaptation during pregnancy; it is caused by an increased ventricular rate and elevated diaphragm.

34. Answer: B. An increase of 300 calories a day.

This is the recommended caloric increase for adult women to meet the increased metabolic demands of pregnancy.

35. Answer: A. Acute hemolytic disease.

When an Rh negative mother carries an Rh positive fetus there is a risk for maternal antibodies against Rh positive blood; antibodies cross the placenta and destroy the fetal RBC's.

36. Answer: B. Production of estrogen.

The increase of estrogen during pregnancy causes hyperplasia of the vaginal mucosa, which leads to increased production of mucus by the endocervical glands. The mucus contains exfoliated epithelial cells.

37. Answer: C. Neural tube defects.

The alpha-fetoprotein test detects neural tube defects and Down syndrome.

38. Answer: B. Walk around until they subside.

Ambulation relieves Braxton Hicks.

39. Answer: B. Cause decreased placental perfusion.

This is because impedance of venous return by the gravid uterus, which causes hypotension and decreased systemic perfusion.

40. Answer: A. Prolactin.

Prolactin is the hormone from the anterior pituitary gland that stimulates mammary gland secretion. Oxytocin, a posterior pituitary hormone, stimulates the uterine musculature to contract and causes the "let down" reflex.

41. Answer: D. "Snowstorm" pattern on ultrasound with no fetus or gestational sac.

The chorionic villi of a molar pregnancy resemble a snowstorm pattern on ultrasound. Bleeding with a hydatidiform mole is often dark brown and may occur erratically for weeks or months.

42. Answer: D. Telangiectasias.

The dilated arterioles that occur during pregnancy are due to the elevated level of circulating estrogen. The linea nigra is a pigmented line extending from the symphysis pubis to the top of the fundus during pregnancy.

43. Answer: C. Physiologic anemia.

Hemoglobin and hematocrit levels decrease during pregnancy as the increase in plasma volume exceeds the increase in red blood cell production.

44. Answer: B. Electrolyte imbalance.

Excessive vomiting in clients with hyperemesis gravidarum often causes weight loss and fluid, electrolyte, and acid-base imbalances.

45. Answer: A. Diet.

Clients with gestational diabetes are usually managed by diet alone to control their glucose intolerance. Oral hypoglycemic agents are contraindicated in pregnancy. NPH isn't usually needed for blood glucose control for GDM.

46. Answer: A. Calcium gluconate.

Calcium gluconate is the antidote for magnesium toxicity. Ten ml of 10% calcium gluconate is given IV push over 3-5 minutes. Hydralazine is given for sustained elevated blood pressures in preeclamptic clients.

47. Answer: D. maternal and fetal blood are never exchanged.

Only nutrients and waste products are transferred across the placenta. Blood exchange only occurs in complications and some medical procedures accidentally.

48. Answer: B. Number of times a female has been pregnant.

Gravida refers to the number of times a female has been pregnant, regardless of pregnancy outcome or the number of neonates delivered.

49. Answer: D. Turn the woman on her side.

During a fundal height measurement the woman is placed in a supine position. This woman is experiencing supine hypotension as a result of uterine compression of the vena cava and abdominal aorta. Turning her on her side will remove the compression and restore cardiac output and blood pressure. Then vital signs can be assessed. Raising her legs will not solve the problem since pressure will still remain on the major abdominal blood vessels, thereby continuing to impede cardiac output. Breathing into a paper bag is the solution for dizziness related to respiratory alkalosis associated with hyperventilation.

50. Answer: A. January 15, 2006.

Naegele's rule requires subtracting 3 months and adding 7 days and 1 year if appropriate to the first day of a pregnant woman's last menstrual period. When this rule, is used with April 8, 2005, the estimated date of birth is January 15, 2006. 50 Qns Antepartum

XVII (17)

1. A nurse is caring for a client in labor. The nurse determines that the client is beginning in the 2nd stage of labor when which of the following assessments is noted?

A. The client begins to expel clear vaginal fluid
B. The contractions are regular
C. The membranes have ruptured
D. The cervix is dilated completely

2. A nurse in the labor room is caring for a client in the active phases of labor. The nurse is assessing the fetal patterns and notes a late deceleration on the monitor strip. The most appropriate nursing action is to:

A. Place the mother in the supine position
B. Document the findings and continue to monitor the fetal patterns
C. Administer oxygen via face mask
D. Increase the rate of pitocin IV infusion

3. A nurse is performing an assessment of a client who is scheduled for a cesareandelivery. Which assessment finding would indicate a need to contact the physician?

A. Fetal heart rate of 180 beats per minute
B. White blood cell count of 12,000
C. Maternal pulse rate of 85 beats per minute
D. Hemoglobin of 11.0 g/dL

4. A client in labor is transported to the delivery room and is prepared for a cesarean delivery. The client is transferred to the delivery room table, and the nurse places the client in the:

A. Trendelenburg's position with the legs in stirrups
B. Semi-Fowler position with a pillow under the knees
C. Prone position with the legs separated and elevated
D. Supine position with a wedge under the right hip

5. A nurse is caring for a client in labor and prepares to auscultate the fetal heart rate by using a Doppler ultrasound device. The nurse most accurately determines that the fetal heart sounds are heard by:

A. Noting if the heart rate is greater than 140 BPM
B. Placing the diaphragm of the Doppler on the mother abdomen
C. Performing Leopold's maneuvers first to determine the location of the fetal heart
D. Palpating the maternal radial pulse while listening to the fetal heart rate

6. A nurse is caring for a client in labor who is receiving Pitocin by IV infusion to stimulate uterine contractions. Which assessment finding would indicate to the nurse that the infusion needs to be discontinued?

A. Three contractions occurring within a 10-minute period
B. A fetal heart rate of 90 beats per minute
C. Adequate resting tone of the uterus palpated between contractions
D. Increased urinary output

7. A nurse is beginning to care for a client in labor. The physician has prescribed an IV infusion of Pitocin. The nurse ensures that which of the following is implemented before initiating the infusion?

A. Placing the client on complete bed rest
B. Continuous electronic fetal monitoring
C. An IV infusion of antibiotics
D. Placing a code cart at the client's bedside

8. A nurse is monitoring a client in active labor and notes that the client is having contractions every 3 minutes that last 45 seconds. The nurse notes that the fetal heart rate between contractions is 100 BPM. Which of the following nursing actions is most appropriate?

A. Encourage the client's coach to continue to encourage breathing exercises
B. Encourage the client to continue pushing with each contraction
C. Continue monitoring the fetal heart rate
D. Notify the physician or nurse midwife

9. A nurse is caring for a client in labor and is monitoring the fetal heart rate patterns. The nurse notes the presence of episodic accelerations on the electronic fetal monitor tracing. Which of the following actions is most appropriate?

A. Document the findings and tell the mother that the monitor indicates fetal well-being
B. Take the mother's vital signs and tell the mother that bed rest is required to conserve oxygen.
C. Notify the physician or nurse midwife of the findings.
D. Reposition the mother and check the monitor for changes in the fetal tracing

10. A nurse is admitting a pregnant client to the labor room and attaches an external electronic fetal monitor to the client's abdomen. After attachment of the monitor, the initial nursing assessment is which of the following?

A. Identifying the types of accelerations
B. Assessing the baseline fetal heart rate
C. Determining the frequency of the contractions
D. Determining the intensity of the contractions

11. A nurse is reviewing the record of a client in the labor room and notes that the nurse midwife has documented that the fetus is at (-1) station. The nurse determines that the fetal presenting part is:

A. 1 cm above the ischial spine
B. 1 fingerbreadth below the symphysis pubis
C. 1 inch below the coccyx
D. 1 inch below the iliac crest

12. A pregnant client is admitted to the labor room. An assessment is performed, and the nurse notes that the client's hemoglobin and hematocrit levels are low, indicating anemia. The nurse determines that the client is at risk for which of the following?

A. A loud mouth
B. Low self-esteem
C. Hemorrhage
D. Postpartum infections

13. A nurse assists in the vaginal delivery of a newborn infant. After the delivery, the nurse observes the umbilical cord lengthen and a spurt of blood from the vagina. The nurse documents these observations as signs of:

A. Hematoma
B. Placenta previa

C. Uterine atony
D. Placental separation

14. A client arrives at a birthing center in active labor. Her membranes are still intact, and the nurse-midwife prepares to perform an amniotomy. A nurse who is assisting the nurse-midwife explains to the client that after this procedure, she will most likely have:

A. Less pressure on her cervix
B. Increased efficiency of contractions
C. Decreased number of contractions
D. The need for increased maternal blood pressure monitoring

15. A nurse is monitoring a client in labor. The nurse suspects umbilical cord compression if which of the following is noted on the external monitor tracing during a contraction?

A. Early decelerations
B. Variable decelerations
C. Late decelerations
D. Short-term variability

16. A nurse explains the purpose of effleurage to a client in early labor. The nurse tells the client that effleurage is:

A. A form of biofeedback to enhance bearing down efforts during delivery
B. Light stroking of the abdomen to facilitate relaxation during labor and provide tactile stimulation to the fetus
C. The application of pressure to the sacrum to relieve a backache
D. Performed to stimulate uterine activity by contracting a specific muscle group while other parts of the body rest

17. A nurse is caring for a client in the second stage of labor. The client is experiencing uterine contractions every 2 minutes and cries out in pain with each contraction. The nurse recognizes this behavior as:

A. Exhaustion
B. Fear of losing control
C. Involuntary grunting
D. Valsalva's maneuver

18. A nurse is monitoring a client in labor who is receiving Pitocin and notes that the client is experiencing hypertonic uterine contractions. List in order of priority the actions that the nurse takes.

A. Stop of Pitocin infusion
B. Perform a vaginal examination
C. Reposition the client

D. Check the client's blood pressure and heart rate
E. Administer oxygen by face mask at 8 to 10 L/min

19. A nurse is assigned to care for a client with hypotonic uterine dysfunction and signs of a slowing labor. The nurse is reviewing the physician's orders and would expect to note which of the following prescribed treatments for this condition?

A. Medication that will provide sedation
B. Increased hydration
C. Oxytocin (Pitocin) infusion
D. Administration of a tocolytic medication

20. A nurse in the labor room is preparing to care for a client with hypertonic uterine dysfunction. The nurse is told that the client is experiencing uncoordinated contractions that are erratic in their frequency, duration, and intensity. The priority nursing intervention would be to:

A. Monitor the Pitocin infusion closely
B. Provide pain relief measures
C. Prepare the client for an amniotomy
D. Promote ambulation every 30 minutes

21. A nurse is developing a plan of care for a client experiencing dystocia and includes several nursing interventions in the plan of care. The nurse prioritizes the plan of care and selects which of the following nursing interventions as the highest priority?

A. Keeping the significant other informed of the progress of the labor
B. Providing comfort measures
C. Monitoring fetal heart rate
D. Changing the client's position frequently

22. A maternity nurse is preparing to care for a pregnant client in labor who will be delivering twins. The nurse monitors the fetal heart rates by placing the external fetal monitor:

A. Over the fetus that is most anterior to the mother's abdomen
B. Over the fetus that is most posterior to the mother's abdomen
C. So that each fetal heart rate is monitored separately
D. So that one fetus is monitored for a 15-minute period followed by a 15 minute fetal monitoring period for the second fetus

23. A nurse in the postpartum unit is caring for a client who has just delivered a newborn infant following a pregnancy with placenta previa. The nurse reviews the plan of care and prepares to monitor the client for which of the following risks associated with placenta previa?

A. Disseminated intravascular coagulation
B. Chronic hypertension

C. Infection
D. Hemorrhage

24. A nurse in the delivery room is assisting with the delivery of a newborn infant. After the delivery of the newborn, the nurse assists in delivering the placenta. Which observation would indicate that the placenta has separated from the uterine wall and is ready for delivery?

A. The umbilical cord shortens in length and changes in color
B. A soft and boggy uterus
C. Maternal complaints of severe uterine cramping
D. Changes in the shape of the uterus

25. A nurse in the labor room is performing a vaginal assessment on a pregnant client in labor. The nurse notes the presence of the umbilical cord protruding from the vagina. Which of the following would be the initial nursing action?

A. Place the client in Trendelenburg's position
B. Call the delivery room to notify the staff that the client will be transported immediately
C. Gently push the cord into the vagina
D. Find the closest telephone and stat page the physician

26. A maternity nurse is caring for a client with abruptio placenta and is monitoring the client for disseminated intravascular coagulopathy. Which assessment finding is least likely to be associated with disseminated intravascular coagulation?

A. Swelling of the calf in one leg
B. Prolonged clotting times
C. Decreased platelet count
D. Petechiae, oozing from injection sites, and hematuria

27. A nurse is assessing a pregnant client in the 2nd trimester of pregnancy who was admitted to the maternity unit with a suspected diagnosis of abruptio placentae. Which of the following assessment findings would the nurse expect to note if this condition is present?

A. Absence of abdominal pain
B. A soft abdomen
C. Uterine tenderness/pain
D. Painless, bright red vaginal bleeding

28. A maternity nurse is preparing for the admission of a client in the 3rd trimester of pregnancy that is experiencing vaginal bleeding and has a suspected diagnosis of placenta previa. The nurse reviews the physician's orders and would question which order?

A. Prepare the client for an ultrasound
B. Obtain equipment for external electronic fetal heart monitoring

C. Obtain equipment for a manual pelvic examination
D. Prepare to draw a Hgb and Hct blood sample

29. An ultrasound is performed on a client at term gestation that is experiencing moderate vaginal bleeding. The results of the ultrasound indicate that an abruptioplacenta is present. Based on these findings, the nurse would prepare the client for:

A. Complete bed rest for the remainder of the pregnancy
B. Delivery of the fetus
C. Strict monitoring of intake and output
D. The need for weekly monitoring of coagulation studies until the time of delivery

30. A nurse in a labor room is assisting with the vaginal delivery of a newborn infant. The nurse would monitor the client closely for the risk of uterine rupture if which of the following occurred?

A. Hypotonic contractions
B. Forceps delivery
C. Schultz delivery
D. Weak bearing down efforts

31. A client is admitted to the birthing suite in early active labor. The priority nursing intervention on admission of this client would be:

A. Auscultating the fetal heart
B. Taking an obstetric history
C. Asking the client when she last ate
D. Ascertaining whether the membranes were ruptured

32. A client who is gravida 1, para 0 is admitted in labor. Her cervix is 100% effaced, and she is dilated to 3 cm. Her fetus is at +1 station. The nurse is aware that the fetus' head is:

A. Not yet engaged
B. Entering the pelvic inlet
C. Below the ischial spines
D. Visible at the vaginal opening

33. After doing Leopold's maneuvers, the nurse determines that the fetus is in the ROP position. To best auscultate the fetal heart tones, the Doppler is placed:

A. Above the umbilicus at the midline
B. Above the umbilicus on the left side
C. Below the umbilicus on the right side
D. Below the umbilicus near the left groin

34. The physician asks the nurse the frequency of a laboring client's contractions. The nurse assesses the client's contractions by timing from the beginning of one contraction:

A. Until the time it is completely over
B. To the end of a second contraction
C. To the beginning of the next contraction
D. Until the time that the uterus becomes very firm

35. The nurse observes the client's amniotic fluid and decides that it appears normal, because it is:

A. Clear and dark amber in color
B. Milky, greenish yellow, containing shreds of mucus
C. Clear, almost colorless, and containing little white specks
D. Cloudy, greenish-yellow, and containing little white specks

36. At 38 weeks gestation, a client is having late decelerations. The fetal pulse oximeter shows 75% to 85%. The nurse should:

A. Discontinue the catheter, if the reading is not above 80%
B. Discontinue the catheter, if the reading does not go below 30%
C. Advance the catheter until the reading is above 90% and continue monitoring
D. Reposition the catheter, recheck the reading, and if it is 55%, keep monitoring

37. When examining the fetal monitor strip after rupture of the membranes in a laboring client, the nurse notes variable decelerations in the fetal heart rate. The nurse should:
A. Stop the oxytocin infusion
B. Change the client's position
C. Prepare for immediate delivery
D. Take the client's blood pressure
38. When monitoring the fetal heart rate of a client in labor, the nurse identifies an elevation of 15 beats above the baseline rate of 135 beats per minute lasting for 15 seconds. This should be documented as:
A. An acceleration
B. An early elevation
C. A sonographic motion
D. A tachycardic heart rate
39. A laboring client complains of low back pain. The nurse replies that this pain occurs most when the position of the fetus is:
A. Breech
B. Transverse
C. Occiput anterior
D. Occiput posterior
40. The breathing technique that the mother should be instructed to use as the fetus' head is crowning is:
A. Blowing
B. Slow chest
C. Shallow
D. Accelerated-decelerated

41. During the period of induction of labor, a client should be observed carefully for signs of:

A. Severe pain
B. Uterine tetany
C. Hypoglycemia
D. Umbilical cord prolapse

42. A client arrives at the hospital in the second stage of labor. The fetus' head is crowning, the client is bearing down, and the birth appears imminent. The nurse should:

A. Transfer her immediately by stretcher to the birthing unit
B. Tell her to breathe through her mouth and not to bear down
C. Instruct the client to pant during contractions and to breathe through her mouth
D. Support the perineum with the hand to prevent tearing and tell the client to pant

43. A laboring client is to have a pudendal block. The nurse plans to tell the client that once the block is working she:

A. Will not feel the episiotomy
B. May lose bladder sensation
C. May lose the ability to push
D. Will no longer feel contractions

44. Which of the following observations indicates fetal distress?

A. Fetal scalp pH of 7.14
B. Fetal heart rate of 144 beats/minute
C. Acceleration of fetal heart rate with contractions
D. Presence of long term variability

45. Which of the following fetal positions is most favorable for birth?

A. Vertex presentation
B. Transverse lie
C. Frank breech presentation
D. Posterior position of the fetal head

46. A laboring client has external electronic fetal monitoring in place. Which of the following assessment data can be determined by examining the fetal heart rate strip produced by the external electronic fetal monitor?

A. Gender of the fetus
B. Fetal position
C. Labor progress
D. Oxygenation

47. A laboring client is in the first stage of labor and has progressed from 4 to 7 cm in cervical dilation. In which of the following phases of the first stage does cervical dilation occur most rapidly?

A. Preparatory phase
B. Latent phase
C. Active phase
D. Transition phase

48. A multiparous client who has been in labor for 2 hours states that she feels the urge to move her bowels. How should the nurse respond?

A. Let the client get up to use the potty
B. Allow the client to use a bedpan
C. Perform a pelvic examination
D. Check the fetal heart rate

49. Labor is a series of events affected by the coordination of the five essential factors. One of these is the passenger (fetus). Which are the other four factors?

A. Contractions, passageway, placental position and function, pattern of care
B. Contractions, maternal response, placental position, psychological response
C. Passageway, contractions, placental position and function, psychological response
D. Passageway, placental position and function, paternal response, psychological response

50. Fetal presentation refers to which of the following descriptions?

A. Fetal body part that enters the maternal pelvis first
B. Relationship of the presenting part to the maternal pelvis
C. Relationship of the long axis of the fetus to the long axis of the mother
D. A classification according to the fetal part

51. A client is admitted to the L & D suite at 36 weeks' gestation. She has a history of C-section and complains of severe abdominal pain that started less than 1 hour earlier. When the nurse palpates tetanic contractions, the client again complains of severe pain. After the client vomits, she states that the pain is better and then passes out. Which is the probable cause of her signs and symptoms?

A. Hysteria compounded by the flu
B. Placental abruption
C. Uterine rupture
D. Dysfunctional labor

52. Upon completion of a vaginal examination on a laboring woman, the nurse records: 50%, 6 cm, -1. Which of the following is a correct interpretation of the data?

A. Fetal presenting part is 1 cm above the ischial spines
B. Effacement is 4 cm from completion
C. Dilation is 50% completed
D. Fetus has achieved passage through the ischial spines

53. Which of the following findings meets the criteria of a reassuring FHR pattern?

A. FHR does not change as a result of fetal activity
B. Average baseline rate ranges between 100 – 140 BPM
C. Mild late deceleration patterns occur with some contractions
D. Variability averages between 6 – 10 BPM

54. Late deceleration patterns are noted when assessing the monitor tracing of a woman whose labor is being induced with an infusion of Pitocin. The woman is in a side-lying position, and her vital signs are stable and fall within a normal range. Contractions are intense, last 90 seconds, and occur every 1 1/2 to 2 minutes. The nurse's immediate action would be to:

A. Change the woman's position
B. Stop the Pitocin
C. Elevate the woman's legs
D. Administer oxygen via a tight mask at 8 to 10 liters/minute

55. The nurse should realize that the most common and potentially harmful maternal complication of epidural anesthesia would be:

A. Severe postpartum headache
B. Limited perception of bladder fullness
C. Increase in respiratory rate
D. Hypotension

56. Perineal care is an important infection control measure. When evaluating a postpartum woman's perineal care technique, the nurse would recognize the need for further instruction if the woman:

A. Uses soap and warm water to wash the vulva and perineum
B. Washes from symphysis pubis back to episiotomy
C. Changes her perineal pad every 2 – 3 hours
D. Uses the peribottle to rinse upward into her vagina

57. Which measure would be least effective in preventing postpartum hemorrhage?

A. Administer Methergine 0.2 mg every 6 hours for 4 doses as ordered
B. Encourage the woman to void every 2 hours

C. Massage the fundus every hour for the first 24 hours following birth
D. Teach the woman the importance of rest and nutrition to enhance healing

58. When making a visit to the home of a postpartum woman one week after birth, the nurse should recognize that the woman would characteristically:

A. Express a strong need to review events and her behavior during the process of laborand birth
B. Exhibit a reduced attention span, limiting readiness to learn
C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn
D. Have reestablished her role as a spouse/partner

59. Four hours after a difficult labor and birth, a primiparous woman refuses to feed her baby, stating that she is too tired and just wants to sleep. The nurse should:

A. Tell the woman she can rest after she feeds her baby
B. Recognize this as a behavior of the taking-hold stage
C. Record the behavior as ineffective maternal-newborn attachment
D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time

60. Parents can facilitate the adjustment of their other children to a new baby by:

A. Having the children choose or make a gift to give to the new baby upon its arrival home
B. Emphasizing activities that keep the new baby and other children together
C. Having the mother carry the new baby into the home so she can show the other children the new baby
D. Reducing stress on other children by limiting their involvement in the care of the new baby

Answers and Rationale

1. Answer: D. The cervix is dilated completely.

The second stage of labor begins when the cervix is dilated completely and ends with the birth of the neonate.

2. Answer: C. Administer oxygen via face mask.

Late decelerations are due to uteroplacental insufficiency as the result of decreased blood flow and oxygen to the fetus during the uterine contractions. This causes hypoxemia; therefore oxygen is necessary. The supine position is avoided because it decreases uterine blood flow to the fetus. The client should be turned to her side to displace pressure of the gravid uterus on the inferior vena cava. An intravenous pitocin infusion is discontinued when a late deceleration is noted.

3. Answer: A. Fetal heart rate of 180 beats per minute.

A normal fetal heart rate is 120-160 beats per minute. A count of 180 beats per minute could indicate fetal distress and would warrant physician notification. By full term, a normal maternal hemoglobin range is 11-13 g/dL as a result of the hemodilution caused by an increase in plasma volume during pregnancy.

4. Answer: D. Supine position with a wedge under the right hip. Vena cava and descending aorta compression by the pregnant uterus impedes blood return from the lower trunk and extremities. This leads to decreasing cardiac return, cardiac output, and blood flow to the uterus and the fetus. The best position to prevent this would be side-lying with the uterus displaced off of abdominal vessels. Positioning for abdominal surgery necessitates a supine position; however, a wedge placed under the right hip provides displacement of the uterus.

5. Answer: D. Palpating the maternal radial pulse while listening to the fetal heart rate.

The nurse simultaneously should palpate the maternal radial or carotid pulse and auscultate the fetal heart rate to differentiate the two. If the fetal and maternal heart rates are similar, the nurse may mistake the maternal heart rate for the fetal heart rate. Leopold's maneuvers may help the examiner locate the position of the fetus but will not ensure a distinction between the two rates.

6. Answer: B. A fetal heart rate of 90 beats per minute.

A normal fetal heart rate is 120-160 BPM. Bradycardia or late or variable decelerations indicate fetal distress and the need to discontinue to pitocin. The goal of laboraugmentation is to achieve three good-quality contractions in a 10-minute period.

7. Answer: B. Continuous electronic fetal monitoring.

Continuous electronic fetal monitoring should be implemented during an IV infusion of Pitocin.

8. Answer: D. Notify the physician or nurse midwife.

A normal fetal heart rate is 120-160 beats per minute. Fetal bradycardia between contractions may indicate the need for immediate medical management, and the physician or nurse midwife needs to be notified.

9. Answer: A. Document the findings and tell the mother that the monitor indicates fetal well-being.

Accelerations are transient increases in the fetal heart rate that often accompany contractions or are caused by fetal movement. Episodic accelerations are thought to be a sign of fetal-well being and adequate oxygen reserve.

10. Answer: B. Assessing the baseline fetal heart rate.

Assessing the baseline fetal heart rate is important so that abnormal variations of the baseline rate will be identified if they occur. Options 1 and 3 are important to assess, but not as the first priority.

11. Answer: A. 1 cm above the ischial spine.

Station is the relationship of the presenting part to an imaginary line drawn between the ischial spines, is measured in centimeters, and is noted as a negative number above the line and a positive number below the line. At -1 station, the fetal presenting part is 1 cm above the ischial spines.

12. Answer: D. Postpartum infections.

Anemic women have a greater likelihood of cardiac decompensation during labor, postpartum infection, and poor wound healing. Anemia does not specifically present a risk for hemorrhage.

13. Answer: D. Placental separation.

As the placenta separates, it settles downward into the lower uterine segment. The umbilical cord lengthens, and a sudden trickle or spurt of blood appears.

14. Answer: B. Increased efficiency of contractions.

Amniotomy can be used to induce labor when the condition of the cervix is favorable (ripe) or to augment labor if the process begins to slow. Rupturing of membranes allows the fetal head to contact the cervix more directly and may increase the efficiency of contractions.

15. Answer: B. Variable decelerations.

Variable decelerations occur if the umbilical cord becomes compressed, thus reducing blood flow between the placenta and the fetus. Early decelerations result from pressure on the fetal head during a contraction. Late decelerations are an ominous pattern in laborbecause it suggests uteroplacental insufficiency during a contraction. Short-term variability refers to the beat-to-beat range in the fetal heart rate.

16. Answer: B. Light stroking of the abdomen to facilitate relaxation during laborand provide tactile stimulation to the fetus.

Effleurage is a specific type of cutaneous stimulation involving light stroking of the abdomen and is used before transition to promote relaxation and relieve mild to moderate pain. Effleurage provides tactile stimulation to the fetus.

17. Answer: B. Fear of losing control.

Pains, helplessness, panicking, and fear of losing control are possible behaviors in the 2nd stage of labor.

18. Answer: A, D, B, E, C.

If uterine hypertonicity occurs, the nurse immediately would intervene to reduce uterine activity and increase fetal oxygenation. The nurse would stop the Pitocin infusion and increase the rate of the non additive solution, check maternal BP for hyper or hypotension, position the woman in a side-lying position, and administer oxygen by snug face mask at 8-10 L/min. The nurse then would attempt to determine the cause of the uterine hypertonicity and perform a vaginal exam to check for prolapsed cord.

19. Answer: C. Oxytocin (Pitocin) infusion.

Therapeutic management for hypotonic uterine dysfunction includes oxytocin augmentation and amniotomy to stimulate a labor that slows.

20. Answer: B. Provide pain relief measures.

Management of hypertonic labor depends on the cause. Relief of pain is the primary intervention to promote a normal labor pattern.

21. Answer: C. Monitoring fetal heart rate.

The priority is to monitor the fetal heart rate.

22. Answer: C. So that each fetal heart rate is monitored separately.

In a client with a multi-fetal pregnancy, each fetal heart rate is monitored separately.

23. Answer: D. Hemorrhage.

Because the placenta is implanted in the lower uterine segment, which does not contain the same intertwining musculature as the fundus of the uterus, this site is more prone to bleeding.

24. Answer: D. Changes in the shape of the uterus.

Signs of placental separation include lengthening of the umbilical cord, a sudden gush of dark blood from the introitus (vagina), a firmly contracted uterus, and the uterus changing from a discoid (like a disk) to a globular (like a globe) shape. The client may experience vaginal fullness, but not severe uterine cramping.

25. Answer: A. Place the client in Trendelenburg's position.

When cord prolapse occurs, prompt actions are taken to relieve cord compression and increase fetal oxygenation. The mother should be positioned with the hips higher than the head to shift the fetal presenting part toward the diaphragm. The nurse should push the call light to summon help, and other staff members should call the physician and notify thedelivery room. No attempt should be made to replace the cord. The examiner, however, may place a gloved hand into the vagina and hold the presenting part off of the umbilical cord. Oxygen at 8 to 10 L/min by face mask is delivered to the mother to increase fetal oxygenation.

26. Answer: A. Swelling of the calf in one leg.

DIC is a state of diffuse clotting in which clotting factors are consumed, leading to widespread bleeding. Platelets are decreased because they are consumed by the

process; coagulation studies show no clot formation (and are thus normal to prolonged); and fibrin plugs may clog the microvasculature diffusely, rather than in an isolated area. The presence of petechiae, oozing from injection sites, and hematuria are signs associated with DIC. Swelling and pain in the calf of one leg are more likely to be associated with thrombophlebitis.

27. Answer: C. Uterine tenderness/pain.

In abruptio placentae, acute abdominal pain is present. Uterine tenderness and pain accompanies placental abruption, especially with a central abruption and trapped blood behind the placenta. The abdomen will feel hard and boardlike on palpation as the blood penetrates the myometrium and causes uterine irritability. Observation of the fetal monitoring often reveals increased uterine resting tone, caused by failure of the uterus to relax in attempt to constrict blood vessels and control bleeding.

28. Answer: C. Obtain equipment for a manual pelvic examination.

Manual pelvic examinations are contraindicated when vaginal bleeding is apparent in the 3rd trimester until a diagnosis is made and placental previa is ruled out. Digital examination of the cervix can lead to maternal and fetal hemorrhage. A diagnosis ofplacenta previa is made by ultrasound. The H/H levels are monitored, and external electronic fetal heart rate monitoring is initiated. External fetal monitoring is crucial in evaluating the fetus that is at risk for severe hypoxia.

29. Answer: B. Delivery of the fetus.

The goal of management in abruptio placentae is to control the hemorrhage and deliver the fetus as soon as possible. Delivery is the treatment of choice if the fetus is at term gestation or if the bleeding is moderate to severe and the mother or fetus is in jeopardy.

30. Answer: B. Forceps delivery.

Excessive fundal pressure, forceps delivery, violent bearing down efforts, tumultuouslabor, and shoulder dystocia can place a woman at risk for traumatic uterine rupture. Hypotonic contractions and weak bearing down efforts do not alone add to the risk of rupture because they do not add to the stress on the uterine wall.

31. Answer: A. Auscultating the fetal heart.

Determining the fetal well-being supersedes all other measures. If the FHR is absent or persistently decelerating, immediate intervention is required.

32. Answer: C. Below the ischial spines.

A station of +1 indicates that the fetal head is 1 cm below the ischial spines.

33. Answer: C. Below the umbilicus on the right side.

Fetal heart tones are best auscultated through the fetal back; because the position is ROP (right occiput presenting), the back would be below the umbilicus and on the right side.

34. Answer: C. To the beginning of the next contraction.

This is the way to determine the frequency of the contractions

35. Answer: C. Clear, almost colorless, and containing little white specks.

By 36 weeks gestation, normal amniotic fluid is colorless with small particles of vernix caseosa present.

36. Answer: D. Reposition the catheter, recheck the reading, and if it is 55%, keep monitoring.

Adjusting the catheter would be indicated. Normal fetal pulse oximetry should be between 30% and 70%. 75% to 85% would indicate maternal readings.

37. Answer: 2. Change the client's position.

Variable decelerations usually are seen as a result of cord compression; a change of position will relieve pressure on the cord.

38. Answer: A. An acceleration.

An acceleration is an abrupt elevation above the baseline of 15 beats per minute for 15 seconds; if the acceleration persists for more than 10 minutes it is considered a change in baseline rate. A tachycardic FHR is above 160 beats per minute.

39. Answer: D. Occiput posterior.

A persistent occiput-posterior position causes intense back pain because of fetal compression of the sacral nerves. Occiput anterior is the most common fetal position and does not cause back pain.

40. Answer: A. Blowing.

Blowing forcefully through the mouth controls the strong urge to push and allows for a more controlled birth of the head.

41. Answer: B. Uterine tetany.

Uterine tetany could result from the use of oxytocin to induce labor. Because oxytocin promotes powerful uterine contractions, uterine tetany may occur. The oxytocin infusion must be stopped to prevent uterine rupture and fetal compromise.

42. Answer: D. Support the perineum with the hand to prevent tearing and tell the client to pant.

Gentle pressure is applied to the baby's head as it emerges so it is not born too rapidly. The head is never held back, and it should be supported as it emerges so there will be no vaginal lacerations. It is impossible to push and pant at the same time.

43. Answer: A. May lose the ability to push.

A pudendal block provides anesthesia to the perineum.

44. Answer: A. Fetal scalp pH of 7.14.

A fetal scalp pH below 7.25 indicates acidosis and fetal hypoxia.

45. Answer: A. Vertex presentation.

Vertex presentation (flexion of the fetal head) is the optimal presentation for passage through the birth canal. Transverse lie is an unacceptable fetal position for vaginal birth and requires a C-section. Frank breech presentation, in which the buttocks present first, can be a difficult vaginal delivery. Posterior positioning of the fetal head can make it difficult for the fetal head to pass under the maternal symphysis pubis.

46. Answer: D. Oxygenation.

Oxygenation of the fetus may be indirectly assessed through fetal monitoring by closely examining the fetal heart rate strip. Accelerations in the fetal heart rate strip indicate good oxygenation, while decelerations in the fetal heart rate sometimes indicate poor fetal oxygenation.

47. Answer: C. Active phase.

Cervical dilation occurs more rapidly during the active phase than any of the previous phases. The active phase is characterized by cervical dilation that progresses from 4 to 7 cm. The preparatory, or latent, phase begins with the onset of regular uterine contractions and ends when rapid cervical dilation begins. Transition is defined as cervical dilation beginning at 8 cm and lasting until 10 cm or complete dilation.

48. Answer: C. Perform a pelvic examination.

A complaint of rectal pressure usually indicates a low presenting fetal part, signaling imminent delivery. The nurse should perform a pelvic examination to assess the dilation of the cervix and station of the presenting fetal part.

49. Answer: C. Passageway, contractions, placental position and function, psychological response.

The five essential factors (5 P's) are passenger (fetus), passageway (pelvis), powers (contractions), placental position and function, and psyche (psychological response of the mother).

50. Answer: A. Fetal body part that enters the maternal pelvis first.

Presentation is the fetal body part that enters the pelvis first; it's classified by the presenting part; the three main presentations are cephalic/occipital, breech, and shoulder. The relationship of the presenting fetal part to the maternal pelvis refers to fetal position. The relationship of the long axis to the fetus to the long axis of the mother refers to fetal lie; the three possible lies are longitudinal, transverse, and oblique.

51. Answer: C. Uterine rupture.

Uterine rupture is a medical emergency that may occur before or during labor. Signs and symptoms typically include abdominal pain that may ease after uterine rupture, vomiting, vaginal bleeding, hypovolemic shock, and fetal distress. With placental

abruption, the client typically complains of vaginal bleeding and constant abdominal pain.

52. Answer: A. Fetal presenting part is 1 cm above the ischial spines.

Station of – 1 indicates that the fetal presenting part is above the ischial spines and has not yet passed through the pelvic inlet. A station of zero would indicate that the presenting part has passed through the inlet and is at the level of the ischial spines or is engaged. Passage through the ischial spines with internal rotation would be indicated by a plus station, such as + 1. Progress of effacement is referred to by percentages with 100% indicating full effacement and dilation by centimeters (cm) with 10 cm indicating full dilation.

53. Answer: D. Variability averages between 6 – 10 BPM.

Variability indicates a well oxygenated fetus with a functioning autonomic nervous system. FHR should accelerate with fetal movement. Baseline range for the FHR is 120 to 160 beats per minute. Late deceleration patterns are never reassuring, though early and mild variable decelerations are expected, reassuring findings.

54. Answer: B. Stop the Pitocin.

Late deceleration patterns noted are most likely related to alteration in uteroplacental perfusion associated with the strong contractions described. The immediate action would be to stop the Pitocin infusion since Pitocin is an oxytocic which stimulates the uterus to contract. The woman is already in an appropriate position for uteroplacental perfusion. Elevation of her legs would be appropriate if hypotension were present. Oxygen is appropriate but not the immediate action.

55. Answer: D. Hypotension.

Epidural anesthesia can lead to vasodilation and a drop in blood pressure that could interfere with adequate placental perfusion. The woman must be well hydrated before and during epidural anesthesia to prevent this problem and maintain an adequate blood pressure. Headache is not a side effect since the spinal fluid is not disturbed by this anesthetic as it would be with a low spinal (saddle block) anesthesia; Response B is an effect of epidural anesthesia but is not the most harmful. Respiratory depression is a potentially serious complication.

56. Answer: D. Uses the peri bottle to rinse upward into her vagina.

Responses A, B, and C are all appropriate measures. The peri bottle should be used in a backward direction over the perineum. The flow should never be directed upward into the vagina since debris would be forced upward into the uterus through the still-open cervix.

57. Answer: C. Massage the fundus every hour for the first 24 hours following birth.

The fundus should be massaged only when boggy or soft. Massaging a firm fundus could cause it to relax. Responses A, B, and D are all effective measures to enhance and maintain contraction of the uterus and to facilitate healing.

58. Answer: C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn.

One week after birth the woman should exhibit behaviors characteristic of the taking-hold stage as described in response C. This stage lasts for as long as 4 to 5 weeks after birth. Responses A and B are characteristic of the taking-in stage, which lasts for the first few days after birth. Response D reflects the letting-go stage, which indicates that psychosocial recovery is complete.

59. Answer: D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time.

Response 1 does not take into consideration the need for the new mother to be nurtured and have her needs met during the taking-in stage. The behavior described is typical of this stage and not a reflection of ineffective attachment unless the behavior persists. Mothers need to reestablish their own well-being in order to effectively care for their baby.

60. Answer: A. Having the children choose or make a gift to give to the new baby upon its arrival home.

Special time should be set aside just for the other children without interruption from the newborn. Someone other than the mother should carry the baby into the home so she can give full attention to greeting her other children. Children should be actively involved in the care of the baby according to their ability without overwhelming them.

XVII (18)

1. A postpartum nurse is preparing to care for a woman who has just delivered a healthy newborn infant. In the immediate postpartum period the nurse plans to take the woman's vital signs:

A. Every 30 minutes during the first hour and then every hour for the next two hours.
B. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.
C. Every hour for the first 2 hours and then every 4 hours
D. Every 5 minutes for the first 30 minutes and then every hour for the next 4 hours.

2. A postpartum nurse is taking the vital signs of a woman who delivered a healthy newborn infant 4 hours ago. The nurse notes that the mother's temperature is 100.2*F. Which of the following actions would be most appropriate?

A. Retake the temperature in 15 minutes
B. Notify the physician
C. Document the findings
D. Increase hydration by encouraging oral fluids

3. The nurse is assessing a client who is 6 hours PP after delivering a full-term healthy infant. The client complains to the nurse of feelings of faintness and dizziness. Which of the following nursing actions would be most appropriate?

A. Obtain hemoglobin and hematocrit levels
B. Instruct the mother to request help when getting out of bed
C. Elevate the mother's legs
D. Inform the nursery room nurse to avoid bringing the newborn infant to the mother until the feelings of lightheadedness and dizziness have subsided.

4. A nurse is preparing to perform a fundal assessment on a postpartum client. The initial nursing action in performing this assessment is which of the following?

A. Ask the client to turn on her side
B. Ask the client to lie flat on her back with the knees and legs flat and straight.
C. Ask the mother to urinate and empty her bladder
D. Massage the fundus gently before determining the level of the fundus.

5. The nurse is assessing the lochia on a 1 day PP patient. The nurse notes that thelochia is red and has a foul-smelling odor. The nurse determines that this assessment finding is:

A. Normal
B. Indicates the presence of infection
C. Indicates the need for increasing oral fluids
D. Indicates the need for increasing ambulation

6. When performing a PP assessment on a client, the nurse notes the presence of clots in the lochia. The nurse examines the clots and notes that they are larger than 1 cm. Which of the following nursing actions is most appropriate?

A. Document the findings
B. Notify the physician
C. Reassess the client in 2 hours
D. Encourage increased intake of fluids.

7. A nurse in a PP unit is instructing a mother regarding lochia and the amount of expected lochia drainage. The nurse instructs the mother that the normal amount oflochia may vary but should never exceed the need for:

A. One peripad per day
B. Two peripads per day
C. Three peripads per day
D. Eight peripads per day

8. A PP nurse is providing instructions to a woman after delivery of a healthy newborn infant. The nurse instructs the mother that she should expect normal bowel elimination to return:

A. One the day of the delivery
B. 3 days PP
C. 7 days PP
D. within 2 weeks PP

9. Select all of the physiological maternal changes that occur during the PP period.

A. Cervical involution ceases immediately
B. Vaginal distention decreases slowly
C. Fundus begins to descend into the pelvis after 24 hours
D. Cardiac output decreases with resultant tachycardia in the first 24 hours
E. Digestive processes slow immediately.

10. A nurse is caring for a PP woman who has received epidural anesthesia and is monitoring the woman for the presence of a vulva hematoma. Which of the following assessment findings would best indicate the presence of a hematoma?

A. Complaints of a tearing sensation
B. Complaints of intense pain
C. Changes in vital signs
D. Signs of heavy bruising

11. A nurse is developing a plan of care for a PP woman with a small vulvar hematoma. The nurse includes which specific intervention in the plan during the first 12 hours following the delivery of this client?

A. Assess vital signs every 4 hours
B. Inform health care provider of assessment findings

C. Measure fundal height every 4 hours
D. Prepare an ice pack for application to the area.

12. A new mother received epidural anesthesia during labor and had a forcepsdelivery after pushing 2 hours. At 6 hours PP, her systolic blood pressure has dropped 20 points, her diastolic BP has dropped 10 points, and her pulse is 120 beats per minute. The client is anxious and restless. On further assessment, a vulvar hematoma is verified. After notifying the health care provider, the nurse immediately plans to:

A. Monitor fundal height
B. Apply perineal pressure
C. Prepare the client for surgery.
D. Reassure the client

13. A nurse is monitoring a new mother in the PP period for signs of hemorrhage. Which of the following signs, if noted in the mother, would be an early sign of excessive blood loss?

A. A temperature of 100.4*F
B. An increase in the pulse from 88 to 102 BPM
C. An increase in the respiratory rate from 18 to 22 breaths per minute
D. A blood pressure change from 130/88 to 124/80 mm Hg

14. A nurse is preparing to assess the uterine fundus of a client in the immediatepostpartum period. When the nurse locates the fundus, she notes that the uterus feels soft and boggy. Which of the following nursing interventions would be most appropriate initially?

A. Massage the fundus until it is firm
B. Elevate the mothers legs
C. Push on the uterus to assist in expressing clots
D. Encourage the mother to void

15. A PP nurse is assessing a mother who delivered a healthy newborn infant by C-section. The nurse is assessing for signs and symptoms of superficial venous thrombosis. Which of the following signs or symptoms would the nurse note if superficial venous thrombosis were present?

A. Paleness of the calf area
B. Enlarged, hardened veins
C. Coolness of the calf area
D. Palpable dorsalis pedis pulses

16. A nurse is providing instructions to a mother who has been diagnosed with mastitis. Which of the following statements if made by the mother indicates a need for further teaching?

1. “I need to take antibiotics, and I should begin to feel better in 24-48 hours.”
2. “I can use analgesics to assist in alleviating some of the discomfort.”
3. “I need to wear a supportive bra to relieve the discomfort.”
4. “I need to stop breastfeeding until this condition resolves.”

17. A PP client is being treated for DVT. The nurse understands that the client's response to treatment will be evaluated by regularly assessing the client for:

A. Dysuria, ecchymosis, and vertigo
B. Epistaxis, hematuria, and dysuria
C. Hematuria, ecchymosis, and epistaxis
D. Hematuria, ecchymosis, and vertigo

18. A nurse performs an assessment on a client who is 4 hours PP. The nurse notes that the client has cool, clammy skin and is restless and excessively thirsty. The nurse prepares immediately to:

A. Assess for hypovolemia and notify the health care provider
B. Begin hourly pad counts and reassure the client
C. Begin fundal massage and start oxygen by mask
D. Elevate the head of the bed and assess vital signs

19. A nurse is assessing a client in the 4th stage if labor and notes that the fundus is firm but that bleeding is excessive. The initial nursing action would be which of the following?

A. Massage the fundus
B. Place the mother in the Trendelenburg's position
C. Notify the physician
D. Record the findings

20. A nurse is caring for a PP client with a diagnosis of DVT who is receiving a continuous intravenous infusion of heparin sodium. Which of the following laboratory results will the nurse specifically review to determine if an effective and appropriate dose of the heparin is being delivered?

A. Prothrombin time
B. International normalized ratio
C. Activated partial thromboplastin time
D. Platelet count

21. A nurse is preparing a list of self-care instructions for a PP client who was diagnosed with mastitis. Select all instructions that would be included on the list.
A. Take the prescribed antibiotics until the soreness subsides.
B. Wear supportive bra
C. Avoid decompression of the breasts by breastfeeding or breast pump
D. Rest during the acute phase
5. Continue to breastfeed if the breasts are not too sore.

22. Methergine or pitocin is prescribed for a woman to treat PP hemorrhage. Before administration of these medications, the priority nursing assessment is to check the:

A. Amount of lochia
B. Blood pressure
C. Deep tendon reflexes
D. Uterine tone

23. Methergine or pitocin are prescribed for a client with PP hemorrhage. Before administering the medication(s), the nurse contacts the health provider who prescribed the medication(s) in which of the following conditions is documented in the client's medical history?

A. Peripheral vascular disease
B. Hypothyroidism
C. Hypotension
D. Type 1 diabetes

24. Which of the following factors might result in a decreased supply of breastmilk in a PP mother?

A. Supplemental feedings with formula
B. Maternal diet high in vitamin C
C. An alcoholic drink
D. Frequent feedings

25. Which of the following interventions would be helpful to a breastfeeding mother who is experiencing engorged breasts?

A. Applying ice
B. Applying a breast binder
C. Teaching how to express her breasts in a warm shower
D. Administering bromocriptine (Parlodel)

26. On completing a fundal assessment, the nurse notes the fundus is situated on the client's left abdomen. Which of the following actions is appropriate?

A. Ask the client to empty her bladder
B. Straight catheterize the client immediately
C. Call the client's health provider for direction
D. Straight catheterize the client for half of her uterine volume

27. The nurse is about the give a Type 2 diabetic her insulin before breakfast on her first day postpartum. Which of the following answers best describes insulin requirements immediately postpartum?

A. Lower than during her pregnancy
B. Higher than during her pregnancy
C. Lower than before she became pregnant
D. Higher than before she became pregnant

28. Which of the following findings would be expected when assessing thepostpartum client?

A. Fundus 1 cm above the umbilicus 1 hour postpartum
B. Fundus 1 cm above the umbilicus on postpartum day 3

C. Fundus palpable in the abdomen at 2 weeks postpartum
D. Fundus slightly to the right; 2 cm above umbilicus on postpartum day 2

29. A client is complaining of painful contractions, or after pains, on postpartumday 2. Which of the following conditions could increase the severity of afterpains?

A. Bottle-feeding
B. Diabetes
C. Multiple gestation
D. Primiparity

30. On which of the postpartum days can the client expect lochia serosa?

A. Days 3 and 4 PP
B. Days 3 to 10 PP
C. Days 10-14 PP
D. Days 14 to 42 PP

31. Which of the following behaviors characterizes the PP mother in the *taking in*phase?

A. Passive and dependant
B. Striving for independence and autonomy
C. Curious and interested in care of the baby
D. Exhibiting maximum readiness for new learning

32. Which of the following complications may be indicated by continuous seepage of blood from the vagina of a PP client, when palpation of the uterus reveals a firm uterus 1 cm below the umbilicus?

A. Retained placental fragments
B. Urinary tract infection
C. Cervical laceration
D. Uterine atony

33. What type of milk is present in the breasts 7 to 10 days PP?

A. Colostrum
B. Hind milk
C. Mature milk
D. Transitional milk

34. Which of the following complications is most likely responsible for a delayedpostpartum hemorrhage?

A. Cervical laceration
B. Clotting deficiency
C. Perineal laceration
D. Uterine subinvolution

35. Before giving a PP client the rubella vaccine, which of the following facts should the nurse include in client teaching?

A. The vaccine is safe in clients with egg allergies
B. Breast-feeding isn't compatible with the vaccine
C. Transient arthralgia and rash are common adverse effects

D. The client should avoid getting pregnant for 3 months after the vaccine because the vaccine has teratogenic effects

36. Which of the following changes best described the insulin needs of a client with type 1 diabetes who has just delivered an infant vaginally without complications?

A. Increase
B. Decrease
C. Remain the same as before pregnancy
D. Remain the same as during pregnancy

37. Which of the following responses is most appropriate for a mother with diabetes who wants to breastfeed her infant but is concerned about the effects of breastfeeding on her health?

A. Mothers with diabetes who breastfeed have a hard time controlling their insulin needs
B. Mothers with diabetes shouldn't breastfeed because of potential complications
C. Mothers with diabetes shouldn't breastfeed; insulin requirements are doubled.
D. Mothers with diabetes may breastfeed; insulin requirements may decrease from breastfeeding.

38. On the first PP night, a client requests that her baby be sent back to the nursery so she can get some sleep. The client is most likely in which of the following phases?

A. Depression phase
B. Letting-go phase
C. Taking-hold phase
D. Taking-in phase

39. Which of the following physiological responses is considered normal in the early postpartum period?

A. Urinary urgency and dysuria
B. Rapid diuresis
C. Decrease in blood pressure
D. Increase motility of the GI system

40. During the 3rd PP day, which of the following observations about the client would the nurse be most likely to make?

A. The client appears interested in learning about neonatal care
B. The client talks a lot about her birth experience
C. The client sleeps whenever the neonate isn't present
D. The client requests help in choosing a name for the neonate.

41. Which of the following circumstances is most likely to cause uterine atony and lead to PP hemorrhage?

A. Hypertension
B. Cervical and vaginal tears
C. Urine retention
D. Endometritis

42. Which type of lochia should the nurse expect to find in a client 2 days PP?

A. Foul-smelling
B. Lochia serosa
C. Lochia alba
D. Lochia rubra

43. After expulsion of the placenta in a client who has six living children, an infusion of lactated ringer's solution with 10 units of pitocin is ordered. The nurse understands that this is indicated for this client because:

A. She had a precipitate birth
B. This was an extramural birth
C. Retained placental fragments must be expelled
D. Multigravidas are at increased risk for uterine atony.

44. As part of the postpartum assessment, the nurse examines the breasts of a primiparous breastfeeding woman who is one day postpartum. An expected finding would be:

A. Soft, non-tender; colostrum is present
B. Leakage of milk at let down
C. Swollen, warm, and tender upon palpation
D. A few blisters and a bruise on each areola

45. Following the birth of her baby, a woman expresses concern about the weight she gained during pregnancy and how quickly she can lose it now that the baby is born. The nurse, in describing the expected pattern of weight loss, should begin by telling this woman that:

A. Return to pre pregnant weight is usually achieved by the end of the postpartum period
B. Fluid loss from diuresis, diaphoresis, and bleeding accounts for about a 3 pound weight loss
C. The expected weight loss immediately after birth averages about 11 to 13 pounds
D. Lactation will inhibit weight loss since caloric intake must increase to support milk production

46. Which of the following findings would be a source of concern if noted during the assessment of a woman who is 12 hours postpartum?

A. Postural hypotension
B. Temperature of 100.4°F
C. Bradycardia — pulse rate of 55 BPM
D. Pain in left calf with dorsiflexion of left foot

47. The nurse examines a woman one hour after birth. The woman's fundus is boggy, midline, and 1 cm below the umbilicus. Her lochial flow is profuse, with two plum-sized clots. The nurse's initial action would be to:

A. Place her on a bedpan to empty her bladder
B. Massage her fundus
C. Call the physician
D. Administer Methergine 0.2 mg IM which has been ordered prn

48. When performing a postpartum check, the nurse should:

A. Assist the woman into a lateral position with upper leg flexed forward to facilitate the examination of her perineum
B. Assist the woman into a supine position with her arms above her head and her legs extended for the examination of her abdomen
C. Instruct the woman to avoid urinating just before the examination since a full bladder will facilitate fundal palpation
D. Wash hands and put on sterile gloves before beginning the check

49. Perineal care is an important infection control measure. When evaluating apostpartum woman's perineal care technique, the nurse would recognize the need for further instruction if the woman:

A. Uses soap and warm water to wash the vulva and perineum
B. Washes from symphysis pubis back to episiotomy
C. Changes her perineal pad every 2 – 3 hours
D. Uses the peribottle to rinse upward into her vagina

50. Which measure would be least effective in preventing postpartum hemorrhage?

A. Administer Methergine 0.2 mg every 6 hours for 4 doses as ordered
B. Encourage the woman to void every 2 hours
C. Massage the fundus every hour for the first 24 hours following birth
D. Teach the woman the importance of rest and nutrition to enhance healing

51. When making a visit to the home of a postpartum woman one week after birth, the nurse should recognize that the woman would characteristically:

A. Express a strong need to review events and her behavior during the process of laborand birth
B. Exhibit a reduced attention span, limiting readiness to learn
C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn
D. Have reestablished her role as a spouse/partner

52. Four hours after a difficult labor and birth, a primiparous woman refuses to feed her baby, stating that she is too tired and just wants to sleep. The nurse should:

A. Tell the woman she can rest after she feeds her baby
B. Recognize this as a behavior of the taking-hold stage
C. Record the behavior as ineffective maternal-newborn attachment

D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time

53. Parents can facilitate the adjustment of their other children to a new baby by:

A. Having the children choose or make a gift to give to the new baby upon its arrival home

B. Emphasizing activities that keep the new baby and other children together

C. Having the mother carry the new baby into the home so she can show the other children the new baby

D. Reducing stress on other children by limiting their involvement in the care of the new baby

54. A primiparous woman is in the taking-in stage of psychosocial recovery and adjustment following birth. The nurse, recognizing the needs of women during this stage, should:

A. Foster an active role in the baby's care

B. Provide time for the mother to reflect on the events of and her behavior during childbirth

C. Recognize the woman's limited attention span by giving her written materials to read when she gets home rather than doing a teaching session now

D. Promote maternal independence by encouraging her to meet her own hygiene and comfort needs

55. All of the following are important in the immediate care of the premature neonate. Which nursing activity should have the greatest priority?

A. Instillation of antibiotic in the eyes

B. Identification by bracelet and foot prints

C. Placement in a warm environment

D. Neurological assessment to determine gestational age

Answers and Rationale

1. Answer: 2. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.

2. Answer: D. Increase hydration by encouraging oral fluids.

The mother's temperature may be taken every 4 hours while she is awake. Temperatures up to 100.4 F (38 C) in the first 24 hours after birth are often related to the dehydrating effects of labor. The most appropriate action is to increase hydration by encouraging oral fluids, which should bring the temperature to a normal reading. Although the nurse would document the findings, the most appropriate action would be to increase the hydration.

3. Answer: B. Instruct the mother to request help when getting out of bed.

Orthostatic hypotension may be evident during the first 8 hours after birth. Feelings of faintness or dizziness are signs that should caution the nurse to be aware of the client's

safety. The nurse should advise the mother to get help the first few times the mother gets out of bed. Obtaining an H/H requires a physician's order.

4. Answer: C. Ask the mother to urinate and empty her bladder.

Before starting the fundal assessment, the nurse should ask the mother to empty her bladder so that an accurate assessment can be done. When the nurse is performing fundal assessment, the nurse asks the woman to lie flat on her back with the knees flexed. Massaging the fundus is not appropriate unless the fundus is boggy and soft, and then it should be massaged gently until firm.

5. Answer: B. Indicates the presence of infection.

Lochia, the discharge present after birth, is red for the first 1 to 3 days and gradually decreases in amount. Normal lochia has a fleshy odor. Foul smelling or purulent lochiausually indicates infection, and these findings are not normal. Encouraging the woman to drink fluids or increase ambulation is not an accurate nursing intervention.

6. Answer: B. Notify the physician.

Normally, one may find a few small clots in the first 1 to 2 days after birth from pooling of blood in the vagina. Clots larger than 1 cm are considered abnormal. The cause of these clots, such as uterine atony or retained placental fragments, needs to be determined and treated to prevent further blood loss. Although the findings would be documented, the most appropriate action is to notify the physician.

7. Answer: D. Eight peripads per day.

The normal amount of lochia may vary with the individual but should never exceed 4 to 8 peripads per day. The average number of peripads is 6 per day.

8. Answer: B. 3 days PP.

After birth, the nurse should auscultate the woman's abdomen in all four quadrants to determine the return of bowel sounds. Normal bowel elimination usually returns 2 to 3 days PP. Surgery, anesthesia, and the use of narcotics and pain control agents also contribute to the longer period of altered bowel function.

9. Answer: A and C. In the PP period, cervical healing occurs rapidly and cervicalinvolution occurs.

After 1 week the muscle begins to regenerate and the cervix feels firm and the external os is the width of a pencil. Although the vaginal mucosa heals and vaginal distention decreases, it takes the entire PP period for complete involution to occur and muscle tone is never restored to the pregravid state. The fundus begins to descent into the pelvic cavity after 24 hours, a process known as involution. Despite blood loss that occurs duringdelivery of the baby, a transient increase in cardiac output occurs. The increase in cardiac output, which persists about 48 hours after childbirth, is probably caused by an increase in stroke volume because Bradycardia is often noted during the

PP period. Soon after childbirth, digestion begins to begin to be active and the new mother is usually hungry because of the energy expended during labor.

10. Answer: C. Changes in vital signs.

Because the woman has had epidural anesthesia and is anesthetized, she cannot feel pain, pressure, or a tearing sensation. Changes in vitals indicate hypovolemia in the anesthetized PP woman with vulvar hematoma. Heavy bruising may be visualized, but vital sign changes indicate hematoma caused by blood collection in the perineal tissues.

11. Answer: D. Prepare an ice pack for application to the area.

Application of ice will reduce swelling caused by hematoma formation in the vulvar area. The other options are not interventions that are specific to the plan of care for a client with a small vulvar hematoma.

12. Answer: C. Prepare the client for surgery.

The use of an epidural, prolonged second stage labor and forceps delivery are predisposing factors for hematoma formation, and a collection of up to 500 ml of blood can occur in the vaginal area. Although the other options may be implemented, the immediate action would be to prepare the client for surgery to stop the bleeding.

13. Answer: B. An increase in the pulse from 88 to 102 BPM.

During the 4th stage of labor, the maternal blood pressure, pulse, and respiration should be checked every 15 minutes during the first hour. A rising pulse is an early sign of excessive blood loss because the heart pumps faster to compensate for reduced blood volume. The blood pressure will fall as the blood volume diminishes, but a decreased blood pressure would not be the earliest sign of hemorrhage. A slight rise in temperature is normal. The respiratory rate is increased slightly.

14. Answer: A. Massage the fundus until it is firm.

If the uterus is not contracted firmly, the first intervention is to massage the fundus until it is firm and to express clots that may have accumulated in the uterus. Pushing on an uncontracted uterus can invert the uterus and cause massive hemorrhage. Elevating the client's legs and encouraging the client to void will not assist in managing uterine atony. If the uterus does not remain contracted as a result of the uterine massage, the problem may be distended bladder and the nurse should assist the mother to urinate, but this would not be the initial action.

15. Answer: B. Enlarged, hardened veins.

Thrombosis of the *superficial* veins is usually accompanied by signs and symptoms of inflammation. These include swelling of the involved extremity and redness, tenderness, and warmth.

16. Answer: D. "I need to stop breastfeeding until this condition resolves."

In most cases, the mother can continue to breastfeed with both breasts. If the affected breast is too sore, the mother can pump the breast gently. Regular emptying of the

breast is important to prevent abscess formation. Antibiotic therapy assists in resolving the mastitis within 24-48 hours. Additional supportive measures include ice packs, breast supports, and analgesics.

17. Answer: C. Hematuria, ecchymosis, and epistaxis.

The treatment for DVT is anticoagulant therapy. The nurse assesses for bleeding, which is an adverse effect of anticoagulants. This includes hematuria, ecchymosis, and epistaxis. Dysuria and vertigo are not associated specifically with bleeding.

18. Answer: A. Assess for hypovolemia and notify the health care provider.

Symptoms of hypovolemia include cool, clammy, pale skin, sensations of anxiety or impending doom, restlessness, and thirst. When these symptoms are present, the nurse should further assess for hypovolemia and notify the health care provider.

19. Answer: C. Notify the physician.

If the bleeding is excessive, the cause may be laceration of the cervix or birth canal. Massaging the fundus if it is firm will not assist in controlling the bleeding. Trendelenburg's position is to be avoided because it may interfere with cardiac function.

20. C. Activated partial thromboplastin time.

Anticoagulation therapy may be used to prevent the extension of thrombus by delaying the clotting time of the blood. Activated partial thromboplastin time should be monitored, and a heparin dose should be adjusted to maintain a therapeutic level of 1.5 to 2.5 times the control. The prothrombin time and the INR are used to monitor coagulation time whenwarfarin (Coumadin) is used.

21. Answers: B, D, and E.

Mastitis are an infection of the lactating breast. Client instructions include resting during the acute phase, maintaining a fluid intake of at least 3 L a day, and taking analgesics to relieve discomfort. Antibiotics may be prescribed and are taken until the complete prescribed course is finished. They are not stopped when the soreness subsides. Additional supportive measures include the use of moist heat or ice packs and wearing a supportive bra. Continued decompression of the breast by breastfeeding or pumping is important to empty the breast and prevent formation of an abscess.

22. Answer: B. Blood pressure.

Methergine and pitocin are agents that are used to prevent or control postpartumhemorrhage by contracting the uterus. They cause continuous uterine contractions and may elevate blood pressure. A priority nursing intervention is to check blood pressure. The physician should be notified if hypertension is present.

23. Answer: A. Peripheral vascular disease.

These medications are avoided in clients with significant cardiovascular disease, peripheral disease, hypertension, eclampsia, or preeclampsia. These conditions are worsened by the vasoconstriction effects of these medications.

24. Answer: A. Supplemental feedings with formula.

Routine formula supplementation may interfere with establishing an adequate milk volume because decreased stimulation to the mother's nipples affects hormonal levels and milk production.

25. Answer: C. Teaching how to express her breasts in a warm shower.

Teaching the client how to express her breasts in a warm shower aids with let-down and will give temporary relief. Ice can promote comfort by vasoconstriction, numbing, and discouraging further letdown of milk.

26. Answer: A. Ask the client to empty her bladder.

A full bladder may displace the uterine fundus to the left or right side of the abdomen. Catheterization is unnecessary invasive if the woman can void on her own.

27. Answer: C. Lower than before she became pregnant.

PP insulin requirements are usually significantly lower than pre pregnancy requirements. Occasionally, clients may require little to no insulin during the first 24 to 48 hourspostpartum.

28. Answer: A. Fundus 1 cm above the umbilicus 1 hour postpartum.

Within the first 12 hours postpartum, the fundus usually is approximately 1 cm above the umbilicus. The fundus should be below the umbilicus by PP day 3. The fundus shouldn't be palpated in the abdomen after day 10.

29. Answer: C. Multiple gestation.

Multiple gestation, breastfeeding, multiparity, and conditions that cause overdistention of the uterus will increase the intensity of after-pains. Bottle-feeding and diabetes aren't directly associated with increasing severity of afterpains unless the client has delivered a macrosomic infant.

30. Answer: B. Days 3 to 10 PP.

On the third and fourth PP days, the lochia becomes a pale pink or brown and contains old blood, serum, leukocytes, and tissue debris. This type of lochia usually lasts until PP day 10. Lochia rubra usually last for the first 3 to 4 days PP. Lochia alba, which contain leukocytes, decidua, epithelial cells, mucus, and bacteria, may continue for 2 to 6 weeks PP.

31. Answer: A. Passive and dependant.

During the taking in phase, which usually lasts 1-3 days, the mother is passive and dependent and expresses her own needs rather than the neonate's needs. The taking hold phase usually lasts from days 3-10 PP. During this stage, the mother strives for

independence and autonomy; she also becomes curious and interested in the care of the baby and is most ready to learn.

32. Answer: C. Cervical laceration.

Continuous seepage of blood may be due to cervical or vaginal lacerations if the uterus is firm and contracting. Retained placental fragments and uterine atony may cause subinvolution of the uterus, making it soft, boggy, and larger than expected. UTI won't cause vaginal bleeding, although hematuria may be present.

33. Answer: D. Transitional milk.

Transitional milk comes after colostrum and usually lasts until 2 weeks PP.

34. Answer: D. Uterine subinvolution.

Late postpartum bleeding is often the result of subinvolution of the uterus. Retained products of conception or infection often cause subinvolution. Cervical or perineal lacerations can cause an immediate postpartum hemorrhage. A client with a clotting deficiency may also have an immediate PP hemorrhage if the deficiency isn't corrected at the time of delivery.

35. Answer: D. The client should avoid getting pregnant for 3 months after the vaccine because the vaccine has teratogenic effects.

The client must understand that she must not become pregnant for 3 months after the vaccination because of its potential teratogenic effects. The rubella vaccine is made from duck eggs so an allergic reaction may occur in clients with egg allergies. The virus is not transmitted into the breast milk, so clients may continue to breastfeed after the vaccination. Transient arthralgia and rash are common adverse effects of the vaccine.

36. Answer: B. Decrease.

The placenta produces the hormone human placental lactogen, an insulin antagonist. After birth, the placenta, the major source of insulin resistance, is gone. Insulin needs decrease and women with type 1 diabetes may only need one-half to two-thirds of the prenatal insulin during the first few PP days.

37. Answer: D. Mothers with diabetes may breastfeed; insulin requirements may decrease from breastfeeding.

Breastfeeding has an antidiabetogenic effect. Insulin needs are decreased because carbohydrates are used in milk production. Breastfeeding mothers are at a higher risk of hypoglycemia in the first PP days after birth because the glucose levels are lower. Mothers with diabetes should be encouraged to breastfeed.

38. Answer: D. Taking-in phase.

The taking-in phase occurs in the first 24 hours after birth. The mother is concerned with her own needs and requires support from staff and relatives. The taking-hold phase occurs when the mother is ready to take responsibility for her care as well as the infant's

care. The letting-go phase begins several weeks later, when the mother incorporates the new infant into the family unit.

39. Answer: B. Rapid diuresis.

In the early PP period, there's an increase in the glomerular filtration rate and a drop in the progesterone levels, which result in rapid diuresis. There should be no urinary urgency, though a woman may feel anxious about voiding. There's a minimal change in blood pressure following childbirth, and a residual decrease in GI motility.

40. Answer: A. The client appears interested in learning about neonatal care.

The third to tenth days of PP care are the "taking-hold" phase, in which the new mother strives for independence and is eager for her neonate. The other options describe the phase in which the mother relives her birth experience.

41. Answer: C. Urine retention.

Urine retention causes a distended bladder to displace the uterus above the umbilicus and to the side, which prevents the uterus from contracting. The uterus needs to remain contracted if bleeding is to stay within normal limits. Cervical and vaginal tears can cause PP hemorrhage but are less common occurrences in the PP period.

42. Answer: D. Lochia rubra

43. Answer: D. Multigravidas are at increased risk for uterine atony.

Multiple full-term pregnancies and deliveries result in overstretched uterine muscles that do not contract efficiently and bleeding may ensue.

44. Answer: A. Soft, non-tender; colostrum is present. Breasts are essentially unchanged for the first two to three days after birth. Colostrum is present and may leak from the nipples.

45. Answer: C. The expected weight loss immediately after birth averages about 11 to 13 pounds.

Prepregnant weight is usually achieved by 2 to 3 months after birth, not within the 6-weekpostpartum period. Weight loss from diuresis, diaphoresis, and bleeding is about 9 pounds. Weight loss continues during breastfeeding since fat stores developed during pregnancy and extra calories consumed are used as part of the lactation process.

46. Answer: D. Pain in left calf with dorsiflexion of left foot.

Responses 1 and 3 are expected related to circulatory changes after birth. A temperature of 100.4°F in the first 24 hours is most likely indicative of dehydration which is easily corrected by increasing oral fluid intake. The findings in response 4 indicate a positive Homan sign and are suggestive of thrombophlebitis and should be investigated further.

47. Answer: B. Massage her fundus.

A boggy or soft fundus indicates that uterine atony is present. This is confirmed by the profuse lochia and passage of clots. The first action would be to massage the fundus until firm, followed by 3 and 4, especially if the fundus does not become or remain firm with massage. There is no indication of a distended bladder since the fundus is midline and below the umbilicus.

48. Answer: A. Assist the woman into a lateral position with upper leg flexed forward to facilitate the examination of her perineum.

While the supine position is best for examining the abdomen, the woman should keep her arms at her sides and slightly flex her knees in order to relax abdominal muscles and facilitate palpation of the fundus. The bladder should be emptied before the check. A full bladder alters the position of the fundus and makes the findings inaccurate. Although hands are washed before starting the check, clean (not sterile) gloves are put on just before the perineum and pad are assessed to protect from contact with blood and secretions.

49. Answer: D. Uses the peribottle to rinse upward into her vagina.

Responses 1, 2, and 3 are all appropriate measures. The peribottle should be used in a backward direction over the perineum. The flow should never be directed upward into the vagina since debris would be forced upward into the uterus through the still-open cervix.

50. Answer: C. Massage the fundus every hour for the first 24 hours following birth.

The fundus should be massaged only when boggy or soft. Massaging a firm fundus could cause it to relax. Responses A, B, and 4 are all effective measures to enhance and maintain contraction of the uterus and to facilitate healing.

51. Answer: C. Express a strong need to review events and her behavior during the process of labor and birth.

One week after birth the woman should exhibit behaviors characteristic of the taking-hold stage as described in response C. This stage lasts for as long as 4 to 5 weeks after birth. Responses A and B are characteristic of the taking-in stage, which lasts for the first few days after birth. Response D reflects the letting-go stage, which indicates that psychosocial recovery is complete.

52. Answer: D. Recognize this as a behavior of the taking-hold stage.

Response A does not take into consideration the need for the new mother to be nurtured and have her needs met during the taking-in stage. The behavior described is typical of this stage and not a reflection of ineffective attachment unless the behavior persists. Mothers need to reestablish their own well-being in order to effectively care for their baby.

53. Answer: A. Having the children choose or make a gift to give to the new baby upon its arrival home.

Special time should be set aside just for the other children without interruption from the newborn. Someone other than the mother should carry the baby into the home so she can give full attention to greeting her other children. Children should be actively involved in the care of the baby according to their ability without overwhelming them.

54. Answer: B. Provide time for the mother to reflect on the events of and her behavior during childbirth.

The focus of the taking-in stage is nurturing the new mother by meeting her dependency needs for rest, comfort, hygiene, and nutrition. Once they are met, she is more able to take an active role, not only in her own care but also the care of her newborn. Women express a need to review their childbirth experience and evaluate their performance. Short teaching sessions, using written materials to reinforce the content presented, are a more effective approach.

55. Answer: C. Placement in a warm environment

XIX (19) New Born

1. A nurse in a delivery room is assisting with the delivery of a newborn infant. After the delivery, the nurse prepares to prevent heat loss in the newborn resulting from evaporation by:

A. Warming the crib pad
B. Turning on the overhead radiant warmer
C. Closing the doors to the room
D. Drying the infant in a warm blanket

2. A nurse is assessing a newborn infant following circumcision and notes that the circumcised area is red with a small amount of bloody drainage. Which of the following nursing actions would be most appropriate?

A. Document the findings
B. Contact the physician
C. Circle the amount of bloody drainage on the dressing and reassess in 30 minutes
D. Reinforce the dressing

3. A nurse in the newborn nursery is monitoring a preterm newborn infant for respiratory distress syndrome. Which assessment signs if noted in the newborninfant would alert the nurse to the possibility of this syndrome?

A. Hypotension and Bradycardia
B. Tachypnea and retractions
C. Acrocyanosis and grunting
D. The presence of a barrel chest with grunting

4. A nurse in a newborn nursery is performing an assessment of a newborn infant. The nurse is preparing to measure the head circumference of the infant. The nurse would most appropriately:

A. Wrap the tape measure around the infant's head and measure just above the eyebrows.
B. Place the tape measure under the infants head at the base of the skull and wrap around to the front just above the eyes
C. Place the tape measure under the infants head, wrap around the occiput, and measure just above the eyes
D. Place the tape measure at the back of the infant's head, wrap around across the ears, and measure across the infant's mouth.

5. A postpartum nurse is providing instructions to the mother of a newborn infant with hyperbilirubinemia who is being breastfed. The nurse provides which most appropriate instructions to the mother?

A. Switch to bottle feeding the baby for 2 weeks
B. Stop the breast feedings and switch to bottle-feeding permanently
C. Feed the newborn infant less frequently
D. Continue to breast-feed every 2-4 hours

6. A nurse on the newborn nursery floor is caring for a neonate. On assessment the infant is exhibiting signs of cyanosis, tachypnea, nasal flaring, and grunting.

Respiratory distress syndrome is diagnosed, and the physician prescribes surfactant replacement therapy. The nurse would prepare to administer this therapy by:

A. Subcutaneous injection
B. Intravenous injection
C. Instillation of the preparation into the lungs through an endotracheal tube
D. Intramuscular injection

7. A nurse is assessing a newborn infant who was born to a mother who is addicted to drugs. Which of the following assessment findings would the nurse expect to note during the assessment of this newborn?

A. Sleepiness
B. Cuddles when being held
C. Lethargy
D. Incessant crying

8. A nurse prepares to administer a vitamin K injection to a newborn infant. The mother asks the nurse why her newborn infant needs the injection. The best response by the nurse would be:

A. "You infant needs vitamin K to develop immunity."
B. "The vitamin K will protect your infant from being jaundiced."
C. "Newborn infants are deficient in vitamin K, and this injection prevents your infant from abnormal bleeding."
D. "Newborn infants have sterile bowels, and vitamin K promotes the growth of bacteria in the bowel."

9. A nurse in a newborn nursery receives a phone call to prepare for the admission of a 43-week-gestation newborn with Apgar scores of 1 and 4. In planning for the admission of this infant, the nurse's highest priority should be to:

A. Connect the resuscitation bag to the oxygen outlet
B. Turn on the apnea and cardiorespiratory monitors
C. Set up the intravenous line with 5% dextrose in water
D. Set the radiant warmer control temperature at 36.5* C (97.6*F)

10. Vitamin K is prescribed for a neonate. A nurse prepares to administer the medication in which muscle site?

A. Deltoid
B. Triceps
C. Vastus lateralis
D. Biceps

11. A nursing instructor asks a nursing student to describe the procedure for administering erythromycin ointment into the eyes if a neonate. The instructor

determines that the student needs to research this procedure further if the student states:

A. "I will cleanse the neonate's eyes before instilling ointment."
B. "I will flush the eyes after instilling the ointment."
C. "I will instill the eye ointment into each of the neonate's conjunctival sacs within one hour after birth."
D. "Administration of the eye ointment may be delayed until an hour or so after birth so that eye contact and parent-infant attachment and bonding can occur."

12. A baby is born precipitously in the ER. The nurses initial action should be to:

A. Establish an airway for the baby
B. Ascertain the condition of the fundus
C. Quickly tie and cut the umbilical cord
D. Move mother and baby to the birthing unit

13. The primary critical observation for Apgar scoring is the:

A. Heart rate
B. Respiratory rate
C. Presence of meconium
D. Evaluation of the Moro reflex

14. When performing a newborn assessment, the nurse should measure the vital signs in the following sequence:

A. Pulse, respirations, temperature
B. Temperature, pulse, respirations
C. Respirations, temperature, pulse
D. Respirations, pulse, temperature

15. Within 3 minutes after birth the normal heart rate of the infant may range between:

A. 100 and 180
B. 130 and 170
C. 120 and 160
D. 100 and 130

16. The expected respiratory rate of a neonate within 3 minutes of birth may be as high as:

A. 50
B. 60
C. 80
D. 100

17. The nurse is aware that a healthy newborn's respirations are:

A. Regular, abdominal, 40-50 per minute, deep
B. Irregular, abdominal, 30-60 per minute, shallow

C. Irregular, initiated by chest wall, 30-60 per minute, deep
D. Regular, initiated by the chest wall, 40-60 per minute, shallow

18. To help limit the development of hyperbilirubinemia in the neonate, the plan of care should include:

A. Monitoring for the passage of meconium each shift
B. Instituting phototherapy for 30 minutes every 6 hours
C. Substituting breastfeeding for formula during the 2nd day after birth
D. Supplementing breastfeeding with glucose water during the first 24 hours

19. A newborn has small, whitish, pinpoint spots over the nose, which the nurse knows are caused by retained sebaceous secretions. When charting this observation, the nurse identifies it as:

A. Milia
B. Lanugo
C. Whiteheads
D. Mongolian spots

20. When newborns have been on formula for 36-48 hours, they should have a:

A. Screening for PKU
B. Vitamin K injection
C. Test for necrotizing enterocolitis
D. Heel stick for blood glucose level

21. The nurse decides on a teaching plan for a new mother and her infant. The plan should include:

A. Discussing the matter with her in a non-threatening manner
B. Showing by example and explanation how to care for the infant
C. Setting up a schedule for teaching the mother how to care for her baby
D. Supplying the emotional support to the mother and encouraging her independence

22. Which action best explains the main role of surfactant in the neonate?

A. Assists with ciliary body maturation in the upper airways
B. Helps maintain a rhythmic breathing pattern
C. Promotes clearing mucus from the respiratory tract
D. Helps the lungs remain expanded after the initiation of breathing

23. While assessing a 2-hour old neonate, the nurse observes the neonate to have acrocyanosis. Which of the following nursing actions should be performed initially?

A. Activate the code blue or emergency system
B. Do nothing because acrocyanosis is normal in the neonate
C. Immediately take the newborn's temperature according to hospital policy
D. Notify the physician of the need for a cardiac consult

24. The nurse is aware that a neonate of a mother with diabetes is at risk for what complication?

A. Anemia
B. Hypoglycemia
C. Nitrogen loss
D. Thrombosis

25. A client with group AB blood whose husband has group O has just given birth. The major sign of ABO blood incompatibility in the neonate is which complication or test result?

A. Negative Coombs test
B. Bleeding from the nose and ear
C. Jaundice after the first 24 hours of life
D. Jaundice within the first 24 hours of life

26. A client has just given birth at 42 weeks' gestation. When assessing the neonate, which physical finding is expected?

A. A sleepy, lethargic baby
B. Lanugo covering the body
C. Desquamation of the epidermis
D. Vernix caseosa covering the body

27. After reviewing the client's maternal history of magnesium sulfate during labor, which condition would the nurse anticipate as a potential problem in the neonate?

A. Hypoglycemia
B. Jitteriness
C. Respiratory depression
D. Tachycardia

28. Neonates of mothers with diabetes are at risk for which complication following birth?

A. Atelectasis
B. Microcephaly
C. Pneumothorax
D. Macrosomia

29. By keeping the nursery temperature warm and wrapping the neonate in blankets, the nurse is preventing which type of heat loss?

A. Conduction
B. Convection
C. Evaporation
D. Radiation

30. A neonate has been diagnosed with caput succedaneum. Which statement is correct about this condition?

A. It usually resolves in 3-6 weeks
B. It doesn't cross the cranial suture line
C. It's a collection of blood between the skull and the periosteum
D. It involves swelling of tissue over the presenting part of the presenting head

31. The most common neonatal sepsis and meningitis infections seen within 24 hours after birth are caused by which organism?

A. *Candida albicans*
B. *Chlamydia trachomatis*
C. *Escherichia coli*
D. Group B beta-hemolytic streptococci

32. When attempting to interact with a neonate experiencing drug withdrawal, which behavior would indicate that the neonate is willing to interact?

A. Gaze aversion
B. Hiccups
C. Quiet alert state
D. Yawning

33. When teaching umbilical cord care to a new mother, the nurse would include which information?

A. Apply peroxide to the cord with each diaper change
B. Cover the cord with petroleum jelly after bathing
C. Keep the cord dry and open to air
D. Wash the cord with soap and water each day during a tub bath

34. A mother of a term neonate asks what the thick, white, cheesy coating is on his skin. Which correctly describes this finding?

A. Lanugo
B. Milia
C. Nevus flammeus
D. Vernix

35. Which condition or treatment best ensures lung maturity in an infant?

A. Meconium in the amniotic fluid
B. Glucocorticoid treatment just before delivery
C. Lecithin to sphingomyelin ratio more than 2:1
D. Absence of phosphatidylglycerol in amniotic fluid

36. When performing nursing care for a neonate after a birth, which intervention has the highest nursing priority?

A. Obtain a dextrostix
B. Give the initial bath

C. Give the vitamin K injection
D. Cover the neonates head with a cap

37. When performing an assessment on a neonate, which assessment finding is most suggestive of hypothermia?

A. Bradycardia
B. Hyperglycemia
C. Metabolic alkalosis
D. Shivering

38. A woman delivers a 3.250 g neonate at 42 weeks' gestation. Which physical finding is expected during an examination if this neonate?

A. Abundant lanugo
B. Absence of sole creases
C. Breast bud of 1-2 mm in diameter
D. Leathery, cracked, and wrinkled skin

39. A healthy term neonate born by C-section was admitted to the transitional nursery 30 minutes ago and placed under a radiant warmer. The neonate has an axillary temperature of 99.5oF, a respiratory rate of 80 breaths/minute, and a heel stick glucose value of 60 mg/dl. Which action should the nurse take?

A. Wrap the neonate warmly and place her in an open crib
B. Administer an oral glucose feeding of 10% dextrose in water
C. Increase the temperature setting on the radiant warmer
D. Obtain an order for IV fluid administration

40. Which neonatal behavior is most commonly associated with fetal alcohol syndrome (FAS)?

A. Hypoactivity
B. High birth weight
C. Poor wake and sleep patterns
D. High threshold of stimulation

41. Which of the following behaviors would indicate that a client was bonding with her baby?

A. The client asks her husband to give the baby a bottle of water.
B. The client talks to the baby and picks him up when he cries.
C. The client feeds the baby every three hours.
D. The client asks the nurse to recommend a good child care manual.

42. A newborn's mother is alarmed to find small amounts of blood on her infant girl's diaper. When the nurse checks the infant's urine it is straw colored and has no offensive odor. Which explanation to the newborn's mother is most appropriate?

1. “It appears your baby has a kidney infection”
2. “Breast-fed babies often experience this type of bleeding problem due to lack of vitamin C in the breast milk”
3. “The baby probably passed a small kidney stone”
4. “Some infants experience menstruation like bleeding when hormones from the mother are not available”

43. An insulin-dependent diabetic delivered a 10-pound male. When the baby is brought to the nursery, the priority of care is to

A. clean the umbilical cord with Betadine to prevent infection
B. give the baby a bath
C. call the laboratory to collect a PKU screening test
D. check the baby’s serum glucose level and administer glucose if < 40 mg/dL

44. Soon after delivery a neonate is admitted to the central nursery. The nursery nurse begins the initial assessment by

A. auscultate bowel sounds.
B. determining chest circumference.
C. inspecting the posture, color, and respiratory effort.
D. checking for identifying birthmarks.

45. The home health nurse visits the Cox family 2 weeks after hospital discharge. She observes that the umbilical cord has dried and fallen off. The area appears healed with no drainage or erythema present. The mother can be instructed to

A. cover the umbilicus with a band-aid.
B. continue to clean the stump with alcohol for one week.
C. apply an antibiotic ointment to the stump.
D. give him a bath in an infant tub now.

46. A neonate is admitted to a hospital’s central nursery. The neonate’s vital signs are: temperature = 96.5 degrees F., heart rate = 120 bpm, and respirations = 40/minute. The infant is pink with slight acrocyanosis. The priority nursing diagnosis for the neonate is

A. Ineffective thermoregulation related to fluctuating environmental temperatures.
B. Potential for infection related to lack of immunity.
C. Altered nutrition, less than body requirements related to diminished sucking reflex.
D. Altered elimination pattern related to lack of nourishment.

47. The nurse hears the mother of a 5-pound neonate telling a friend on the telephone, “As soon as I get home, I’ll give him some cereal to get him to gain weight?” The nurse recognizes the need for further instruction about infant feeding and tells her

A. “If you give the baby cereal, be sure to use Rice to prevent allergy.”
B. “The baby is not able to swallow cereal, because he is too small.”
C. “The infant’s digestive tract cannot handle complex carbohydrates like cereal.”
D. “If you want him to gain weight, just double his daily intake of formula.”

48. The nurse instructs a primipara about safety considerations for the neonate. The nurse determines that the client does not understand the instructions when she says

A. “All neonates should be in an approved car seat when in an automobile.”
B. “It’s acceptable to prop the infant’s bottle once in awhile.”
C. “Pillows should not be used in the infant’s crib.”
D. “Infants should never be left unattended on an unguarded surface.”

49. The nurse manager is presenting education to her staff to promote consistency in the interventions used with lactating mothers. She emphasizes that the optimum time to initiate lactation is

A. as soon as possible after the infant’s birth.
B. after the mother has rested for 4-6 hours.
C. during the infant’s second period of reactivity.
D. after the infant has taken sterile water without complications.

50. The nurse is preparing to discharge a multipara 24 hours after a vaginaldelivery. The client is breastfeeding her newborn. The nurse instructs the client that if engorgement occurs the client should

A. wear a tight fitting bra or breast binder.
B. apply warm, moist heat to the breasts.
C. contact the nurse midwife for a lactation suppressant.
D. restrict fluid intake to 1000 ml. daily .

Answers and Rationale

1. Answer: D. Drying the infant in a warm blanket.

Evaporation of moisture from a wet body dissipates heat along with the moisture. Keeping the newborn dry by drying the wet newborn infant will prevent hypothermia via evaporation.

2. Answer: A. Document the findings. The penis is normally red during the healing process.

A yellow exudate may be noted in 24 hours, and this is a part of normal healing. The nurse would expect that the area would be red with a small amount of bloody drainage. If the bleeding is excessive, the nurse would apply gentle pressure with sterile gauze. If

bleeding is not controlled, then the blood vessel may need to be ligated, and the nurse would contact the physician. Because the findings identified in the question are normal, the nurse would document the assessment.

3. Answer: B. Acrocyanosis and grunting.

The infant with respiratory distress syndrome may present with signs of cyanosis, tachypnea or apnea, nasal flaring, chest wall retractions, or audible grunts.

4. Answer: C. Place the tape measure under the infant's head, wrap around the occiput, and measure just above the eyes.

To measure the head circumference, the nurse should place the tape measure under the infant's head, wrap the tape around the occiput, and measure just above the eyebrows so that the largest area of the occiput is included.

5. Answer: D. Continue to breastfeed every 2-4 hours.

Breast feeding should be initiated within 2 hours after birth and every 2-4 hours thereafter. The other options are not necessary.

6. Answer: C. Instillation of the preparation into the lungs through an endotracheal tube.

The aim of therapy in RDS is to support the disease until the disease runs its course with the subsequent development of surfactant. The infant may benefit from surfactant replacement therapy. In surfactant replacement, an exogenous surfactant preparation is instilled into the lungs through an endotracheal tube.

7. Answer: D. Incessant crying.

A newborn infant born to a woman using drugs is irritable. The infant is overloaded easily by sensory stimulation. The infant may cry incessantly and posture rather than cuddle when being held.

8. Answer: 3. "Newborn infants are deficient in vitamin K, and this injection prevents your infant from abnormal bleeding."

Vitamin K is necessary for the body to synthesize coagulation factors. Vitamin K is administered to the newborn infant to prevent abnormal bleeding. Newborn infants are vitamin K deficient because the bowel does not have the bacteria necessary for synthesizing fat-soluble vitamin K. The infant's bowel does not have support the production of vitamin K until bacteria adequately colonizes it by food ingestion.

9. Answer: A. Connect the resuscitation bag to the oxygen outlet.

The highest priority on admission to the nursery for a newborn with low Apgar scores is airway, which would involve preparing respiratory resuscitation equipment. The other options are also important, although they are of lower priority.

10. Answer: 3. Vastus lateralis.

11. Answer: 2. "I will flush the eyes after instilling the ointment."

Eye prophylaxis protects the neonate against *Neisseria gonorrhoeae* and *Chlamydia trachomatis*. The eyes are not flushed after instillation of the medication because the flush will wash away the administered medication.

12. Answer: A. Establish an airway for the baby.

The nurse should position the baby with head lower than chest and rub the infant's back to stimulate crying to promote oxygenation. There is no haste in cutting the cord.

13. Answer: A. Heart rate.

The heart rate is vital for life and is the most critical observation in Apgar scoring. Respiratory effect rather than rate is included in the Apgar score; the rate is very erratic.

14. Answer: D. Respirations, pulse, temperature.

This sequence is least disturbing. Touching with the stethoscope and inserting the thermometer increase anxiety and elevate vital signs.

15. Answer: C. 120 and 160.

The heart rate varies with activity; crying will increase the rate, whereas deep sleep will lower it; a rate between 120 and 160 is expected.

16. Answer: B. 60.

The respiratory rate is associated with activity and can be as rapid as 60 breaths per minute; over 60 breaths per minute are considered tachypneic in the infant.

17. Answer: B. Irregular, abdominal, 30-60 per minute, shallow.

Normally the newborn's breathing is abdominal and irregular in depth and rhythm; the rate ranges from 30-60 breaths per minute.

18. Answer: A. Monitoring for the passage of meconium each shift.

Bilirubin is excreted via the GI tract; if meconium is retained, the bilirubin is reabsorbed.

19. Answer: A. Milia.

Milia occur commonly, are not indicative of any illness, and eventually disappear.

20. Answer: A. Screening for PKU.

By now the newborn will have ingested an ample amount of the amino acid phenylalanine, which, if not metabolized because of a lack of the liver enzyme, can deposit injurious metabolites into the bloodstream and brain; early detection can determine if the liver enzyme is absent.

21. Answer: B. Showing by example and explanation how to care for the infant.

Teaching the mother by example is a non-threatening approach that allows her to proceed at her own pace.

22. Answer: D. Helps the lungs remain expanded after the initiation of breathing.

Surfactant works by reducing surface tension in the lung. Surfactant allows the lung to remain slightly expanded, decreasing the amount of work required for inspiration.

23. Answer: B. Do nothing because acrocyanosis is normal in the neonate.

Acrocyanosis, or bluish discoloration of the hands and feet in the neonate (also called peripheral cyanosis), is a normal finding and shouldn't last more than 24 hours after birth.

24. Answer: B. Hypoglycemia.

Neonates of mothers with diabetes are at risk for hypoglycemia due to increased insulin levels. During gestation, an increased amount of glucose is transferred to the fetus across the placenta. The neonate's liver cannot initially adjust to the changing glucose levels after birth. This may result in an overabundance of insulin in the neonate, resulting in hypoglycemia.

25. Answer: D. Jaundice within the first 24 hours of life.

The neonate with ABO blood incompatibility with its mother will have jaundice (pathologic) within the first 24 hours of life. The neonate would have a positive Coombs test result.

26. Answer: C. Desquamation of the epidermis.

Postdate fetuses lose the vernix caseosa, and the epidermis may become desquamated. These neonates are usually very alert. Lanugo is missing in the postdate neonate.

27. Answer: C. Respiratory depression.

Magnesium sulfate crosses the placenta and adverse neonatal effects are respiratory depression, hypotonia, and Bradycardia.

28. Answer: D. Macrosomia.

Neonates of mothers with diabetes are at increased risk for macrosomia (excessive fetal growth) as a result of the combination of the increased supply of maternal glucose and an increase in fetal insulin.

29. Answer: B. Convection.

Convection heat loss is the flow of heat from the body surface to the cooler air.

30. Answer: D. It involves swelling of tissue over the presenting part of the presenting head.

Caput succedaneum is the swelling of tissue over the presenting part of the fetal scalp due to sustained pressure; it resolves in 3-4 days.

31. Answer: D. Group B beta-hemolytic streptococci.

Transmission of Group B beta-hemolytic streptococci to the fetus results in respiratory distress that can rapidly lead to septic shock.

32. Answer: C. Quiet alert state.

When caring for a neonate experiencing drug withdrawal, the nurse needs to be alert for distress signals from the neonate. Stimuli should be introduced one at a time when the neonate is in a quiet and alert state. Gaze aversion, yawning, sneezing, hiccups, and body arching are distress signals that the neonate cannot handle stimuli at that time.

33. Answer: C. Keep the cord dry and open to air.

Keeping the cord dry and open to air helps reduce infection and hastens drying.

34. Answer: 4. Vernix.

35. Answer: C. Lecithin to sphingomyelin ratio more than 2:1.

Lecithin and sphingomyelin are phospholipids that help compose surfactant in the lungs; lecithin peaks at 36 weeks and sphingomyelin concentrations remain stable.

36. Answer: D. Cover the neonate's head with a cap.

Covering the neonate's head with a cap helps prevent cold stress due to excessive evaporative heat loss from the neonate's wet head. Vitamin K can be given up to 4 hours after birth.

37. Answer: A. Bradycardia.

Hypothermic neonates become bradycardic proportional to the degree of core temperature. Hypoglycemia is seen in hypothermic neonates.

38. Answer: D. Leathery, cracked, and wrinkled skin.

Neonatal skin thickens with maturity and is often peeling by post term.

39. Answer: D. Obtain an order for IV fluid administration.

Assessment findings indicate that the neonate is in respiratory distress—most likely from transient tachypnea, which is common after cesarean delivery. A neonate with a rate of 80 breaths a minute shouldn't be fed but should receive IV fluids until the respiratory rate returns to normal. To allow for close observation for worsening respiratory distress, the neonate should be kept unclothed in the radiant warmer.

40. Answer: C. Poor wake and sleep patterns.

Altered sleep patterns are caused by disturbances in the CNS from alcohol exposure in utero. Hyperactivity is a characteristic generally noted. Low birth weight is a physical defect seen in neonates with FAS. Neonates with FAS generally have a low threshold for stimulation.

41. Answer: B. The client talks to the baby and picks him up when he cries.

42. Answer: D. "Some infants experience menstruation like bleeding when hormones from the mother are not available".

43. Answer: D. check the baby's serum glucose level and administer glucose if < 40 mg/dL.

44. Answer: C. inspecting the posture, color, and respiratory effort.

45. Answer:D. give him a bath in an infant tub now.

46. Answer: A. Ineffective thermoregulation related to fluctuating environmental temperatures.

47. Answer: C. "The infant's digestive tract cannot handle complex carbohydrates like cereal."

48. Answer: B. "It's acceptable to prop the infant's bottle once in a while."

49. Answer: A. as soon as possible after the infant's birth.

50. Answer: B. apply warm, moist heat to the breasts.

XX (20) Pediatric Nsg

1. Molly, with suspected rheumatic fever, is admitted to the pediatric unit. When obtaining the child's history, the nurse considers which information to be most important?

A. A fever that started 3 days ago
B. Lack of interest in food
C. A recent episode of pharyngitis
D. Vomiting for 2 days

2. Nurse Analiza is administering a medication via the intraosseous route to a child. Intraosseous drug administration is typically used when a child is:

A. Under age 3
B. Over age 3
C. Critically ill and under age 3
D. Critically ill and over age 3

3. When assessing a child's cultural background, the nurse in charge should keep in mind that:

A. Cultural background usually has little bearing on a family's health practices
B. Physical characteristics mark the child as part of a particular culture
C. Heritage dictates a group's shared values
D. Behavioral patterns are passed from one generation to the next

4. While examining a 2-year-old child, the nurse in charge sees that the anterior fontanel is open. The nurse should:

A. Notify the doctor
B. Look for other signs of abuse
C. Recognize this as a normal finding
D. Ask about a family history of Tay-Sachs disease

5. The nurse is aware that the most common assessment finding in a child with ulcerative colitis is:

A. Intense abdominal cramps
B. Profuse diarrhea
C. Anal fissures
D. Abdominal distention

6. When administering an I.M. injection to an infant, the nurse in charge should use which site?

A. Deltoid
B. Dorsogluteal
C. Ventrogluteal
D. Vastus lateralis

7. A child with a poor nutritional status and weight loss is at risk for a negative nitrogen balance. To help diagnose this problem, the nurse in charge anticipates that the doctor will order which laboratory test?

A. Total iron-binding capacity
B. Hemoglobin
C. Total protein
D. Serum transferrin

8. When developing a plan of care for a male adolescent, the nurse considers the child's psychosocial needs. During adolescence, psychosocial development focuses on:

A. Becoming industrious
B. Establishing an identity
C. Achieving intimacy
D. Developing initiative

9. When developing a plan care for a hospitalized child, nurse Mica knows that children in which age group are most likely to view illness as a punishment for misdeeds?

A. Infancy
B. Preschool age
C. School age
D. Adolescence

10. Nurse Sunshine suspects that a child, age 4, is being neglected physically. To best assess the child's nutritional status, the nurse should ask the parents which question?

A. "Has your child always been so thin?"
B. "Is your child a picky eater?"
C. "What did your child eat for breakfast?"
D. "Do you think your child eats enough?"

11. A female child, age 2, is brought to the emergency department after ingesting an unknown number of aspirin tablets about 30 minutes earlier. On entering the examination room, the child is crying and clinging to the mother. Which data should the nurse obtain first?

A. Heart rate, respiratory rate, and blood pressure
B. Recent exposure to communicable diseases
C. Number of immunizations received
D. Height and weight

12. A mother asks the nurse how to handle her 5-year-old child, who recently started wetting the pants after being completely toilet trained. The child just

started attending nursery school 2 days a week. Which principle should guide the nurse's response?

A. The child forgets previously learned skills
B. The child experiences growth while regressing, regrouping, and then progressing
C. The parents may refer less mature behaviors
D. The child returns to a level of behavior that increases the sense of security.

13. A female child, age 6, is brought to the health clinic for a routine checkup. To assess the child's vision, the nurse should ask:

A. "Do you have any problems seeing different colors?"
B. "Do you have trouble seeing at night?"
C. "Do you have problems with glare?"
D. "How are you doing in school?"

14. During a well-baby visit, Liza asks the nurse when she should start giving her infant solid foods. The nurse should instruct her to introduce which solid food first?

A. Applesauce
B. Egg whites
C. Rice cereal
D. Yogurt

15. To decrease the likelihood of bradyarrhythmias in children during endotracheal intubation, succinylcholine (Anectine) is used with which of the following agents?

A. Epinephrine (Adrenalin)
B. Isoproterenol (Isuprel)
C. Atropine sulfate
D. Lidocaine hydrochloride (Xylocaine)

16. A 1-year-and 2-month-old child weighing 26 lb (11.8 kg) is admitted for traction to treat congenital hip dislocation. When preparing the patient's room, the nurse anticipates using which traction system?

A. Bryant's traction
B. Buck's extension traction
C. Overhead suspension traction
D. 90-90 traction

17. Hannah, age 12, is 7 months pregnant. When teaching parenting skills to an adolescent, the nurse knows that which teaching strategy is least effective?

A. Providing a one-on-one demonstration and requesting a return demonstration, using a live infant model

B. Initiating a teenage parent support group with first – and – second-time mothers
C. Using audiovisual aids that show discussions of feelings and skills
D. Providing age-appropriate reading materials

18. When performing a physical examination on an infant, the nurse in charge notes abnormally low-set ears. This findings is associated with:

A. Otogenous tetanus
B. Tracheoesophageal fistula
C. Congenital heart defects
D. Renal anomalies

19. Nurse Walter should expect a 3-year-old child to be able to perform which action?

A. Ride a tricycle
B. Tie the shoelaces
C. Roller-skates
D. Jump rope

20. Nurse Kim is teaching a group of parents about otitis media. When discussing why children are predisposed to this disorder, the nurse should mention the significance of which anatomical feature?

A. Eustachian tubes
B. Nasopharynx
C. Tympanic membrane
D. External ear canal

21. The nurse is evaluating a female child with acute poststreptococcal glomerulonephritis for signs of improvement. Which finding typically is the earliest sign of improvement?

A. Increased urine output
B. Increased appetite
C. Increased energy level
D. Decreased diarrhea

22. Dr. Jones prescribes corticosteroids for a child with nephritic syndrome. What is the primary purpose of administering corticosteroids to this child?

A. To increase blood pressure
B. To reduce inflammation
C. To decrease proteinuria
D. To prevent infection

23. Parents bring their infant to the clinic, seeking treatment for vomiting and diarrhea that has lasted for 2 days. On assessment, the nurse in charge detects dry mucous membranes and lethargy. What other findings suggests a fluid volume deficit?

A. A sunken fontanel
B. Decreased pulse rate
C. Increased blood pressure
D. Low urine specific gravity

24. How should the nurse prepare a suspension before administration?

A. By diluting it with normal saline solution
B. By diluting it with 5% dextrose solution
C. By shaking it so that all the drug particles are dispersed uniformly
D. By crushing remaining particles with a mortar and pestle

25. What should be the initial bolus of crystalloid fluid replacement for a pediatric patient in shock?

A. 20 ml/kg
B. 10 ml/kg
C. 30 ml/kg
D. 15 ml/kg

26. Lily , age 5, with intelligence quotient of 65 is admitted to the hospital for evaluation. When planning care, the nurse should keep in mind that this child is:

A. Within the lower range of normal intelligence
B. Mildly retarded but educable
C. Moderately retarded but trainable
D. Completely dependent on others for care

27. Mandy, age 12, is brought to the clinic for evaluation for a suspected eating disorder. To best assess the effects of role and relationship patterns on the child's nutritional intake, the nurse should ask:

A. "What activities do you engage in during the day?"
B. "Do you have any allergies to foods?"
C. "Do you like yourself physically?"
D. "What kinds of food do you like to eat?"

28. Sudden infant death syndrome (SIDS) is one of the most common causes of death in infants. At what age is the diagnosis of SIDS most likely?

A. At 1 to 2 years of age
B. At I week to 1 year of age, peaking at 2 to 4 months
C. At 6 months to 1 year of age, peaking at 10 months
D. At 6 to 8 weeks of age

29. When evaluating a severely depressed adolescent, the nurse knows that one indicator of a high risk for suicide is:

A. Depression
B. Excessive sleepiness

C. A history of cocaine use
D. A preoccupation with death

30. A child is diagnosed with Wilms' tumor. During assessment, the nurse in charge expects to detect:

A. Gross hematuria
B. Dysuria
C. Nausea and vomiting
D. An abdominal mass

31. Which of the following would be inappropriate when administering chemotherapy to a child?

A. Monitoring the child for both general and specific adverse effects
B. Observing the child for 10 minutes to note for signs of anaphylaxis
C. Administering medication through a free-flowing intravenous line
D. Assessing for signs of infusion infiltration and irritation

32. Which of the following is the best method for performing a physical examination on a toddler

A. From head to toe
B. Distally to proximally
C. From abdomen to toes, the to head
D. From least to most intrusive

33. Which of the following organisms is responsible for the development of rheumatic fever?

A. Streptococcal pneumonia
B. Haemophilus influenza
C. Group A β-hemolytic streptococcus
D. Staphylococcus aureus

34. Which of the following is most likely associated with a cerebrovascular accident (CVA) resulting from congenital heart disease?

A. Polycythemia
B. Cardiomyopathy
C. Endocarditis
D. Low blood pressure

35. How does the nurse appropriately administer mycostatin suspension in an infant?

A. Have the infant drink water, and then administer mycostatin in a syringe
B. Place mycostatin on the nipple of the feeding bottle and have the infant suck it
C. Mix mycostatin with formula
D. Swab mycostatin on the affected areas

36. A mother tells the nurse that she is very worried because her 2-year old child does not finish his meals. What should the nurse advise the mother?

A. make the child seat with the family in the dining room until he finishes his meal
B. provide quiet environment for the child before meals
C. do not give snacks to the child before meals
D. put the child on a chair and feed him

37. The nurse is assessing a newborn who had undergone vaginal delivery. Which of the following findings is least likely to be observed in a normal newborn?

A. uneven head shape
B. respirations are irregular, abdominal, 30-60 bpm
c. (+) moro reflex
D. heart rate is 80 bpm

38. Which of the following situations increase risk of lead poisoning in children?

A. playing in the park with heavy traffic and with many vehicles passing by
B. playing sand in the park
C. playing plastic balls with other children
D. playing with stuffed toys at home

39. An inborn error of metabolism that causes premature destruction of RBC?

A. G6PD
B. Hemocystinuria
C. Phenylketonuria
D. Celiac Disease

40. Which of the following blood study results would the nurse expect as most likely when caring for the child with iron deficiency anemia?

A. Increased hemoglobin
B. Normal hematocrit
C. Decreased mean corpuscular volume (MCV)
D. Normal total iron-binding capacity (TIBC)

41. The nurse answers a call bell and finds a frightened mother whose child, the patient, is having a seizure. Which of these actions should the nurse take?

A. The nurse should insert a padded tongue blade in the patient's mouth to prevent the child from swallowing or choking on his tongue.
B. The nurse should help the mother restrain the child to prevent him from injuring himself.
C. The nurse should call the operator to page for seizure assistance.
D. The nurse should clear the area and position the client safely.

42. At the community center, the nurse leads an adolescent health information group, which often expands into other areas of discussion. She knows that these youths are trying to find out "who they are," and discussion often focuses on which directions they want to take in school and life, as well as peer relationships. According to Erikson, this stage is known as:

A. identity vs. role confusion.
B. adolescent rebellion.

C. career experimentation.
D. relationship testing

43. The nurse is assessing a 9-month-old boy for a well-baby check up. Which of the following observations would be of most concern?

A. The baby cannot say “mama” when he wants his mother.
B. The mother has not given him finger foods.
C. The child does not sit unsupported.
D. The baby cries whenever the mother goes out.

44. Cherry, the mother of an 11-month-old girl, Elizabeth, is in the clinic for her daughter’s immunizations. She expresses concern to the nurse that Elizabeth cannot yet walk. The nurse correctly replies that, according to the Denver Developmental Screen, the median age for walking is:

A. 12 months.
B. 15 months.
C. 10 months.
D. 14 months.

45. Sunshine, age 13, has had a lumbar puncture to examine the CSF to determine if bacterial infection exists. The best position to keep her in after the procedure is:

A. prone for two hours to prevent aspiration, should she vomit.
B. semi-fowler’s so she can watch TV for five hours and be entertained.
C. supine for several hours, to prevent headache.
D. on her right sides to encourage return of CSF

46. Buck’s traction with a 10 lb. weight is securing a patient’s leg while she is waiting for surgery to repair a hip fracture. It is important to check circulation-sensation-movement:

A. every shift.
B. every day.
C. every 4 hours.
D. every 15 minutes.

47. Kim is using bronchodilators for asthma. The side effects of these drugs that you need to monitor this patient for include:

A. tachycardia, nausea, vomiting, heart palpitations, inability to sleep, restlessness, and seizures.
B. tachycardia, headache, dyspnea, temp . 101 F, and wheezing.
C. blurred vision, tachycardia, hypertension, headache, insomnia, and oliguria.
D. restlessness, insomnia, blurred vision, hypertension, chest pain, and muscle weakness.

48. The adolescent patient has symptoms of meningitis: nuchal rigidity, fever, vomiting, and lethargy. The nurse knows to prepare for the following test:

A. blood culture.
B. throat and ear culture.
C. CAT scan.
D. lumbar puncture.

49. The nurse is drawing blood from the diabetic patient for a glycosylated hemoglobin test. She explains to the woman that the test is used to determine:

A. the highest glucose level in the past week.
B. her insulin level.
C. glucose levels over the past several months.
D. her usual fasting glucose level.

50. The twelve-year-old boy has fractured his arm because of a fall from his bike. After the injury has been casted, the nurse knows it is most important to perform all of the following assessments on the area distal to the injury except:

A. capillary refill.
B. radial and ulnar pulse.
C. finger movement
D. skin integrity

Answers and Rationale

1. Answer: C. A recent episode of pharyngitis

A recent episode of pharyngitis is the most important factor in establishing the diagnosis of rheumatic fever. Although the child may have a history of fever or vomiting or lack interest in food, these findings are not specific to rheumatic fever.

2. Answer: C. Critically ill and under age 3

In an emergency, intraosseous drug administration is typically used when a child is critically ill and under age 3.

3. Answer: D. Behavioral patterns are passed from one generation to the next

A family's behavioral patterns and values are passed from one generation to the next. Cultural background commonly plays a major role in determining a family's health practices. Physical characteristics do not indicate a child's culture. Although heritage plays a role in culture, it does not dictate a group's shared values and its effect on culture is weaker than that of behavioral patterns.

4. Answer: A. Notify the doctor

Because the anterior fontanel normally closes between ages 12 and 18 months, the nurse should notify the doctor promptly of this finding. An open fontanel does not indicate abuse and is not associated with Tay-Sachs disease.

5. Answer: B. Profuse diarrhea

Ulcerative colitis causes profuse diarrhea, intense abdominal cramps, anal fissures, and abdominal distensions are more common in Crohn's disease.

6. Answer: D. Vastus lateralis

The recommended injection site for an infant is the vastus lateralis or rectus femoris muscles. The deltoid is inappropriate. The dorsogluteal and ventrogluteal sites can be used only in toddlers who have been walking for about 1 year.

7. Answer: C. Total protein

A negative nitrogen balance may result from inadequate protein intake and is best detected by measuring the total protein level. Measuring total iron-binding capacity, hemoglobin, and serum transferrin levels would help detect iron-deficiency anemia, not a negative nitrogen balance.

8. Answer: B. Establishing an identity

According to Erikson, the primary psychosocial task during adolescence is to establish a personal identity confusion. The adolescent attempts to establish a group identity by seeking acceptance and approval from peers, and strives to attain a personal identity by becoming more independent from the family. Becoming industrious is the developmental task of the school-age child, achieving intimacy is the task of the young adult, and developing initiative is the task of the preschooler.

9. Answer: B. Preschool age

Preschool-age children are most likely to view illness as a punishment for misdeeds. Separation anxiety, although seen in all age group, is most common in older infants. Fear of death is typical of older school-age children and adolescents. Adolescents also fear mutilation.

10. Answer: C. "What did your child eat for breakfast?"

The nurse should obtain objective information about the child's nutritional intake, such as by asking about what the child ate for a specific meal. The other options ask for subjective replies that would be open to interpretation.

11. Answer: A. Heart rate, respiratory rate, and blood pressure

The most important data to obtain on a child's arrival in the emergency department are vital sign measurements. The nurse should gather the other data later.

12. Answer: D. The child returns to a level of behavior that increases the sense of security.

The stress of starting nursery school may trigger a return to a level of successful behavior from earlier stages of development. A child's skills remain intact, although increased stress may prevent the child from using these skills. Growth occurs when the child does not regress. Parents rarely desire less mature behaviors.

13. Answer: D. "How are you doing in school?"

A child's poor progress in school may indicate a visual disturbance. The other options are more appropriate questions to ask when assessing vision in a geriatric patient.

14. Answer: C. Rice cereal

Rice cereal is the first solid food an infant should receive because it is easy to digest and is associated with few allergies. Next, the infant can receive pureed fruits, such as bananas, applesauce, and pears, followed by pureed vegetables, egg yolks, cheese, yogurt, and finally, meat. Egg whites should not be given until age 9 months because they may trigger a food allergy.

15. Answer: C. Atropine sulfate

Succinylcholine is an ultra-short-acting depolarizing agent used for rapid-sequence intubation. Bradycardia can occur, especially in children. Atropine is the drug of choice in treating succinylcholine-induced bradycardia. Lidocaine is used in adults only. Epinephrine bolus and isoproterenol are not used in rapid-sequence intubation because of their profound cardiac effects.

16. Answer: A. Bryant's traction

Bryant's traction is used to treat femoral fractures of congenital hip dislocation in children under age 2 who weigh less than 30 lb (13.6 kg). Buck's extension traction is skin traction used for short-term immobilization or to correct bone deformities or contractures; overhead suspension traction is used to treat fractures of the humerus; and 90-90 traction is used to treat femoral fracture in children over age 2.

17. Answer: D. Providing age-appropriate reading materials

Because adolescents absorb less information through reading, providing age-appropriate reading materials is the least effective way to teach parenting skills to an adolescent. The other options engage more than one of the senses and therefore serve as effective teaching strategies.

18. Answer: D. Renal anomalies

Normally the top of the ear aligns with an imaginary line drawn across the inner and outer canthus of the eye. Ears set below this line are associated with renal anomalies or mental retardation. Low-set ears do not accompany otogenous tetanus, tracheoesophageal fistula, or congenital heart defects.

19. Answer: A. Ride a tricycle

At age 3, gross motor development and refinement in eye-hand coordination enable a child to ride a tricycle. The fine motor skills required to tie shoelaces and the gross motor skills requires for roller-skating and jumping rope develop around age 5.

20. Answer: A. Eustachian tubes

In a child, Eustachian tubes are short and lie in a horizontal plane, promoting entry of nasopharyngeal secretions into the tubes and thus setting the stage for otitis media. The nasopharynx, tympanic membrane, external ear canal have no unusual features that would predispose a child to otitis media.

21. Answer: A. Increased urine output

Increased urine output, a sign of improving kidney function, typically is the first sign that a child with acute poststreptococcal glomerulonephritis (APSGN) is improving. Increased appetite, an increased energy level, and decreased diarrhea are not specific to APSGN.

22. Answer: C. To decrease proteinuria

The primary purpose of administering corticosteroids to a child with nephritic syndrome is to decrease proteinuria. Corticosteroids have no effect on blood pressure. Although they help reduce inflammation, this is not the reason for their use in patients with nephritic syndrome. Corticosteroids may predispose a patient to infection.

23. Answer: A. A sunken fontanel

In an infant, signs of fluid volume deficit (dehydration) include sunken fontanels, increased pulse rate, and decreased blood pressure. They occur when the body can no longer maintain sufficient intravascular fluid volume. When this happens, the kidneys conserve water to minimize fluid loss, which results in concentrated urine with a high specific gravity.

24. Answer: C. By shaking it so that all the drug particles are dispersed uniformly

The nurse should shake a suspension before administration to dispersed drug particles uniformly. Diluting the suspension and crushing particles are not recommended for this drug form.

25. Answer: A. 20 ml/kg

Fluid volume replacement must be calculated to the child's weight to avoid over-hydration. Initial fluid bolus is administered at 20 ml/kg, followed by another 20 ml/kg bolus if there is no improvement in fluid status.

26. Answer: B. Mildly retarded but educable

According to the American Association on Mental Deficiency, a person with an intelligence quotient (IQ) between 50 and 70 is classified as mildly mentally retarded but educable. One with an IQ between 35 and 50 is classified as moderately retarded but

trainable. One with an IQ below 36 is severely and profoundly impaired, requiring custodial care.

27. Answer: C. "Do you like yourself physically?"

Role and relationship patterns focus on body image and the patient's relationship with others, which commonly interrelated with food intake. Questions about activities and food preferences elicit information about health promotion and health protection behaviors. Questions about food allergies elicit information about health and illness patterns.

28. Answer: B. At I week to 1 year of age, peaking at 2 to 4 months

SIDS can occur any time between 1 week and 1 year of age. The incidence peaks at 2 to 4 months of age.

29. Answer: D. A preoccupation with death

An adolescent who demonstrates a preoccupation with death (such as by talking about death frequently) should be considered at high risk for suicide. Although depression, excessive sleepiness, and a history of cocaine use may occur in suicidal adolescents, they also occur in adolescents who are not suicidal.

30. Answer: D. An abdominal mass

The most common sign of Wilms' tumor is a painless, palpable abdominal mass, sometimes accompanied by an increase in abdominal girth. Gross hematuria is uncommon, although microscopic hematuria may be present. Dysuria is not associated with Wilms' tumor. Nausea and vomiting are rare in children with Wilms' tumor.

31. Answer: B. Observing the child for 10 minutes to note for signs of anaphylaxis

When administering chemotherapy, the nurse should observe for an anaphylactic reaction for 20 minutes and stop the medication if one is suspected. Chemotherapy is associated with both general and specific adverse effects, therefore close monitoring for them is important.

32. Answer: D. From least to most intrusive

When examining a toddler or any small child, the best way to perform the exam is from least to most intrusive. Starting at the head or abdomen is intrusive and should be avoided. Proceeding from distal to proximal is inappropriate at any age.

33. Answer: C. Group A β-hemolytic streptococcus

Rheumatic fever results as a delayed reaction to inadequately treated group A β-hemolytic streptococcal infection.

34. Answer: A. Polycythemia

The child with congenital heart disease develops polycythemia resulting from an inadequate mechanism to compensate for decreased oxygen saturation

35. Answer: D. Swab mycostatin on the affected areas

Mycostatin suspension is given as swab. Never mix medications with food and formula.

36. Answer C. do not give snacks to the child before meals

If the child is hungry he/she more likely would finish his meals. Therefore, the mother should be advised not to give snacks to the child. The child is a "busy toddler." He/she will not able to keep still for a long time.

37. Answer D. heart rate is 80 bpm

Normal heart rate of the newborn is 120 to 160 bpm. Choices A, B, and C are normal assessment findings (uneven head shape is molding).

38. Answer: A. playing in the park with heavy traffic and with many vehicles passing by

Lead poisoning may be caused by inhalation of dust and smoke from leaded gas. It may also be caused by lead-based paint, soil, water (especially from plumbings of old houses).

39. Answer: A. G6PD

Glucose-6-phosphate dehydrogenase deficiency (G6PD) is an X-linked recessive hereditary disease characterised by abnormally low levels of glucose-6-phosphate dehydrogenase (abbreviated G6PD or G6PDH), a metabolic enzyme involved in the pentose phosphate pathway, especially important in red blood cell metabolism.

40. Answer: C. Decreased mean corpuscular volume (MCV)

For the child with iron deficiency anemia, the blood study results most likely would reveal decreased mean corpuscular volume (MCV) which demonstrates microcytic anemia, decreased hemoglobin, decreased hematocrit and elevated total iron binding capacity.

41. Answer: D. The nurse should clear the area and position the client safely.

The primary role of the nurse when a patient has a seizure is to protect the patient from harming him or herself.

42. Answer: A. identity vs. role confusion.

During this period, which lasts up to the age of 18-21 years, the individual develops a sense of “self.” Peers have a major big influence over behavior, and the major decision is to determine a vocational goal.

43. Answer: C. The child does not sit unsupported.

Over 90% percent of babies can sit unsupported by nine months. Most babies cannot say “mama” in the sense that it refers to their mother at this time.

44. Answer: A. 12 months.

By 12 months, 50 percent of children can walk well.

45. Answer: C. supine for several hours, to prevent headache.

Lying flat keeps the patient from having a “spinal headache.” Increasing the fluid intake will assist in replenishing the lost fluid during this time.

46. Answer: C. every 4 hours.

The patient can lose vascular status without the nurse being aware if left for more than 4 hours, yet checks should not be so frequent that the patient becomes anxious. Vital signs are generally checked q4h, at which time the CSM checks can easily be performed.

47. Answer: A. tachycardia, nausea, vomiting, heart palpitations, inability to sleep, restlessness, and seizures.

Bronchodilators can produce the side effects listed in answer choice (A) for a short time after the patient begins using them.

48. Answer: D. lumbar puncture.

Meningitis is an infection of the meninges, the outer membrane of the brain. Since it is surrounded by cerebrospinal fluid, a lumbar puncture will help to identify the organism involved.

49. Answer: C. glucose levels over the past several months.

The glycosylated hemoglobin test measures glucose levels for the previous 3 to 4 months.

50. Answer: D. skin integrity

Capillary refill, pulses, and skin temperature and color are indicative of intact circulation and absence of compartment syndrome. Skin integrity is less important.

XXI (21) MCH

1. A postpartum patient was in labor for 30 hours and had ruptured membranes for 24 hours. For which of the following would the nurse be alert?

A. Endometritis
B. Endometriosis
C. Salpingitis
D. Pelvic thrombophlebitis

2. A client at 36 weeks gestation is schedule for a routine ultrasound prior to anamniocentesis. After teaching the client about the purpose for the ultrasound, which of the following client statements would indicate to the nurse in charge that the client needs further instruction?

A. The ultrasound will help to locate the placenta
B. The ultrasound identifies blood flow through the umbilical cord
C. The test will determine where to insert the needle
D. The ultrasound locates a pool of amniotic fluid

3. While the postpartum client is receiving heparin for thrombophlebitis, which of the following drugs would the nurse expect to administer if the client develops complications related to heparin therapy?

A. Calcium gluconate
B. Protamine sulfate
C. Methylergonovine (Methergine)
D. Nitrofurantoin (macrodantin)

4. When caring for a 3-day-old neonate who is receiving phototherapy to treat jaundice, the nurse in charge would expect to do which of the following?

A. Turn the neonate every 6 hours
B. Encourage the mother to discontinue breast-feeding
C. Notify the physician if the skin becomes bronze in color
D. Check the vital signs every 2 to 4 hours

5. A primigravida in active labor is about 9 days post-term. The client desires a bilateral pudendal block anesthesia before delivery. After the nurse explains this type of anesthesia to the client, which of the following locations identified by the client as the area of relief would indicate to the nurse that the teaching was effective?

A. Back
B. Abdomen
C. Fundus
D. Perineum

6. The nurse is caring for a primigravida at about 2 months and 1 week gestation. After explaining self-care measures for common discomforts of pregnancy, the nurse determines that the client understands the instructions when she says:

A. “Nausea and vomiting can be decreased if I eat a few crackers before arising”
B. “If I start to leak colostrum, I should cleanse my nipples with soap and water”
C. “If I have a vaginal discharge, I should wear nylon underwear”
D. “Leg cramps can be alleviated if I put an ice pack on the area”

7. Thirty hours after delivery, the nurse in charge plans discharge teaching for the client about infant care. By this time, the nurse expects that the phase ofpostpartum psychological adaptation that the client would be in would be termed which of the following?

A. Taking in
B. Letting go
C. Taking hold
D. Resolution

8. A pregnant client is diagnosed with partial placenta previa. In explaining the diagnosis, the nurse tells the client that the usual treatment for partial placenta previa is which of the following?

A. Activity limited to bed rest
B. Platelet infusion
C. Immediate cesarean delivery
D. Labor induction with oxytocin

9. The nurse plans to instruct the postpartum client about methods to prevent breast engorgement. Which of the following measures would the nurse include in the teaching plan?

A. Feeding the neonate a maximum of 5 minutes per side on the first day
B. Wearing a supportive brassiere with nipple shields
C. Breast-feeding the neonate at frequent intervals
D. Decreasing fluid intake for the first 24 to 48 hours

10. When the nurse on duty accidentally bumps the bassinet, the neonate throws out its arms, hands opened, and begins to cry. The nurse interprets this reaction as indicative of which of the following reflexes?

A. Startle reflex
B. Babinski reflex
C. Grasping reflex
D. Tonic neck reflex

11. A primigravida client at 25 weeks gestation visits the clinic and tells the nurse that her lower back aches when she arrives home from work. The nurse should suggest that the client perform:

A. Tailor sitting
B. Leg lifting
C. Shoulder circling
D. Squatting exercises

12. Which of the following would the nurse in charge do first after observing a 2-cm circle of bright red bleeding on the diaper of a neonate who just had a circumcision?

A. Notify the neonate's pediatrician immediately
B. Check the diaper and circumcision again in 30 minutes
C. Secure the diaper tightly to apply pressure on the site
D. Apply gentle pressure to the site with a sterile gauze pad

13. Which of the following would the nurse most likely expect to find when assessing a pregnant client with abruption placenta?

A. Excessive vaginal bleeding
B. Rigid, board-like abdomen
C. Titanic uterine contractions
D. Premature rupture of membranes

14. While the client is in active labor with twins and the cervix is 5 cm dilates, the nurse observes contractions occurring at a rate of every 7 to 8 minutes in a 30-minute period. Which of the following would be the nurse's most appropriate action?

A. Note the fetal heart rate patterns
B. Notify the physician immediately
C. Administer oxygen at 6 liters by mask
D. Have the client pant-blow during the contractions

15. A client tells the nurse, "I think my baby likes to hear me talk to him." When discussing neonates and stimulation with sound, which of the following would the nurse include as a means to elicit the best response?

A. High-pitched speech with tonal variations
B. Low-pitched speech with a sameness of tone
C. Cooing sounds rather than words
D. Repeated stimulation with loud sounds

16. A 31-year-old multipara is admitted to the birthing room after initial examination reveals her cervix to be at 8 cm, completely effaced (100 %), and at 0 station. What phase of labor is she in?

A. Active phase
B. Latent phase
C. Expulsive phase
D. Transitional phase

17. A pregnant patient asks the nurse if she can take castor oil for her constipation. How should the nurse respond?

A. "Yes, it produces no adverse effect."
B. "No, it can initiate premature uterine contractions."
C. "No, it can promote sodium retention."
D. "No, it can lead to increased absorption of fat-soluble vitamins."

18. A patient in her 14th week of pregnancy has presented with abdominal cramping and vaginal bleeding for the past 8 hours. She has passed several cloth. What is the primary nursing diagnosis for this patient?

A. Knowledge deficit
B. Fluid volume deficit
C. Anticipatory grieving
D. Pain

19. Immediately after a delivery, the nurse-midwife assesses the neonate's head for signs of molding. Which factors determine the type of molding?

A. Fetal body flexion or extension
B. Maternal age, body frame, and weight
C. Maternal and paternal ethnic backgrounds
D. Maternal parity and gravidity

20. For a patient in active labor, the nurse-midwife plans to use an internal electronic fetal monitoring (EFM) device. What must occur before the internal EFM can be applied?

A. The membranes must rupture
B. The fetus must be at 0 station
C. The cervix must be dilated fully
D. The patient must receive anesthesia

21. A primigravida patient is admitted to the labor delivery area. Assessment reveals that she is in early part of the first stage of labor. Her pain is likely to be most intense:

A. Around the pelvic girdle
B. Around the pelvic girdle and in the upper arms
C. Around the pelvic girdle and at the perineum
D. At the perineum

22. A female adult patient is taking a progestin-only oral contraceptive, or mini pill. Progestin use may increase the patient's risk for:

A. Endometriosis
B. Female hypogonadism
C. Premenstrual syndrome
D. Tubal or ectopic pregnancy

23. A patient with pregnancy-induced hypertension probably exhibits which of the following symptoms?

A. Proteinuria, headaches, vaginal bleeding
B. Headaches, double vision, vaginal bleeding
C. Proteinuria, headaches, double vision
D. Proteinuria, double vision, uterine contractions

24. Because cervical effacement and dilation are not progressing in a patient inlabor,the doctor orders I.V. administration of oxytocin (Pitocin). Why must the nurse monitor the patient's fluid intake and output closely during oxytocinadministration?

A. Oxytocin causes water intoxication
B. Oxytocin causes excessive thirst

C. Oxytocin is toxic to the kidneys
D. Oxytocin has a diuretic effect

25. Five hours after birth, a neonate is transferred to the nursery, where the nurse intervenes to prevent hypothermia. What is a common source of radiant heat loss?

A. Low room humidity
B. Cold weight scale
C. Cools incubator walls
D. Cool room temperature

26. After administering bethanechol to a patient with urine retention, the nurse in charge monitors the patient for adverse effects. Which is most likely to occur?

A. Decreased peristalsis
B. Increase heart rate
C. Dry mucous membranes
D. Nausea and Vomiting

27. The nurse in charge is caring for a patient who is in the first stage of labor. What is the shortest but most difficult part of this stage?

A. Active phase
B. Complete phase
C. Latent phase
D. Transitional phase

28. After 3 days of breast-feeding, a postpartal patient reports nipple soreness. To relieve her discomfort, the nurse should suggest that she:

A. Apply warm compresses to her nipples just before feedings
B. Lubricate her nipples with expressed milk before feeding
C. Dry her nipples with a soft towel after feedings
D. Apply soap directly to her nipples, and then rinse

29. The nurse is developing a teaching plan for a patient who is 8 weeks pregnant. The nurse should tell the patient that she can expect to feel the fetus move at which time?

A. Between 10 and 12 weeks' gestation
B. Between 16 and 20 weeks' gestation
C. Between 21 and 23 weeks' gestation
D. Between 24 and 26 weeks' gestation

30. Normal lochial findings in the first 24 hours post-delivery include:

A. Bright red blood
B. Large clots or tissue fragments
C. A foul odor
D. The complete absence of lochia

Answers and Rationale

1. Answer: A. Endometritis

Endometritis is an infection of the uterine lining and can occur after prolonged rupture of membranes. Endometriosis does not occur after a strong labor and prolonged rupture of membranes. Salpingitis is a tubal infection and could occur if endometritis is not treated.

Pelvic thrombophlebitis involves a clot formation but it is not a complication of prolonged rupture of membranes.

2. Answer: B. The ultrasound identifies blood flow through the umbilical cord

Before amniocentesis, a routine ultrasound is valuable in locating the placenta, locating a pool of amniotic fluid, and showing the physician where to insert the needle. Color Doppler imaging ultrasonography identifies blood flow through the umbilical cord. A routine ultrasound does not accomplish this.

3. Answer: B. Protamine sulfate

Protamine sulfate is a heparin antagonist given intravenously to counteract bleeding complications caused by heparin overdose.

4. Answer: D. Check the vital signs every 2 to 4 hours

While caring for an infant receiving phototherapy for treatment of jaundice, vital signs are checked every 2 to 4 hours because hyperthermia can occur due to the phototherapy lights.

5. Answer: D. Perineum

A bilateral pudendal block is used for vaginal deliveries to relieve pain primarily in the perineum and vagina. Pudendal block anesthesia is adequate for episiotomy and its repair.

6. Answer: A. "Nausea and vomiting can be decreased if I eat a few crackers before arising"

Eating dry crackers before arising can assist in decreasing the common discomfort of nausea and vomiting. Avoiding strong food odors and eating a high-protein snack before bedtime can also help.

7. Answer: C. Taking hold

Beginning after completion of the taking-in phase, the taking-hold phase lasts about 10 days. During this phase, the client is concerned with her need to resume control of all facets of her life in a competent manner. At this time, she is ready to learn self-care and infant care skills.

8. Answer: A. Activity limited to bed rest

Treatment of partial placenta previa includes bed rest, hydration, and careful monitoring of the client's bleeding.

9. Answer: C. Breast-feeding the neonate at frequent intervals

Prevention of breast engorgement is key. The best technique is to empty the breast regularly with feeding. Engorgement is less likely when the mother and neonate are together, as in single room maternity care continuous rooming in, because nursing can be done conveniently to meet the neonate's and mother's needs.

10. Answer: A. Startle reflex

The Moro, or startle, reflex occurs when the neonate responds to stimuli by extending the arms, hands open, and then moving the arms in an embracing motion. The Moro reflex, present at birth, disappears at about age 3 months.

11. Answer: A. Tailor sitting

Tailor sitting is an excellent exercise that helps to strengthen the client's back muscles and also prepares the client for the process of labor. The client should be encouraged to rest periodically during the day and avoid standing or sitting in one position for a long time.

12. Answer: D. Apply gentle pressure to the site with a sterile gauze pad

If bleeding occurs after circumcision, the nurse should first apply gently pressure on the area with sterile gauze. Bleeding is not common but requires attention when it occurs.

13. Answer: B. Rigid, board-like abdomen

The most common assessment finding in a client with abruption placenta is a rigid or boardlike abdomen. Pain, usually reported as a sharp stabbing sensation high in the uterine fundus with the initial separation, also is common.

14. Answer: B. Notify the physician immediately

The nurse should contact the physician immediately because the client is most likely experiencing hypotonic uterine contractions. These contractions tend to be painful but ineffective. The usual treatment is oxytocin augmentation, unless cephalopelvic disproportion exists.

15. Answer: A. High-pitched speech with tonal variations

Providing stimulation and speaking to neonates is important. Some authorities believe that speech is the most important type of sensory stimulation for a neonate. Neonates respond best to speech with tonal variations and a high-pitched voice. A neonate can hear all sound louder than about 55 decibels.

16. Answer: D. Transitional phase

The transitional phase of labor extends from 8 to 10 cm; it is the shortest but most difficult and intense for the patient. The latent phase extends from 0 to 3 cm; it is mild in nature. The active phase extends from 4 to 7 cm; it is moderate for the patient. The expulsive phase begins immediately after the birth and ends with separation and expulsion of theplacenta.

17. Answer: B. "No, it can initiate premature uterine contractions."

Castor oil can initiate premature uterine contractions in pregnant women. It also can produce other adverse effects, but it does not promote sodium retention. Castor oils is not known to increase absorption of fat-soluble vitamins, although laxatives in general may decrease absorption if intestinal motility is increased.

18. Answer: B. Fluid volume deficit

If bleeding and clots are excessive, this patient may become hypovolemic. Pad count should be instituted. Although the other diagnoses are applicable to this patient, they are not the primary diagnosis.

19. Answer: A. Fetal body flexion or extension

Fetal attitude—the overall degree of body flexion or extension—determines the type of molding in the head a neonate. Molding is not influenced by maternal age, body frame, weight, parity, and gravidity or by maternal and paternal ethnic backgrounds.

20. Answer: A. The membranes must rupture

Internal EFM can be applied only after the patient's membranes have ruptured, when the fetus is at least at the -1 station, and when the cervix is dilated at least 2 cm. although the patient may receive anesthesia, it is not required before application of an internal EFM device.

21. Answer: A. Around the pelvic girdle

During most of the first stage of labor, pain centers around the pelvic girdle. During the late part of this stage and the early part of the second stage, pain spreads to the upper legs and perineum. During the late part of the second stage and during childbirth, intense pain occurs at the perineum. Upper arm pain is not common during any stage of labor.

22. Answer: D. Tubal or ectopic pregnancy

Women taking the minipill have a higher incidence of tubal and ectopic pregnancies, possibly because progestin slows ovum transport through the fallopian tubes. Endometriosis, female hypogonadism, and premenstrual syndrome are not associated with progestin-only oral contraceptives.

23. Answer: C. Proteinuria, headaches, double vision

A patient with pregnancy-induced hypertension complains of headache, double vision, and sudden weight gain. A urine specimen reveals proteinuria. Vaginal bleeding and uterine contractions are not associated with pregnancy-induced hypertension.

24. Answer: A. Oxytocin causes water intoxication

The nurse should monitor fluid intake and output because prolonged oxytocin infusion may cause severe water intoxication, leading to seizures, coma, and death. Excessive thirst results from the work of labor and limited oral fluid intake—not oxytocin. Oxytocinhas no nephrotoxic or diuretic effects. In fact, it produces an antidiuretic effect.

25. Answer: C. Cools incubator walls

Common source of radiant heat loss includes cool incubator walls and windows. Low room humidity promotes evaporative heat loss. When the skin directly contacts a cooler object, such as a cold weight scale, conductive heat loss may occur. A cool room temperature may lead to convective heat loss.

26. Answer: D. Nausea and Vomiting

Bethanechol will increase GI motility, which may cause nausea, belching, vomiting, intestinal cramps, and diarrhea. Peristalsis is increased rather than decreased. With high doses of bethanechol, cardiovascular responses may include vasodilation, decreased cardiac rate, and decreased force of cardiac contraction, which may cause hypotension. Salivation or sweating may gently increase.

27. Answer: D. Transitional phase

The transitional phase, which lasts 1 to 3 hours, is the shortest but most difficult part of the first stage of labor. This phase is characterized by intense uterine contractions that occur every 1 ½ to 2 minutes and last 45 to 90 seconds. The active phase lasts 4 ½ to 6 hours; it is characterized by contractions that starts out moderately intense, grow stronger, and last about 60 seconds. The complete phase occurs during the second, not first, stage of labor. The latent phase lasts 5 to 8 hours and is marked by mild, short, irregular contractions.

28. Answer: B. Lubricate her nipples with expressed milk before feeding

Measures that help relieve nipple soreness in a breast-feeding patient include lubrication the nipples with a few drops of expressed milk before feedings, applying ice compresses just before feeding, letting the nipples air dry after feedings, and avoiding the use of soap on the nipples.

29. Answer: B. Between 16 and 20 weeks' gestation

A pregnant woman usually can detect fetal movement (quickening) between 16 and 20 weeks' gestation. Before 16 weeks, the fetus is not developed enough for the woman to detect movement. After 20 weeks, the fetus continues to gain weight steadily, the lungs start to produce surfactant, the brain is grossly formed, and myelination of the spinal cord begins.

30. Answer: A. Bright red blood

Lochia should never contain large clots, tissue fragments, or membranes. A foul odor may signal infection, as may absence of lochia.

XXII (22)

1. Accompanied by her husband, a patient seeks admission to the labor anddelivery area. The client states that she is in labor and says she attended the hospital clinic for prenatal care. Which question should the nurse ask her first?

A. “Do you have any chronic illness?”
B. “Do you have any allergies?”
C. “What is your expected due date?”
D. “Who will be with you during labor?”

2. A patient is in the second stage of labor. During this stage, how frequently should the nurse in charge assess her uterine contractions?

A. Every 5 minutes
B. Every 15 minutes
C. Every 30 minutes
D. Every 60 minutes

3. A patient is in her last trimester of pregnancy. Nurse Vickie should instruct her to notify her primary health care provider immediately if she notices:

A. Blurred vision
B. Hemorrhoids
C. Increased vaginal mucus
D. Shortness of breath on exertion

4. The nurse in-charge is reviewing a patient’s prenatal history. Which finding indicates a genetic risk factor?

A. The patient is 25 years old
B. The patient has a child with cystic fibrosis
C. The patient was exposed to rubella at 36 weeks’ gestation
D. The patient has a history of preterm labor at 32 weeks’ gestation

5. A adult female patient is using the rhythm (calendar-basal body temperature) method of family planning. In this method, the unsafe period for sexual intercourse is indicated by:

A. Return preovulatory basal body temperature
B. Basal body temperature increase of 0.1 degrees to 0.2 degrees on the 2nd or 3rd day of cycle
C. 3 full days of elevated basal body temperature and clear, thin cervical mucus
D. Breast tenderness and mittelschmerz

6. During a nonstress test (NST), the electronic tracing displays a relatively flat line for fetal movement, making it difficult to evaluate the fetal heart rate (FHR). To mark the strip, the nurse in charge should instruct the client to push the control button at which time?

A. At the beginning of each fetal movement
B. At the beginning of each contraction
C. After every three fetal movements
D. At the end of fetal movement

7. When evaluating a client's knowledge of symptoms to report during her pregnancy, which statement would indicate to the nurse in charge that the client understands the information given to her?

A. "I'll report increased frequency of urination."
B. "If I have blurred or double vision, I should call the clinic immediately."
C. "If I feel tired after resting, I should report it immediately."
D. "Nausea should be reported immediately."

8. When assessing a client during her first prenatal visit, the nurse discovers that the client had a reduction mammoplasty. The mother indicates she wants to breast-feed. What information should the nurse give to this mother regardingbreastfeeding success?

A. "It's contraindicated for you to breastfeed following this type of surgery."
B. "I support your commitment; however, you may have to supplement each feeding with formula."
C. "You should check with your surgeon to determine whether breast-feeding would be possible."
D. "You should be able to breastfeed without difficulty."

9. Following a precipitous delivery, examination of the client's vagina reveals a fourth-degree laceration. Which of the following would be contraindicated when caring for this client?

A. Applying cold to limit edema during the first 12 to 24 hours
B. Instructing the client to use two or more peri pads to cushion the area
C. Instructing the client on the use of sitz baths if ordered
D. Instructing the client about the importance of perineal (Kegel) exercises

10. A client makes a routine visit to the prenatal clinic. Although she is 14 weeks pregnant, the size of her uterus approximates that in an 18- to 20-week pregnancy. Dr. Charles diagnoses gestational trophoblastic disease and orders ultrasonography. The nurse expects ultrasonography to reveal:

A. an empty gestational sac.
B. grapelike clusters.
C. a severely malformed fetus.
D. an extrauterine pregnancy.

11. After completing a second vaginal examination of a client in labor, the nurse-midwife determines that the fetus is in the right occiput anterior position and at (–1) station. Based on these findings, the nurse-midwife knows that the fetal presenting part is:

A. 1 cm below the ischial spines.
B. directly in line with the ischial spines.
C. 1 cm above the ischial spines.
D. in no relationship to the ischial spines.

12. Which of the following would be inappropriate to assess in a mother who'sbreastfeeding?

A. The attachment of the baby to the breast.
B. The mother's comfort level with positioning the baby.
C. Audible swallowing.
D. The baby's lips smacking

13. During a prenatal visit at 4 months gestation, a pregnant client asks whether tests can be done to identify fetal abnormalities. Between 18 and 40 weeks gestation, which procedure is used to detect fetal anomalies?

A. Amniocentesis.
B. Chorionic villi sampling.
C. Fetoscopy.
D. Ultrasound

14. A client, 30 weeks pregnant, is scheduled for a biophysical profile (BPP) to evaluate the health of her fetus. Her BPP score is 8. What does this score indicate?

A. The fetus should be delivered within 24 hours.
B. The client should repeat the test in 24 hours.
C. The fetus isn't in distress at this time.
D. The client should repeat the test in 1 week.

15. A client who is 36 weeks pregnant comes to the clinic for a prenatal checkup. To assess the client's preparation for parenting, the nurse might ask which question?

A. "Are you planning to have epidural anesthesia?"
B. "Have you begun prenatal classes?"
C. "What changes have you made at home to get ready for the baby?"
D. "Can you tell me about the meals you typically eat each day?"

16. A client who's admitted to labor and delivery has the following assessment findings: gravida 2 para 1, estimated 40 weeks gestation, contractions 2 minutes apart, lasting 45 seconds, vertex +4 station. Which of the following would be the priority at this time?

A. Placing the client in bed to begin fetal monitoring.
B. Preparing for immediate delivery.

C. Checking for ruptured membranes.
D. Providing comfort measures.

17. The nurse is caring for a client in labor. The external fetal monitor shows a pattern of variable decelerations in fetal heart rate. What should the nurse do first?

A. Change the client's position.
B. Prepare for emergency cesarean section.
C. Check for placenta previa.
D. Administer oxygen.

18. The nurse in charge is caring for a postpartum client who had a vaginal deliverywith a midline episiotomy. Which nursing diagnosis takes priority for this client?

A. Risk for deficient fluid volume related to hemorrhage
B. Risk for infection related to the type of delivery
C. Pain related to the type of incision
D. Urinary retention related to periurethral edema

19. Which change would the nurse identify as a progressive physiological change in postpartum period?

A. Lactation
B. Lochia
C. Uterine involution
D. Diuresis

20. A 39-year-old at 37 weeks gestation is admitted to the hospital with complaints of vaginal bleeding following the use of cocaine 1 hour earlier. Which complication is most likely causing the client's complaint of vaginal bleeding?

A. Placenta previa
B. Abruptio placentae
C. Ectopic pregnancy
D. Spontaneous abortion

21. A client with type 1 diabetes mellitus who is a multigravida visits the clinic at 27 weeks gestation. The nurse should instruct the client that for most pregnant women with type 1 diabetes mellitus:

A. Weekly fetal movement counts are made by the mother.
B. Contraction stress testing is performed weekly.
C. Induction of labor is begun at 34 weeks' gestation.
D. Nonstress testing is performed weekly until 32 weeks' gestation

22. When administering magnesium sulfate to a client with preeclampsia, the nurse understands that this drug is given to:

A. Prevent seizures
B. Reduce blood pressure
C. Slow the process of labor
D. Increase dieresis

23. What is the approximate time that the blastocyst spends traveling to the uterus for implantation?

A. 2 days
B. 7 days
C. 10 days
D. 14 weeks

24. After teaching a pregnant woman who is in labor about the purpose of the episiotomy, which of the following purposes stated by the client would indicate to the nurse that the teaching was effective?

A. Shortens the second stage of labor
B. Enlarges the pelvic inlet
C. Prevents perineal edema
D. Ensures quick placenta delivery

25. A primigravida client at about 35 weeks gestation in active labor has had no prenatal care and admits to cocaine use during the pregnancy. Which of the following persons must the nurse notify?

A. Nursing unit manager so appropriate agencies can be notified
B. Head of the hospital's security department
C. Chaplain in case the fetus dies in utero
D. Physician who will attend the delivery of the infant

26. When preparing a teaching plan for a client who is to receive a rubella vaccine during the postpartum period, the nurse in charge should include which of the following?

A. The vaccine prevents a future fetus from developing congenital anomalies
B. Pregnancy should be avoided for 3 months after the immunization
C. The client should avoid contact with children diagnosed with rubella
D. The injection will provide immunity against the 7-day measles.

27. A client with eclampsia begins to experience a seizure. Which of the following would the nurse in charge do first?

A. Pad the side rails
B. Place a pillow under the left buttock

C. Insert a padded tongue blade into the mouth
D. Maintain a patent airway

28. While caring for a multigravida client in early labor in a birthing center, which of the following foods would be best if the client requests a snack?

A. Yogurt
B. Cereal with milk
C. Vegetable soup
D. Peanut butter cookies

29. The multigravida mother with a history of rapid labor who us in active laborcalls out to the nurse, "The baby is coming!" which of the following would be the nurse's first action?

A. Inspect the perineum
B. Time the contractions
C. Auscultate the fetal heart rate
D. Contact the birth attendant

30. While assessing a primipara during the immediate postpartum period, the nurse in charge plans to use both hands to assess the client's fundus to:

A. Prevent uterine inversion
B. Promote uterine involution
C. Hasten the puerperium period
D. Determine the size of the fundus

Answers and Rationale

1. Answer: C. "What is your expected due date?"
When obtaining the history of a patient who may be in labor, the nurse's highest priority is to determine her current status, particularly her due date, gravidity, and parity. Gravidity and parity affect the duration of labor and the potential for labor complications. Later, the nurse should ask about chronic illness, allergies, and support persons.

2. Answer: B. Every 15 minutes
During the second stage of labor, the nurse should assess the strength, frequency, and duration of contraction every 15 minutes. If maternal or fetal problems are detected, more frequent monitoring is necessary. An interval of 30 to 60 minutes between assessments is too long because of variations in the length and duration of patient's labor.

3. Answer: A. Blurred vision

Blurred vision or other visual disturbance, excessive weight gain, edema, and increased blood pressure may signal severe preeclampsia. This condition may lead to eclampsia, which has potentially serious consequences for both the patient and fetus. Although hemorrhoids may be a problem during pregnancy, they do not require immediate attention. Increased vaginal mucus and dyspnea on exertion are expected as pregnancy progresses.

4. Answer: B. The patient has a child with cystic fibrosis

Cystic fibrosis is a recessive trait; each offspring has a one in four chance of having the trait or the disorder. Maternal age is not a risk factor until age 35, when the incidence of chromosomal defects increases. Maternal exposure to rubella during the first trimester may cause congenital defects. Although a history or preterm labor may place the patient at risk for preterm labor, it does not correlate with genetic defects.

5. Answer: C. 3 full days of elevated basal body temperature and clear, thin cervical mucus

Ovulation (the period when pregnancy can occur) is accompanied by a basal body temperature increase of 0.7 degrees F to 0.8 degrees F and clear, thin cervical mucus. A return to the preovulatory body temperature indicates a safe period for sexual intercourse. A slight rise in basal temperature early in the cycle is not significant. Breast tenderness and mittelschmerz are not reliable indicators of ovulation.

6. Answer: A. At the beginning of each fetal movement

An NST assesses the FHR during fetal movement. In a healthy fetus, the FHR accelerates with each movement. By pushing the control button when a fetal movement starts, the client marks the strip to allow easy correlation of fetal movement with the FHR. The FHR is assessed during uterine contractions in the oxytocin contraction test, not the NST. Pushing the control button after every three fetal movements or at the end of fetal movement wouldn't allow accurate comparison of fetal movement and FHR changes.

7. Answer: B. "If I have blurred or double vision, I should call the clinic immediately."

Blurred or double vision may indicate hypertension or preeclampsia and should be reported immediately. Urinary frequency is a common problem during pregnancy caused by increased weight pressure on the bladder from the uterus. Clients generally experience fatigue and nausea during pregnancy.

8. Answer: B. "I support your commitment; however, you may have to supplement each feeding with formula."

Recent breast reduction surgeries are done in a way to protect the milk sacs and ducts, so breast-feeding after surgery is possible. Still, it's good to check with the surgeon to determine what breast reduction procedure was done. There is the possibility that reduction surgery may have decreased the mother's ability to meet all of her baby's nutritional needs, and some supplemental feeding may be required. Preparing the

mother for this possibility is extremely important because the client's psychological adaptation to mothering may be dependent on how successfully she breast-feeds.

9. Answer: B. Instructing the client to use two or more peri pads to cushion the area

Using two or more peripads would do little to reduce the pain or promote perineal healing. Cold applications, sitz baths, and Kegel exercises are important measures when the client has a fourth-degree laceration.

10. Answer: B. grapelike clusters.

In a client with gestational trophoblastic disease, an ultrasound performed after the 3rd month shows grapelike clusters of transparent vesicles rather than a fetus. The vesicles contain a clear fluid and may involve all or part of the decidual lining of the uterus. Usually no embryo (and therefore no fetus) is present because it has been absorbed. Because there is no fetus, there can be no extrauterine pregnancy. An extrauterine pregnancy is seen with an ectopic pregnancy.

11. Answer: C. 1 cm above the ischial spines.

Fetal station — the relationship of the fetal presenting part to the maternal ischial spines — is described in the number of centimeters above or below the spines. A presenting part above the ischial spines is designated as –1, –2, or –3. A presenting part below the ischial spines, as +1, +2, or +3.

12. Answer: D. The baby's lips smacking

Assessing the attachment process for breast-feeding should include all of the answers except the smacking of lips. A baby who's smacking his lips isn't well attached and can injure the mother's nipples.

13. Answer: D. Ultrasound

Ultrasound is used between 18 and 40 weeks' gestation to identify normal fetal growthand detect fetal anomalies and other problems. Amniocentesis is done during the third trimester to determine fetal lung maturity. Chorionic villi sampling is performed at 8 to 12 weeks' gestation to detect genetic disease. Fetoscopy is done at approximately 18 weeks' gestation to observe the fetus directly and obtain a skin or blood sample.

14. Answer: C. The fetus isn't in distress at this time.

The BPP evaluates fetal health by assessing five variables: fetal breathing movements, gross body movements, fetal tone, reactive fetal heart rate, and qualitative amniotic fluidvolume. A normal response for each variable receives 2 points; an abnormal response receives 0 points. A score between 8 and 10 is considered normal, indicating that the fetus has a low risk of oxygen deprivation and isn't in distress. A fetus with a score of 6 or lower is at risk for asphyxia and premature birth; this score warrants detailed investigation. The BPP may or may not be repeated if the score isn't within normal limits.

15. Answer: C. "What changes have you made at home to get ready for the baby?"

During the third trimester, the pregnant client typically perceives the fetus as a separate being. To verify that this has occurred, the nurse should ask whether she has made appropriate changes at home such as obtaining infant supplies and equipment. The type of anesthesia planned doesn't reflect the client's preparation for parenting. The client should have begun prenatal classes earlier in the pregnancy. The nurse should have obtained dietary information during the first trimester to give the client time to make any necessary changes.

16. Answer: B. Preparing for immediate delivery.

This question requires an understanding of station as part of the intrapartum assessment process. Based on the client's assessment findings, this client is ready for delivery, which is the nurse's top priority. Placing the client in bed, checking for ruptured membranes, and providing comfort measures could be done, but the priority here is immediate delivery.

17. Answer: A. Change the client's position.

Variable decelerations in fetal heart rate are an ominous sign, indicating compression of the umbilical cord. Changing the client's position from supine to side-lying may immediately correct the problem. An emergency cesarean section is necessary only if other measures, such as changing position and amnioinfusion with sterile saline, prove unsuccessful. Administering oxygen may be helpful, but the priority is to change the woman's position and relieve cord compression.

18. Answer: A. Risk for deficient fluid volume related to hemorrhage

Hemorrhage jeopardizes the client's oxygen supply — the first priority among human physiologic needs. Therefore, the nursing diagnosis of Risk for deficient fluid volume related to hemorrhage takes priority over diagnoses of Risk for infection, Pain, and Urinary retention.

19. Answer: A. Lactation

Lactation is an example of a progressive physiological change that occurs during thepostpartum period.

20. Answer: B. Abruptio placentae

The major maternal adverse reactions from cocaine use in pregnancy include spontaneous abortion first, not third, trimester abortion and abruptio placentae.

21. Answer: D. Nonstress testing is performed weekly until 32 weeks' gestation

For most clients with type 1 diabetes mellitus, non stress testing is done weekly until 32 weeks' gestation and twice a week to assess fetal well-being.

22. Answer: A. Prevent seizures

The chemical makeup of magnesium is similar to that of calcium and, therefore, magnesium will act like calcium in the body. As a result, magnesium will block seizure activity in a hyper stimulated neurologic system by interfering with signal transmission at the neuromuscular junction.

23. Answer: B. 7 days

The blastocyst takes approximately 1 week to travel to the uterus for implantation.

24. Answer: A. Shortens the second stage of labor

An episiotomy serves several purposes. It shortens the second stage of labor, substitutes a clean surgical incision for a tear, and decreases undue stretching of perineal muscles. An episiotomy helps prevent tearing of the rectum but it does not necessarily relieves pressure on the rectum. Tearing may still occur.

25. Answer: D. Physician who will attend the delivery of the infant

The fetus of a cocaine-addicted mother is at risk for hypoxia, meconium aspiration, and intrauterine growth retardation (IUGR). Therefore, the nurse must notify the physician of the client's cocaine use because this knowledge will influence the care of the client and neonate. The information is used only in relation to the client's care.

26. Answer: B. Pregnancy should be avoided for 3 months after the immunization

After administration of rubella vaccine, the client should be instructed to avoid pregnancy for at least 3 months to prevent the possibility of the vaccines toxic effects to the fetus.

27. Answer: D. Maintain a patent airway

The priority for the pregnant client having a seizure is to maintain a patent airway to ensure adequate oxygenation to the mother and the fetus. Additionally, oxygen may be administered by face mask to prevent fetal hypoxia.

28. Answer: A. Yogurt

In some birth settings, intravenous therapy is not used with low-risk clients. Thus, clients in early labor are encouraged to eat healthy snacks and drink fluid to avoid dehydration. Yogurt, which is an excellent source of calcium and riboflavin, is soft and easily digested. During pregnancy, gastric emptying time is delayed. In most hospital settings, clients are allowed only ice chips or clear liquids.

29. Answer: A. Inspect the perineum

When the client says the baby is coming, the nurse should first inspect the perineum and observe for crowning to validate the client's statement. If the client is not delivering precipitously, the nurse can calm her and use appropriate breathing techniques.

30. Answer: A. Prevent uterine inversion

Using both hands to assess the fundus is useful for preventing uterine inversion.

XXIII(23) FON

1. 60 year old post CVA patient is taking TPA for his disease, the nurse understands that this is an example of what level of prevention?

a. primary
b. secondary
c. tertiary
d. nota

2. A female client undergoes yearly mammography. This is a type of what level of prevention?

a. primary
b. secondary
c. tertiary
d. nota

3. A diabetic patient was amputated following an unexpected necrosis on the right leg, he sustained and undergone BKA. He then underwent therapy on how to use his new prosthetic leg. This is a type of what level of prevention?

a. primary
b. secondary
c. tertiary
d. nota

4. As a care provider, The nurse should do first:

a. Provide direct nursing care.
b. Participate with the team in performing nursing intervention.
c. Therapeutic use of self.
d. Early recognition of the client's needs.

5. As a manager, the nurse should:

a. Initiates nursing action with co workers.
b. Plans nursing care with the patient.
c. Speaks in behalf of the patient.
d. Works together with the team.

6. The nurse shows a patient advocate role when

a. defend the patients right
b. refer patient for other services she needs
c. work with significant others
d. intercedes in behalf of the patient.

7. Which is the following is the most appropriate during the orientation phase?

a. patients perception on the reason of her hospitalization
b. identification of more effective ways of coping
c. exploration of inadequate coping skills
d. establishment of regular meeting of schedules

8. Preparing the client for the termination phase begins:

a. pre orientation
b. orientation
c. working
d. termination

9. A helping relationship is a process characterized by:

a. recovery promoting
b. mutual interaction
c. growth facilitating
d. health enhancing

10. During the nurse patient interaction, the nurse assesses the following to determine the patients coping strategy:

a. how are you feeling right now?
b. do you have anyone to take you home?
c. what do you think will help you right now?
d. How does your problem affect your life?

11. As a counselor, the nurse performs which of the following task?

a. encourage client to express feelings and concerns
b. helps client to learn a dance or song to enable her to participate in activities
c. help the client prepare in group activities
d. assist the client in setting limits on her behavior

12. Freud stresses out that the EGO

a. Distinguishes between things in the mind and things in the reality.
b. Moral arm of the personality that strives for perfection than pleasure.
c. Reservoir of instincts and drives
d. Control the physical needs instincts.

13. A 16 year old child is hospitalized, according to Erik Erikson, what is an appropriate intervention?

a. tell the friends to visit the child
b. encourage patient to help child learn lessons missed
c. call the priest to intervene
d. tell the child's girlfriend to visit the child.

14. NMS is characterized by :

a. hypertension, hyperthermia, flushed and dry skin.
b. Hypotension, hypothermia, flushed and dry skin.
c. Hypertension, hyperthermia, diaphoresis
d. Hypertension, hypothermia, diaphoresis

15. Which of the following drugs needs a WBC level checked regularly?

a. Lithane
b. Clozaril
c. Tofranil
d. Diazepam

16. Initially, The nurse identifies which of the ff: Nursing diagnosis:

a. self centred disturbance
b. impaired social interaction
c. sensory perceptual alteration
d. altered thought process

17. Which of the ff: is not a characteristic of PD?

a. disregard rights of others
b. loss of cognitive functioning
c. fails to conform to social norms
d. not capable of experiencing guild or remorse for their behaviour

18. The most effective treatment modality for persons if anti social PD is

a. hypnotherapy
b. gestalt therapy
c. behavior therapy
d. crisis intervention

19. Which of the following is not an example of alteration of perception?

a. ideas of reference
b. flight of ideas
c. illusion
d. hallucination

20. The type of anxiety that leads to personality disorganization is:

a. Mild
b. moderate
c. severe
d. panic

21. A client is admitted to the hospital. Twelve hours later the nurse observes hand tremors, hyperexicitability, tachycardia, diaphoresis and hypertension. The nurse suspects alcohol withdrawal. The nurse should ask the client:

a. at what time was your last drink taken?
b. Why didn't you tell us you're a drinker?
c. Do you drink beer or hard liquor?
d. How long have you been drinking?

22. Client with a history of schizophrenia has been admitted for suicidal ideation. The client states "God is telling me to kill myself right now." The nurse's best response is:

a. I understand that god's voice are real to you, But I don't hear anything. I will stay with you.
b. The voices are part of your illness; it will stop if you take medication
c. The voices are all in your imagination, think of something else and itll go away
d. don't think of anything right now, just go and relax.

23. In assessing a client's suicide potential, which statement by the client would give the nurse the HIGHEST cause for concern?

a. my thoughts of hurting myself are scary to me
b. I'd like to go to sleep and not wake up
c. I've thought about taking pills and alcohol till I pass out
d. I'd like to be free from all these worries

24. A client with paranoid schizophrenia has persecutory delusions and auditory hallucinations and is extremely agitated. He has been given a PRN dose ofThorazine IM. Which of the following would indicate to the nurse that the medication is having the desired effect?

a. Complains of dry mouth
b. State he feels restless in his body
c. Stops pacing and sits with the nurse
d. Exhibits increase activity and speech

25. A client who was wandering aimlessly around the streets acting inappropriately and appeared disheveled and unkempt was admitted to a psychiatric unit and is experiencing auditory and visual hallucinations. The nurse would develop a plan of care based on:

a. borderline personality disorder
b. anxiety disorder
c. schizophrenia
d. depression

26. A decision is made to not hospitalize a client with obsessive-compulsive disorder. Of the following abilities the client has demonstrated, the one that probably most influenced the decision not to hospitalize him is his ability to:

a. Hold a job.
b. Relate to his peers.
c. Perform activities of daily living.
d. Behave in an outwardly normal

27. A client is admitted to the inpatient psychiatric unit. He is unshaven, has body odor, and has spots on his shirt and pants. He moves slowly, gazes at the floor, and has a flat affect. The nurse's highest priority in assessing the client on admission would be to ask him:

a. How he sleeps at night.
b. If he is thinking about hurting himself.
c. About recent stresses.
d. How he feels about himself.

28. The nurse should know that the normal therapeutic level of lithium is :

a. .6 to 1.2 meq/L
b. 6 to 12 meq/L
c. .6 to .12 cc/ml
d. .6 to .12 cc3/L

29. The patient complaint of vomiting, diarrhea and restlessness after taking lithane. The nurse's initial intervention is:

a. recognize that this is a sign of toxicity and withhold the next medication.
b. Notify the physician.
c. Check V/S to validate patient's concerns.
d. Recognize that this is a normal side effects of lithium and still continue the drug.

30. The client is taking TOFRANIL. The nurse should closely monitor the patient for:

a. Hypertension
b. Hypothermia
c. Increase Intra Ocular Pressure
d. Increase Intra Cranial Pressure

31. A client was hospitalized with major depression with suicidal ideation for 1 week. He is taking venlafaxine (Effexor), 75 mg three times a day, and is planning to return to work. The nurse asks the client if he is experiencing thoughts of self-harm. The client responds, "I hardly think about it anymore and wouldn't do anything to hurt myself." The nurse judges:

a. The client to be decompensating and in need of being readmitted to the hospital.
b. The client to need an adjustment or increase in his dose of antidepressant.
c. The depression to be improving and the suicidal ideation to be lessening.
d. The presence of suicidal ideation to warrant a telephone call to the client's physician

32. The client is taking sertraline (Zoloft), 50 mg q AM. The nurse includes which of the following in the teaching plan about Zoloft?

a. Zoloft causes erectile dysfunction in men.
b. Zoloft causes postural hypotension
c. Zoloft increases appetite and weight gain
d. It may take 3-4 weeks before client will start feeling better.

33. After 3 days of taking haloperidol, the client shows an inability to sit still, is restless and fidgety, and paces around the unit. Of the following extrapyramidal adverse reactions, the client is showing signs of:

a. Dystonia.
b. Akathisia.
c. Parkinsonism.
d. Tardive dyskinesia.

34. After 10 days of lithium therapy, the client's lithium level is 1.0 mEq/L. The nurse knows that this value indicates which of the following?

a. A laboratory error.
b. An anticipated therapeutic blood level of the drug.
c. An atypical client response to the drug.
d. A toxic level.

35. When caring for a client receiving haloperidol (Haldol), the nurse would assess for which of the following?

a. Hypertensive episodes.
b. Extrapyramidal symptoms.
c. Hypersalivation.
d. Oversedation.

36. A client is brought to the hospital's emergency room by a friend, who states, "I guess he had some bad junk (heroin) today." In assessing the client, the nurse would likely find which of the following symptoms?

a. Increased heart rate, dilated pupils, and fever.
b. Tremulousness, impaired coordination, increased blood pressure, and ruddy complexion.
c. Decreased respirations, constricted pupils, and pallor.
d. Eye irritation, tinnitus, and irritation of nasal and oral mucosa.

37. The client has been taking the monoamine oxidase inhibitor (MAOI) phenelzine(Nardil), 10 mg bid. The physician orders a selective serotonin reuptake inhibitor (SSRI), paroxetine (Paxil), 20 mg given every morning. The nurse:

a. Gives the medication as ordered.
b. Questions the physician about the order.
c. Questions the dosage ordered.
d. Asks the physician to order benztropine (Cogentin) for the side effects.

38. Which of the following client statements about clozapine (Clozaril) indicates that the client needs additional teaching?

a. "I need to have my blood checked once every several months while I'm taking this drug."
b. "I need to sit on the side of the bed for a while when I wake up in the morning."
c. "The sleepiness I feel will decrease as my body adjusts to clozapine."
d. "I need to call my doctor whenever I notice that I have a fever or sore throat."

39. A client has been taking lithium carbonate (Lithane) for hyperactivity, as prescribed by his physician. While the client is taking this drug, the nurse should ensure that he has an adequate intake of:

a. Sodium.
b. Iron.
c. Iodine.
d. Calcium.

40. The client has been taking clomipramine (Anafranil) for his obsessive-compulsive disorder. He tells the nurse, "I'm not really better, and I've been taking the medication faithfully for the past 3 days just like it says on this prescription bottle." Which of the following actions would the nurse do first?

a. Tell the client to continue taking the medication as prescribed because it takes 5 to 10 weeks for a full therapeutic effect.
b. Tell the client to stop taking the medication and to call the physician.
c. Encourage the client to double the dose of his medication.
d. Ask the client if he has resumed smoking cigarettes.

41. The nurse judges correctly that a client is experiencing an adverse effect fromamitriptyline hydrochloride (Elavil) when the client demonstrates:

a. An elevated blood glucose level.
b. Insomnia.
c. Hypertension.
d. Urinary retention.

42. Which of the following health status assessments must be completed before the client starts taking imipramine (Tofranil)?

a. Electrocardiogram (ECG).
b. Urine sample for protein.
c. Thyroid scan.
d. Creatinine clearance test.

43. A client comes to the outpatient mental health clinic 2 days after being discharged from the hospital. The client was given a 1-week supply of clozapine(Clozaril). The nurse reviews information about clozapine with the client. Which client statement indicates an accurate understanding of the nurse's teaching about this medication?

a."I need to call my doctor in 2 weeks for a checkup."
b."I need to keep my appointment here at the hospital this week for a blood test."
c. "I can drink alcohol with this medication."
d. "I can take over-the-counter sleeping medication if I have trouble sleeping."

44. The client is taking risperidone (Risperdal) to treat the positive and negative symptoms of schizophrenia. Which of the following negative symptoms will improve?

a. Abnormal thought form.
b. Hallucinations and delusions.
c. Bizarre behaviour.
d. Asocial behaviour and anergia.

45. The nurse would teach the client taking tranylcypromine sulfate (Parnate) to avoid which food because of its high tyramine content?

a. Nuts.
b. Aged cheeses.
c. Grain cereals.
d. Reconstituted milk.

46. Which of the following clinical manifestations would alert the nurse to lithium toxicity?

a. Increasingly agitated behaviour.
b. Markedly increased food intake.
c. Sudden increase in blood pressure.
d.Anorexia with nausea and vomiting.

47. The client with depression has been hospitalized for 3 days on the psychiatric unit. This is the second hospitalization during the past year. The physician orders a different drug, tranylcypromine sulfate (Parnate), when the client does not respond positively to a tricyclic antidepressant. Which of the following reactions should the client be cautioned about if her diet includes foods containing tryaminetyramine?

a. Heart block.
b. Grand mal seizure.
c. Respiratory arrest.
d. Hypertensive crisis.

48. After the nurse has taught the client who is being discharged on lithium (Eskalith) about the drug, which of the following client statements would indicate that the teaching has been successful?

a. "I need to restrict eating any foods that contain salt."
b. "If I forget a dose, I can double the dose the next time I take it."
c. "I'll call my doctor right away for any vomiting, severe hand tremors, or muscle weakness."
d. "I should increase my fluid"

49. A nurse is caring for a client with Parkinson's disease who has been taking carbidopa/levodopa (Sinemet) for a year. Which of the following adverse reactions will the nurse monitor the client for?

a. dykinesia
b. glaucoma
c. hypotension
d. respiratory depression

50. A client is taking fluoxetine hydrochloride (Prozac) for treatment of depression. The client asks the nurse when the maximum therapeutic response occurs. The nurse's best response is that the maximum therapeutic response for fluoxetine hydrochloride may occur in the:

a. 10-14 days
b. First week
c. Third week
d. Fourth week

Answers & Rationale

1. **C. Tertiary :**
The client already had stroke, TPA stands for TRANSPLASMINOGEN ACTIVATOR which are thrombolytics, dissolving clots formed in the vessels of the brain. We are just preventing COMPLICATIONS here.
2. **b. secondary :**
The client is never sick of anything but we are detecting the POSSIBILITY by giving yearly mammography. Remember that all kinds of tests, case findings and treatment belongs
to the secondary level of prevention.

3. **c. tertiary :**
Tertiary prevention involves rehabilitation. Client is now being assisted to perform ADLs at his optimum functioning. Remember that all kinds of rehabilitatory and palliative management is included in tertiary prevention.

4. **d. Early recognition of the client's needs. :**
we are talking about what should the nurse do first. ASSESSMENT involves early recognition of clients needs. A,B,C are all involve in the intervention phase of the nursing process.

5. **d. Works together with the team. :**
As a nurse manager, you should be able to work with the team. A,B,C are not specific of a nurse manager. They can be done by an ordinary R.N.

6. **a. defend the patients right :**
An advocate role is shown when the nurse defends the rights of the client. Interceding in behalf of the patient should not be done by a nurse. Counter transference can develop in that case and we should avoid that. Only the family and the health attorney of the patient can intercede or speak for the patient.

7. **d. establishment of regular meeting of schedules :**
Orientation phase is synonymous with CONTRACT ESTABLISHMENT. Here, the nurse will establish regular meeting of schedule, agreements and giving the client information that there is a TERMINATION. Letter A and B assesses the client's coping skills, which is in the working phase and so is letter B. In working phase, The nurse assesses the coping
skills of the client and formulate plans and intervention to correct deficiencies. Although assessment is also made in the orientation phase, COPING SKILLS are assessed in the working phase.

8. **c. working :**
Telling the client that there is a TERMINATION PHASE should be in the ORIENTATION PHASE, however, in preparing the client for the TERMINATION, it should be done in the working phase.
The nurse will start to lessen the number of meetings to prevent development of transference or counter transference.

9. **c. growth facilitating :**
In psychiatric nursing, The epitome of all nursing goal should focus on facilitating GROWTH of the client.

10. **d. How does your problem affect your life? :**
this is the only question that determines the effects of the problem on the client and the ways she is dealing with it. Letter A can only be answered by FINE
and close further communication. B is unrelated to coping strategies. Letter C, asking the client what do you think can help you right now is INAPPROPRIATE for the nurse to ask. The client is in the hospital because she needs help. If she knows something that can help her with her problem she shouldn't be there.

11. **a. encourage client to express feelings and concerns :**
A counselor is much more of a listener than a speaker. She encourage the client to

express feelings and concerns as to formulate necessary response and facilitate a channel to express anger, disappointments and frustrations.

12. **a. Distinguishes between things in the mind and things in the reality. :**
The ego is responsible for distinguishing what is REAL and what is NOT. It is the one that balances the ID and super ego. B and D
is a characteristic of the SUPER EGO which is the CONTROLLER of instincts and drives and serve as our CONSCIENCE or the MORAL ARM. The ID is our DRIVES and INSTINCTS that is mediated by the EGO and controlled by the SUPER EGO.

13. **a. tell the friends to visit the child :**
The child is 16 years old, In the stage of IDENTITY VS. ROLE CONFUSION. The most significant persons in this group are the PEERS. B refers to children in the school age while C refers to the young adulthood stage of INTIMACY VS. ISOLATION. The child is not dying and the situation did not even talk about the child's belief therefore, calling the priest is unnecessary.

14. **c. Hypertension, hyperthermia, diaphoresis. :**
Neuroleptic malignant syndrome is a side effect of neuroleptics. This is characterized by fever, increase in blood pressure and warm, diaphoretic skin.

15. **b. Clozaril :**
Clozapine is a dreaded aypical antipsychotic because it causes severe bone marrow depression, agranulocytosis, infection and sore throat. WBC count is important to assess if the clients immune function is severely impaired. The first presenting sign of agranulocytosis is SORE THROAT.

16. **b. impaired social interaction :**
There is no such nursing diagnosis as A , looking at C and D, they are much more compatible to schizophrenia which is not a characteristic of an ANTI SOCIAL P.D which is shown in the situation. Remember that Personality Disorder is FAR from Psychoses. When client exhibits altered thought process or sensory alteration, It is not anymore a personality disorder but rather, a sign and symptom of psychoses.

17. **b. loss of cognitive functioning :**
As I said, symptoms of PD will never show alteration in cognitive functioning. They are much more of SOCIAL Disturbances rather than PSYCHOLOGICAL.

18. **c. behavior therapy :**
The problem of the patient is his behavior. A is done for patient who has insomnia or severe anxiety. B is a therapy that promotes growth by providing a contact, either a person or an environment who will facilitate the growth of an individual. It is a humanistic psychotherapeutic model approach. D is done on clients who are in crisis like trauma, post traumatic disorders, raped or accidents.

19.**b. flight of ideas :**
Flight of ideas is a condition in which patient talks continuously and then switching to unrelated topic. An example is " Ang ganda ng bulaklak na ito no budek? Rose ito hindi ba? Kilala mo ba si jack yung boyfriend ni rose? Grabe yung barko no ang laki laki

tapos lumubog lang. Dapat sana nag seaman ako eh, gusto kasi ng nanay ko. “. Loose association is somewhat similar but the switch in topic is more obvious and completely unrelated. Example “ Ang cute nung rabbit, paano si paul kasi tanga eh, papapatay ko yan kay albert. Ang ganda nung bag na binigay ni jenny, tanga nga lang yung aswang dun sa kanto. Pero bakit ka ba andito? Wala akong pagkain, Penge ako kotse aakyat ako everest.”
A,C,D are all alteration in perception. A refers to a person thinking that everyone is talking about him. C and D are all sensory alterations. The difference is that, in hallucination, there is no need for a stimuli. In illusion, a stimuli [A phone cord] is mistakenly identified by the client as something else [Snake]

20. **d. panic :**
Panic is the only level of anxiety that leads to personality disorganization.

21. **a. at what time was your last drink taken? :**
This question will give the nurse idea WHEN will the withdrawal occur. Withdrawal occurs 5 to 10 hours after the last intake of alcohol. This is a crucial and mortality is very high during this period. Client will undergo delirium tremens, seizures and DEATH if not recognize earlier by the nurse. B is very judgmental, C is non specific, whether it is a beer or a wine It is still alcohol and has the same effects. D is a valuable question to determine the chronic effects of alcohol ingestion but asking letter A can broaden the line between life and death.

22. **a. I understand that god’s voice are real to you, But I don’t hear anything. I will stay with you. :**
The nurse should first ACKNOWLEDGE that the voices are real to the patient and then, PRESENT REALITY by telling the patient that you do not hear anything. The third part of the nursing intervention in hallucination is LESSENING THE STIMULI by either staying with the patient or removing the patient from a highly stimulating place. Telling the client that the voices is part of his illness is not therapeutic. People with schizophrenia do not think that they are ILL. Letter C and D disregards the client’s concern and therefore, not therapeutic.

23. **c. I’ve thought about taking pills and alcohol till I pass out :**
This is the only statement of the client that contains a specific and technical plan. B,D are all indicative of suicidal ideation but it contains
no specific plans to carry out the objective. Letter A admits the client thinks of hurting himself, but not doing it because it scares him, therefore, it is not indicative of suicidal ideation.

24.**c. Stops pacing and sits with the nurse :**
Thorazine is a neuroleptic. Desired effect evolve on controlling the client’s psychoses. Letter A is the side effect of the drug, which is not desired. B and D
indicates that the drug is not effective in controlling the client’s agitation, restlessness and disorders of perception.
25. **c. schizophrenia :**
When disorders of perception and thoughts came in, The only feasible diagnosis a

doctor can make is among the choices is schizophrenia. A,B and D can occur in normal individuals without altering their perceptions. Schizophrenia is characterized by disorders of thoughts, hallucination, delusion, illusion and disorganization.

26. **c. Perform activities of daily living :**
If a client can do ADLs , there is no reason for that client to be hospitalized.

27. **b. If he is thinking about hurting himself :**
The client shows typical sign and symptoms of DEPRESSION. Moving slowly, gazes on the floor, blank stares and showing flat affect. The highest priority among depressed client is assessing any suicide plans or ideation for the nurse to establish a no suicide contract early on or, in any case client do not participate in a no suicide contract, a 24 hour continuous
monitoring is established.

28. **a. .6 to .12 meq/L :**
According to brunner and suddarths MS nursing, The normal therapeutic level of lithium is .6 to 1.2 meq/L. Some books will say .5 to 1.5 meq/L.

29. **a. Recognize that this is a sign of toxicity and withhold the next medication. :**
The nurse should recognize that this is an early s/s of lithium toxicity. Taking the clients vital signs will not confirm diarrhea,
vomiting or restlessness. Notifying the physician is unnecessary at this point and the physician will likely to withhold the medication.

30. **c. Increase Intra Ocular Pressure :**
Tofranil is a neuroleptic. It is well known that this is the antipsychotic that increases the IOP and contraindicated in patients with glaucoma. Hypertension is not specific with TOFRANIL. All neuroleptics can cause NMS or the neuroleptic malignant syndrome.

31. **c. The depression to be improving and the suicidal ideation to be lessening. :**
too obvious, no need to rationalize.

32. **a. Zoloft causes erectile dysfunction in men :**
When you take zoloft, mag zozoloft ka nalang sa buhay. Because it causes erectile dysfuntion and decrease libido. Letter B and C are specific of TCAs.
Zoloft will exert its effects as early as 1 week.

33. **b. Akathisia :**
The client shows sign of motor restlessness, which is specific for Akathisia or MAKATI SYA.

34. **b. An anticipated therapeutic blood level of the drug.**

35. **b. Extrapyramidal symptoms :**
Haldol is a neuroleptic, Specific to these neuroleptics are the EPS. The client will likely be hypotensive than hypertensive because neuroleptics causes postural hypotension, The client will complaint of dry mouth due to its anticholinergic properties. Dizziness and drowsiness are side effects of neuroleptics but not oversedation.

36.**c. Decreased respirations, constricted pupils, and pallor. :**
Heroin is a narcotic. Together with morphine, meperidine, codeine and opiods, they are DEPRESSANTS and will cause decrease respiration,
constricted pupils and pallor due to vasoconstriction.

37. **b. Questions the physician about the order :**
2 anti depressants cannot be given at the same time unless the other one is tapered while the other one is given gradually.

38. **d. "I need to call my doctor whenever I notice that I have a fever or sore throat." :**
Clozapine causes AGRANULOCYTOSIS and bone marrow depression. Early s/s includes fever and sore throat. The
medication is to be withheld this time or the patient might develop severe infection leading to death.

39. **a. Sodium :**
The levels of lithium in the body are dependent on sodium. The higher the sodium, The lower the levels of lithium. Clients should have an adequate intake of sodium to prevent sudden increase in the levels of lithium leading to toxicity and death.

40. **a. Tell the client to continue taking the medication as prescribed because it takes 5 to 10 weeks for a full therapeutic effect.** :
Anafranil is an anti depressant, effects are noticeable within 1 to 2 weeks.

41. **d. Urinary retention :**
Elavil is an TC antidepressant. It should not cause insomnia. Hypertension are specific of MAOI anti depressants when tyramine is ingested. Due to the anticholinergic s/e of TCAs, Urinary retention is an adverse effect.

42. **a. Electrocardiogram (ECG).** :
Aside from tonometry or IOP measurement, Client should undergo regular ECG schedule. Most TCAs cause tachycardias and ECG changes, an ECG should be done before
the client takes the medication.

43. **b."I need to keep my appointment here at the hospital this week for a blood test." :**
Regular blood check up is required for patients taking clozaril. As frequent as every 2 weeks. Clozapine can cause bone marrow depression, therefore, frequent blood counts are necessary.

44. **d. Asocial behaviour and anergia :**
A,B and C are all positive symptoms of schizophrenia. Negative symptoms includes anhedonia, anergia, associative looseness and Asocial behavior.

45. **b. Aged cheeses. :**
This is high in tyramine, and therefore, removed from patients diet to prevent hypertensive crisis.

46. **d.Anorexia with nausea and vomiting.**

47.**d. Hypertensive crisis.**

48. **c. "I'll call my doctor right away for any vomiting, severe hand tremors, or muscle weakness." :**

This is a sign of light lithium toxicity. Increasing fluid intake will cause dilutional decrease of lithium level. Restriction of sodium will cause dilutional increase in lithium level.

49. **c. hypotension :**
Hypotension, dizziness and lethargy are side effects of anti parkinson drugs like levodopaand carbidopa.

50. **c. Third week :**
A and B are similar, therefore, removed them first. Recognizing that mostantidepressants exert their effects within 2-3 weeks will lead you to letter C.

XXIV (24)

1. Using the principles of standard precautions, the nurse would wear gloves in what nursing interventions?
A. Providing a back massage
B. Feeding a client
C. Providing hair care
D. Providing oral hygiene

2. The nurse is preparing to take vital sign in an alert client admitted to the hospital with dehydration secondary to vomiting and diarrhea. What is the best method used to assess the client's temperature?
A. Oral
B. Axillary
C. Radial
D. Heat sensitive tape

3. A nurse obtained a client's pulse and found the rate to be above normal. The nurse document this findings as:
A. Tachypnea
B. Hyperpyrexia
C. Arrhythmia
D. Tachycardia

4. Which of the following actions should the nurse take to use a wide base support when assisting a client to get up in a chair?
A. Bend at the waist and place arms under the client's arms and lift
B. Face the client, bend knees and place hands on client's forearm and lift
C. Spread his or her feet apart
D. Tighten his or her pelvic muscles

5. A client had oral surgery following a motor vehicle accident. The nurse assessing the client finds the skin flushed and warm. Which of the following would be the best method to take the client's body temperature?
A. Oral
B. Axillary
C. Arterial line
D. Rectal

6. A client who is unconscious needs frequent mouth care. When performing a mouth care, the best position of a client is:
A. Fowler's position
B. Side lying
C. Supine
D. Trendelenburg

7. A client is hospitalized for the first time, which of the following actions ensure the safety of the client?

A. Keep unnecessary furniture out of the way
B. Keep the lights on at all time
C. Keep side rails up at all time
D. Keep all equipment out of view

8. A walk-in client enters into the clinic with a chief complaint of abdominal pain and diarrhea. The nurse takes the client's vital sign hereafter. What phrase of nursing process is being implemented here by the nurse?

A. Assessment
B. Diagnosis
C. Planning
D. Implementation

9. It is best describe as a systematic, rational method of planning and providing nursing care for individual, families, group and community

A. Assessment
B. Nursing Process
C. Diagnosis
D. Implementation

10. Exchange of gases takes place in which of the following organ?

A. Kidney
B. Lungs
C. Liver
D. Heart

11. The chamber of the heart that receives oxygenated blood from the lungs is the:

A. Left atrium
B. Right atrium
C. Left ventricle
D. Right ventricle

12. A muscular enlarge pouch or sac that lies slightly to the left which is used for temporary storage of food…

A. Gallbladder
B. Urinary bladder
C. Stomach
D. Lungs

13. The ability of the body to defend itself against scientific invading agent such as baceria, toxin, viruses and foreign body

A. Hormones
B. Secretion
C. Immunity
D. Glands

14. Hormones secreted by Islets of Langerhans

A. Progesterone
B. Testosterone
C. Insulin
D. Hemoglobin

15. It is a transparent membrane that focuses the light that enters the eyes to the retina.

A. Lens
B. Sclera
C. Cornea
D. Pupils

16. Which of the following is included in Orem's theory?

A. Maintenance of a sufficient intake of air
B. Self perception
C. Love and belongingness
D. Physiologic needs

17. Which of the following cluster of data belong to Maslow's hierarchy of needs

A. Love and belonging
B. Physiologic needs
C. Self actualization
D. All of the above

18. This is characterized by severe symptoms relatively of short duration.

A. Chronic Illness
B. Acute Illness
C. Pain
D. Syndrome

19. Which of the following is the nurse's role in the health promotion

A. Health risk appraisal
B. Teach client to be effective health consumer
C. Worksite wellness
D. None of the above

20. It is describe as a collection of people who share some attributes of their lives.

A. Family
B. Illness

C. Community
D. Nursing

21. Five teaspoon is equivalent to how many milliliters (ml)?
A. 30 ml
B. 25 ml
C. 12 ml
D. 22 ml

22. 1800 ml is equal to how many liters?
A. 1.8
B. 18000
C. 180
D. 2800

23. Which of the following is the abbreviation of drops?
A. Gtt.
B. Gtts.
C. Dp.
D. Dr.

24. The abbreviation for micro drop is…
A. µgtt
B. gtt
C. mdr
D. mgts

25. Which of the following is the meaning of PRN?
A. When advice
B. Immediately
C. When necessary
D. Now

26. Which of the following is the appropriate meaning of CBR?
A. Cardiac Board Room
B. Complete Bathroom
C. Complete Bed Rest
D. Complete Board Room

27. One (1) tsp is equals to how many drops?
A. 15
B. 60
C. 10
D. 30

28. 20 cc is equal to how many ml?
A. 2
B. 20
C. 2000
D. 20000

29. 1 cup is equals to how many ounces?
A. 8
B. 80
C. 800
D. 8000

30. The nurse must verify the client's identity before administration of medication. Which of the following is the safest way to identify the client?
A. Ask the client his name
B. Check the client's identification band
C. State the client's name aloud and have the client repeat it
D. Check the room number

31. The nurse prepares to administer buccal medication. The medicine should be placed…
A. On the client's skin
B. Between the client's cheeks and gums
C. Under the client's tongue
D. On the client's conjunctiva

32. The nurse administers cleansing enema. The common position for this procedure is…
A. Sims left lateral
B. Dorsal Recumbent
C. Supine
D. Prone

33. A client complains of difficulty of swallowing, when the nurse try to administer capsule medication. Which of the following measures the nurse should do?
A. Dissolve the capsule in a glass of water
B. Break the capsule and give the content with an applesauce
C. Check the availability of a liquid preparation
D. Crash the capsule and place it under the tongue

34. Which of the following is the appropriate route of administration for insulin?
A. Intramuscular
B. Intradermal
C. Subcutaneous
D. Intravenous

35. The nurse is ordered to administer ampicillin capsule TID p.o. The nurse should give the medication…
A. Three times a day orally
B. Three times a day after meals
C. Two time a day by mouth
D. Two times a day before meals

36. Back Care is best describe as:

A. Caring for the back by means of massage
B. Washing of the back
C. Application of cold compress at the back
D. Application of hot compress at the back

37. It refers to the preparation of the bed with a new set of linens

A. Bed bath
B. Bed making
C. Bed shampoo
D. Bed lining

38. Which of the following is the most important purpose of handwashing

A. To promote hand circulation
B. To prevent the transfer of microorganism
C. To avoid touching the client with a dirty hand
D. To provide comfort

39. What should be done in order to prevent contaminating of the environment in bed making?

A. Avoid fanning soiled linens
B. Strip all linens at the same time
C. Finished both sides at the time
D. Embrace soiled linen

40. The most important purpose of cleansing bed bath is:

A. To cleanse, refresh and give comfort to the client who must remain in bed
B. To expose the necessary parts of the body
C. To develop skills in bed bath
D. To check the body temperature of the client in bed

41. Which of the following technique involves the sense of sight?

A. Inspection
B. Palpation
C. Percussion
D. Auscultation

42. The first techniques used examining the abdomen of a client is:

A. Palpation
B. Auscultation
C. Percussion
D. Inspection

43. A technique in physical examination that is use to assess the movement of air through the tracheobronchial tree:

A. Palpation
B. Auscultation
C. Inspection
D. Percussion

44. An instrument used for auscultation is:

A. Percussion-hammer
B. Audiometer
C. Stethoscope
D. Sphygmomanometer

45. Resonance is best describe as:
A. Sounds created by air filled lungs
B. Short, high pitch and thudding
C. Moderately loud with musical quality
D. Drum-like

46. The best position for examining the rectum is:
A. Prone
B. Sim's
C. Knee-chest
D. Lithotomy

47. It refers to the manner of walking
A. Gait
B. Range of motion
C. Flexion and extension
D. Hopping

48. The nurse asked the client to read the Snellen chart. Which of the following is tested:
A. Optic
B. Olfactory
C. Oculomotor
D. Trochlear

49. Another name for knee-chest position is:
A. Genu-dorsal
B. Genu-pectoral
C. Lithotomy
D. Sim's

50. The nurse prepare IM injection that is irritating to the subcutaneous tissue. Which of the following is the best action in order to prevent tracking of the medication
A. Use a small gauge needle
B. Apply ice on the injection site
C. Administer at a 45° angle
D. Use the Z-track technique

Answers and Rationale

1. Answer: D. Providing oral hygiene

Doing oral care requires the nurse to wear gloves.

2. Answer: B. Axillary

Axilla is the most accessible body part in this situation.

3. Answer: D. Tachycardia

Tachycardia means rapid heart rate. Tachypnea (Option A) refers to rapid respiratory rate. Hyperpyrexia (Option B) means increase in temperature. Arrhythmia (Option C) means irregular heart rate.

4. Answer: B. Face the client, bend knees and place hands on client's forearm and lift

This is the proper way on supporting the client to get up in a chair that conforms to safety and proper body mechanics.

5. Answer: B. Axillary

Taking the temperature via the oral route is incorrect since the client had oral surgery. Choice C and D are unnecessary. Taking the temperature via the axilla is the most appropriate route.

6. Answer: B. Side lying

An unconscious client is best placed on his side when doing oral care to prevent aspiration.

7. Answer: C. Keep side rails up at all time

Although the other choices seem correct, they are not the best answer.

8. Answer: A. Assessment

Assessment is the first phase of the nursing process where a nurse collects information about the client. Diagnosis is the formulation of the nursing diagnosis from the information collected during the assessment. In Planning, the nurse sets achievable and measurable short and long term goals. Implementation is where nursing care is given.

9. Answer: B. Nursing Process

The statement describes the Nursing Process. The Nursing Process is the essential core of practice for the registered nurse to deliver holistic, patient-focused care.

10. Answer: B. Lungs

11. Answer: A. Left atrium

The **left atrium** receives oxygenated blood from the lungs and pumps it to the **left ventricle**. The right atrium receives blood from the veins and pumps it to the right ventricle. The **right ventricle** receives blood from the right atrium and pumps it to the lungs, where it is loaded with oxygen. The **left ventricle** (the strongest chamber) pumps oxygen-rich blood to the rest of the body, its vigorous contractions create the blood pressure.

12. Answer: C. Stomach

13. Answer: C. Immunity

14. Answer: C. Insulin

The Islets of Langerhans are the regions of the pancreas that contain its endocrine cells.Progesterone (Choice A) is produced by the ovaries. Testosterone (Choice B) is secreted by the testicles of males and ovaries of females. Hemoglobin (Choice D) is a protein molecule in the red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide.

15. Answer: C. Cornea

The cornea is the transparent front part of the eye that covers the iris, pupil, and anterior chamber. The cornea is like the crystal of a watch.

16. Answer: A. Maintenance of a sufficient intake of air

Dorothea Orem's Self-Care Theory defined Nursing as "The act of assisting others in the provision and management of self-care to maintain or improve human functioning at home level of effectiveness." Choices B, C, and D are from Abraham Maslow's Hierarchy of Needs.

17. Answer: D. All of the above

All of the choices are part of Maslow's Hierarchy of Needs.

18. Answer: B. Acute Illness

Chronic Illness (Choice A) are illnesses that are persistent or long-term.

19. Answer: B. Teach client to be effective health consumer

20. Answer: C. Community

Family is defined as a group consisting typically of parents and children living together in a household.

21. Answer: B. 25 ml

One teaspoon is equal to 5ml.

22. Answer: A. 1.8

23. Answer: B. Gtts.

Gtt (Choice A) is an abbreviation for drop. Dp and Dr are not recognized abbreviation for measurement.

24. Answer: A. µgtt

25. Answer: C. When necessary

PRN comes from the Latin "pro re nata" meaning, for an occasion that has arisen or as circumstances require.

26. Answer: C. Complete Bed Rest

CBR means complete bed rest. For more abbreviations, please see this post.

27. Answer: B. 60

One teaspoon (tsp) is equal to 60 drops (gtts).

28. Answer: B. 20

One cubic centimeter is equal to one milliliter.

29. Answer: A. 8

One cup is equal to 8 ounces.

30. Answer: B. Check the client's identification band

The identification band is the safest way to know the identity of a patient whether he is conscious or unconscious. Ask the client his name only after you have checked his ID band.

31. Answer: B. Between the client's cheeks and gums

32. Answer: A. Sims left lateral

This position provides comfort to the patient and an easy access to the natural curvature of the rectum.

33. Answer: C. Check the availability of a liquid preparation

The nurse should check first if the medication is available in liquid form before doing Choice A. Placing it under the tongue is not the intended way of administering an oral medication.

34. Answer: C. Subcutaneous

The subcutaneous tissue of the abdomen is preferred because absorption of the insulin is more consistent from this location than subcutaneous tissues in other locations.

35. Answer: A. Three times a day orally
TID is the Latin for "ter in die" which means three times a day. P.O. means per orem or through mouth.
36. Answer: A. Caring for the back by means of massage
37. Answer: B. Bed making
38. Answer: B. To prevent the transfer of microorganism
Hand washing is the single most effective infection control measure.

38. Answer: A. Avoid fanning soiled linens
Fanning soiled linens would scatter the lodged microorganisms and dead skin cells on the linens.

40. Answer: A. To cleanse, refresh and give comfort to the client who must remain in bed

41. Answer: A. Inspection

Palpation is a method of feeling with the fingers or hands during a physical examination. **Percussion** is a method of tapping on a surface to determine the underlying structure, and is used in clinical examinations to assess the condition of the

thorax or abdomen. **Auscultation** (based on the Latin verb auscultare “to listen”) is listening to the internal sounds of the body, usually using a stethoscope.

42. Answer: D. Inspection

For abdominal exam, auscultation is performed before palpation because the act of palpation could change what was auscultated. Remember the mnemonic “I-A-Per-Pal”.

43. Answer: B. Auscultation

44. Answer: C. Stethoscope

45. Answer: A. Sounds created by air filled lungs

46. Answer: C. Knee-chest

To assume the genupectoral position the person kneels so that the weight of the body is supported by the knees and chest, with the buttocks raised. The head is turned to one side and the arms are flexed so that the upper part of the body can be supported in part by the elbows.

47. Answer: A. Gait

48. Answer: A. Optic

Cranial Nerve II or the optic nerve is tested through the use of the Snellen chart.

49. Answer: B. Genu-pectoral

50. Answer: D. Use the Z-track technique

During the procedure, skin and tissue are pulled and held firmly while a long needle is inserted into the muscle. After the medication is injected, the skin and tissue are released. The needle track that forms during this procedure takes the shape of the letter “Z,” which gives the procedure its name. This zigzag track line is what prevents medication from leaking from the muscle into surrounding tissue.

XXV (25)

1. The most appropriate nursing order for a patient who develops dyspnea and shortness of breath would be…

A. Maintain the patient on strict bed rest at all times
B. Maintain the patient in an orthopneic position as needed
C. Administer oxygen by Venturi mask at 24%, as needed
D. Allow a 1 hour rest period between activities

2. The nurse observes that Mr. Adams begins to have increased difficulty breathing. She elevates the head of the bed to the high Fowler position, which decreases his respiratory distress. The nurse documents this breathing as:

A. Tachypnea
B. Eupnea
C. Orthopnea
D. Hyperventilation

3. The physician orders a platelet count to be performed on Mrs. Smith after breakfast. The nurse is responsible for:

A. Instructing the patient about this diagnostic test
B. Writing the order for this test
C. Giving the patient breakfast
D. All of the above

4. Mrs. Mitchell has been given a copy of her diet. The nurse discusses the foods allowed on a 500-mg low sodium diet. These include:

A. A ham and Swiss cheese sandwich on whole wheat bread
B. Mashed potatoes and broiled chicken
C. A tossed salad with oil and vinegar and olives
D. Chicken bouillon

5. The physician orders a maintenance dose of 5,000 units of subcutaneous heparin (an anticoagulant) daily. Nursing responsibilities for Mrs. Mitchell now include:

A. Reviewing daily activated partial thromboplastin time (APTT) and prothrombin time.
B. Reporting an APTT above 45 seconds to the physician
C. Assessing the patient for signs and symptoms of frank and occult bleeding
D. All of the above

6. The four main concepts common to nursing that appear in each of the current conceptual models are:

A. Person, nursing, environment, medicine
B. Person, health, nursing, support systems
C. Person, health, psychology, nursing
D. Person, environment, health, nursing

7. In Maslow's hierarchy of physiologic needs, the human need of greatest priority is:

A. Love
B. Elimination
C. Nutrition
D. Oxygen

8. The family of an accident victim who has been declared brain-dead seems amenable to organ donation. What should the nurse do?

A. Discourage them from making a decision until their grief has eased
B. Listen to their concerns and answer their questions honestly
C. Encourage them to sign the consent form right away
D. Tell them the body will not be available for a wake or funeral

9. A new head nurse on a unit is distressed about the poor staffing on the 11 p.m. to 7 a.m. shift. What should she do?

A. Complain to her fellow nurses
B. Wait until she knows more about the unit
C. Discuss the problem with her supervisor
D. Inform the staff that they must volunteer to rotate

10. Which of the following principles of primary nursing has proven the most satisfying to the patient and nurse?

A. Continuity of patient care promotes efficient, cost-effective nursing care
B. Autonomy and authority for planning are best delegated to a nurse who knows the patient well
C. Accountability is clearest when one nurse is responsible for the overall plan and its implementation.
D. The holistic approach provides for a therapeutic relationship, continuity, and efficient nursing care.

11. If nurse administers an injection to a patient who refuses that injection, she has committed:

A. Assault and battery
B. Negligence
C. Malpractice
D. None of the above

12. If patient asks the nurse her opinion about a particular physicians and the nurse replies that the physician is incompetent, the nurse could be held liable for:

A. Slander
B. Libel
C. Assault
D. Respondent superior

13. A registered nurse reaches to answer the telephone on a busy pediatric unit, momentarily turning away from a 3 month-old infant she has been weighing. The infant falls off the scale, suffering a skull fracture. The nurse could be charged with:

A. Defamation
B. Assault
C. Battery
D. Malpractice

14. Which of the following is an example of nursing malpractice?

A. The nurse administers penicillin to a patient with a documented history of allergy to the drug. The patient experiences an allergic reaction and has cerebral damage resulting from anoxia.
B. The nurse applies a hot water bottle or a heating pad to the abdomen of a patient with abdominal cramping.
C. The nurse assists a patient out of bed with the bed locked in position; the patient slips and fractures his right humerus.
D. The nurse administers the wrong medication to a patient and the patient vomits. This information is documented and reported to the physician and the nursing supervisor.

15. Which of the following signs and symptoms would the nurse expect to find when assessing an Asian patient for postoperative pain following abdominal surgery?

A. Decreased blood pressure and heart rate and shallow respirations
B. Quiet crying
C. Immobility, diaphoresis, and avoidance of deep breathing or coughing
D. Changing position every 2 hours

16. A patient is admitted to the hospital with complaints of nausea, vomiting, diarrhea, and severe abdominal pain. Which of the following would immediately alert the nurse that the patient has bleeding from the GI tract?

A. Complete blood count
B. Guaiac test
C. Vital signs
C. Abdominal girth

17. The correct sequence for assessing the abdomen is:

A. Tympanic percussion, measurement of abdominal girth, and inspection
B. Assessment for distention, tenderness, and discoloration around the umbilicus.
C. Percussions, palpation, and auscultation
D. Auscultation, percussion, and palpation

18. High-pitched gurgles head over the right lower quadrant are:

A. A sign of increased bowel motility
B. A sign of decreased bowel motility
C. Normal bowel sounds
D. A sign of abdominal cramping

19. A patient about to undergo abdominal inspection is best placed in which of the following positions?

A. Prone
B. Trendelenburg
C. Supine
D. Side-lying

20. For a rectal examination, the patient can be directed to assume which of the following positions?

A. Genupectoral
B. Sims
C. Horizontal recumbent
D. All of the above

21. During a Romberg test, the nurse asks the patient to assume which position?

A. Sitting
B. Standing
C. Genupectoral
D. Trendelenburg

22. If a patient's blood pressure is 150/96, his pulse pressure is:

A. 54
B. 96
C. 150
D. 246

23. A patient is kept off food and fluids for 10 hours before surgery. His oral temperature at 8 a.m. is 99.8 F (37.7 C) This temperature reading probably indicates:

A. Infection
B. Hypothermia
C. Anxiety
D. Dehydration

24. Which of the following parameters should be checked when assessing respirations?

A. Rate
B. Rhythm
C. Symmetry
D. All of the above

25. A 38-year old patient's vital signs at 8 a.m. are axillary temperature 99.6 F (37.6 C); pulse rate, 88; respiratory rate, 30. Which findings should be reported?

A. Respiratory rate only
B. Temperature only
C. Pulse rate and temperature
D. Temperature and respiratory rate

26. All of the following can cause tachycardia except:

A. Fever
B. Exercise
C. Sympathetic nervous system stimulation
D. Parasympathetic nervous system stimulation

27. Palpating the midclavicular line is the correct technique for assessing

A. Baseline vital signs
B. Systolic blood pressure
C. Respiratory rate
D. Apical pulse

28. The absence of which pulse may not be a significant finding when a patient is admitted to the hospital?

A. Apical
B. Radial
C. Pedal
D. Femoral

29. Which of the following patients is at greatest risk for developing pressure ulcers?

A. An alert, chronic arthritic patient treated with steroids and aspirin
B. An 88-year old incontinent patient with gastric cancer who is confined to his bed at home
C. An apathetic 63-year old COPD patient receiving nasal oxygen via cannula
D. A confused 78-year old patient with congestive heart failure (CHF) who requires assistance to get out of bed.

30. The physician orders the administration of high-humidity oxygen by face mask and placement of the patient in a high Fowler's position. After assessing Mrs. Paul, the nurse writes the following nursing diagnosis: Impaired gas exchange related to increased secretions. Which of the following nursing interventions has the greatest potential for improving this situation?

A. Encourage the patient to increase her fluid intake to 200 ml every 2 hours
B. Place a humidifier in the patient's room.
C. Continue administering oxygen by high humidity face mask
D. Perform chest physiotherapy on a regular schedule

31. The most common deficiency seen in alcoholics is:

A. Thiamine
B. Riboflavin
C. Pyridoxine
D. Pantothenic acid

32. Which of the following statement is incorrect about a patient with dysphagia?

A. The patient will find pureed or soft foods, such as custards, easier to swallow than water
B. Fowler's or semi Fowler's position reduces the risk of aspiration during swallowing
C. The patient should always feed himself
D. The nurse should perform oral hygiene before assisting with feeding.

33. To assess the kidney function of a patient with an indwelling urinary (Foley) catheter, the nurse measures his hourly urine output. She should notify the physician if the urine output is:

A. Less than 30 ml/hour
B. 64 ml in 2 hours
C. 90 ml in 3 hours
D. 125 ml in 4 hours

34. Certain substances increase the amount of urine produced. These include:

A. Caffeine-containing drinks, such as coffee and cola.
B. Beets
C. Urinary analgesics
D. Kaolin with pectin (Kaopectate)

35. A male patient who had surgery 2 days ago for head and neck cancer is about to make his first attempt to ambulate outside his room. The nurse notes that he is steady on his feet and that his vision was unaffected by the surgery. Which of the following nursing interventions would be appropriate?

A. Encourage the patient to walk in the hall alone
B. Discourage the patient from walking in the hall for a few more days
C. Accompany the patient for his walk.
D. Consult a physical therapist before allowing the patient to ambulate

36. A patient has exacerbation of chronic obstructive pulmonary disease (COPD) manifested by shortness of breath; orthopnea: thick, tenacious secretions; and a dry hacking cough. An appropriate nursing diagnosis would be:

A. Ineffective airway clearance related to thick, tenacious secretions.
B. Ineffective airway clearance related to dry, hacking cough.
C. Ineffective individual coping to COPD.
D. Pain related to immobilization of affected leg.

37. Mrs. Lim begins to cry as the nurse discusses hair loss. The best response would be:

A. “Don’t worry. It’s only temporary”
B. “Why are you crying? I didn’t get to the bad news yet”
C. “Your hair is really pretty”
D. “I know this will be difficult for you, but your hair will grow back after the completion of chemotheraphy”

38. An additional Vitamin C is required during all of the following periods except:

A. Infancy
B. Young adulthood
C. Childhood
D. Pregnancy

39. A prescribed amount of oxygen s needed for a patient with COPD to prevent:

A. Cardiac arrest related to increased partial pressure of carbon dioxide in arterial blood (PaCO2)
B. Circulatory overload due to hypervolemia
C. Respiratory excitement
D. Inhibition of the respiratory hypoxic stimulus

40. After 1 week of hospitalization, Mr. Gray develops hypokalemia. Which of the following is the most significant symptom of his disorder?

A. Lethargy
B. Increased pulse rate and blood pressure
C. Muscle weakness
D. Muscle irritability

41. Which of the following nursing interventions promotes patient safety?

A. Asses the patient's ability to ambulate and transfer from a bed to a chair
B. Demonstrate the signal system to the patient
C. Check to see that the patient is wearing his identification band
D. All of the above

42. Studies have shown that about 40% of patients fall out of bed despite the use of side rails; this has led to which of the following conclusions?

A. Side rails are ineffective
B. Side rails should not be used
C. Side rails are a deterrent that prevent a patient from falling out of bed.
D. Side rails are a reminder to a patient not to get out of bed

43. Examples of patients suffering from impaired awareness include all of the following except:

A. A semiconscious or over fatigued patient
B. A disoriented or confused patient
C. A patient who cannot care for himself at home
D. A patient demonstrating symptoms of drugs or alcohol withdrawal

44. The most common injury among elderly persons is:

A. Atheroscleotic changes in the blood vessels
B. Increased incidence of gallbladder disease
C. Urinary Tract Infection
D. Hip fracture

45. The most common psychogenic disorder among elderly person is:

A. Depression
B. Sleep disturbances (such as bizarre dreams)
C. Inability to concentrate
D. Decreased appetite

46. Which of the following vascular system changes results from aging?

A. Increased peripheral resistance of the blood vessels
B. Decreased blood flow
C. Increased workload of the left ventricle
D. All of the above

47. Which of the following is the most common cause of dementia among elderly persons?

A. Parkinson's disease
B. Multiple sclerosis
C. Amyotrophic lateral sclerosis (Lou Gehrig's disease)
D. Alzheimer's disease

48. The nurse's most important legal responsibility after a patient's death in a hospital is:

A. Obtaining a consent of an autopsy
B. Notifying the coroner or medical examiner
C. Labeling the corpse appropriately
D. Ensuring that the attending physician issues the death certification

49. Before rigor mortis occurs, the nurse is responsible for:

A. Providing a complete bath and dressing change
B. Placing one pillow under the body's head and shoulders
C. Removing the body's clothing and wrapping the body in a shroud
D. Allowing the body to relax normally

50. When a patient in the terminal stages of lung cancer begins to exhibit loss of consciousness, a major nursing priority is to:

A. Protect the patient from injury
B. Insert an airway
C. Elevate the head of the bed
D. Withdraw all pain medications

Answers and Rationale

1. Answer: B. Maintain the patient in an orthopneic position as needed

When a patient develops dyspnea and shortness of breath, the orthopneic position encourages maximum chest expansion and keeps the abdominal organs from pressing against the diaphragm, thus improving ventilation. Bed rest and oxygen by Venturi mask at 24% would improve oxygenation of the tissues and cells but must be ordered by a physician. Allowing for rest periods decreases the possibility of hypoxia.

2. Answer: C. Orthopnea

Orthopnea is difficulty of breathing except in the upright position. Tachypnea is rapid respiration characterized by quick, shallow breaths. Eupnea is normal respiration – quiet, rhythmic, and without effort.

3. Answer: C. Giving the patient breakfast

A platelet count evaluates the number of platelets in the circulating blood volume. The nurse is responsible for giving the patient breakfast at the scheduled time. The physician is responsible for instructing the patient about the test and for writing the order for the test.

4. Answer: B. Mashed potatoes and broiled chicken

Mashed potatoes and broiled chicken are low in natural sodium chloride. Ham, olives, and chicken bouillon contain large amounts of sodium and are contraindicated on a low sodium diet.

5. Answer: D. All of the above

All of the identified nursing responsibilities are pertinent when a patient is receiving heparin. The normal activated partial thromboplastin time is 16 to 25 seconds and the normal prothrombin time is 12 to 15 seconds; these levels must remain within two to two and one half the normal levels. All patients receiving anticoagulant therapy must be observed for signs and symptoms of frank and occult bleeding (including hemorrhage, hypotension, tachycardia, tachypnea, restlessness, pallor, cold and clammy skin, thirst and confusion); blood pressure should be measured every 4 hours and the patient should be instructed to report promptly any bleeding that occurs with tooth brushing, bowel movements, urination or heavy prolonged menstruation.

6. Answer: D. Person, environment, health, nursing

The focus concepts that have been accepted by all theorists as the focus of nursing practice from the time of Florence Nightingale include the person receiving nursing care, his environment, his health on the health illness continuum, and the nursing actions necessary to meet his needs.

7. Answer: D. Oxygen

Maslow, who defined a need as a satisfaction whose absence causes illness, considered oxygen to be the most important physiologic need; without it, human life could not exist. According to this theory, other physiologic needs (including food, water, elimination, shelter, rest and sleep, activity and temperature regulation) must be met before proceeding to the next hierarchical levels on psychosocial needs.

8. Answer: B. Listen to their concerns and answer their questions honestly

The brain-dead patient's family needs support and reassurance in making a decision about organ donation. Because transplants are done within hours of death, decisions about organ donation must be made as soon as possible. However, the family's concerns must be addressed before members are asked to sign a consent form. The body of an organ donor is available for burial.

9. Answer: C. Discuss the problem with her supervisor

Although a new head nurse should initially spend time observing the unit for its strengths and weakness, she should take action if a problem threatens patient safety. In this case, the supervisor is the resource person to approach.

10. Answer: D. The holistic approach provides for a therapeutic relationship, continuity, and efficient nursing care.

Studies have shown that patients and nurses both respond well to primary nursing care units. Patients feel less anxious and isolated and more secure because they are allowed to participate in planning their own care. Nurses feel personal satisfaction, much of it related to positive feedback from the patients. They also seem to gain a greater sense of achievement and esprit de corps.

11. Answer: A. Assault and battery

Assault is the unjustifiable attempt or threat to touch or injure another person. Battery is the unlawful touching of another person or the carrying out of threatened physical harm. Thus, any act that a nurse performs on the patient against his will is considered assault and battery.

12. Answer: A. Slander

Oral communication that injures an individual's reputation is considered slander. Written communication that does the same is considered libel.

13. Answer: D. Malpractice

Malpractice is defined as injurious or unprofessional actions that harm another. It involves professional misconduct, such as omission or commission of an act that a reasonable and prudent nurse would or would not do. In this example, the standard of care was breached; a 3-month-old infant should never be left unattended on a scale.

14. Answer: A. The nurse administers penicillin to a patient with a documented history of allergy to the drug. The patient experiences an allergic reaction and has cerebral damage resulting from anoxia.

The three elements necessary to establish a nursing malpractice are nursing error (administering penicillin to a patient with a documented allergy to the drug), injury (cerebral damage), and proximal cause (administering the penicillin caused the cerebral damage). Applying a hot water bottle or heating pad to a patient without a physician's order does not include the three required components. Assisting a patient out of bed with the bed locked in position is the correct nursing practice; therefore, the fracture was not the result of malpractice. Administering an incorrect medication is a nursing error; however, if such action resulted in a serious illness or chronic problem, the nurse could be sued for malpractice.

15. Answer: C. Immobility, diaphoresis, and avoidance of deep breathing or coughing

An Asian patient is likely to hide his pain. Consequently, the nurse must observe for objective signs. In an abdominal surgery patient, these might include immobility, diaphoresis, and avoidance of deep breathing or coughing, as well as increased heart rate, shallow respirations (stemming from pain upon moving the diaphragm and respiratory muscles), and guarding or rigidity of the abdominal wall. Such a patient is unlikely to display emotion, such as crying.

16. Answer: B. Guaiac test

To assess for GI tract bleeding when frank blood is absent, the nurse has two options: She can test for occult blood in vomitus, if present, or in stool – through guaiac (Hemoccult) test. A complete blood count does not provide immediate results and does not always immediately reflect blood loss. Changes in vital signs may be cause by factors other than blood loss. Abdominal girth is unrelated to blood loss.

17. Answer: D. Auscultation, percussion, and palpation

Because percussion and palpation can affect bowel motility and thus bowel sounds, they should follow auscultation in abdominal assessment. Tympanic percussion, measurement of abdominal girth, and inspection are methods of assessing the abdomen. Assessing for distention, tenderness and discoloration around the umbilicus can indicate various bowel-related conditions, such as cholecystitis, appendicitis and peritonitis.

18. Answer: C. Normal bowel sounds

Hyperactive sounds indicate increased bowel motility; two or three sounds per minute indicate decreased bowel motility. Abdominal cramping with hyperactive, high pitched tinkling bowel sounds can indicate a bowel obstruction.

19. Answer: C. Supine

The supine position (also called the dorsal position), in which the patient lies on his back with his face upward, allows for easy access to the abdomen. In the prone position, the patient lies on his abdomen with his face turned to the side. In the Trendelenburg

position, the head of the bed is tilted downward to 30 to 40 degrees so that the upper body is lower than the legs. In the lateral position, the patient lies on his side.

20. Answer: D. All of the above

All of these positions are appropriate for a rectal examination. In the genupectoral (knee-chest) position, the patient kneels and rests his chest on the table, forming a 90 degree angle between the torso and upper legs. In Sims' position, the patient lies on his left side with the left arm behind the body and his right leg flexed. In the horizontal recumbent position, the patient lies on his back with legs extended and hips rotated outward.

21. Answer: B. Standing

During a Romberg test, which evaluates for sensory or cerebellar ataxia, the patient must stand with feet together and arms resting at the sides—first with eyes open, then with eyes closed. The need to move the feet apart to maintain this stance is an abnormal finding.

22. Answer: A. 54

The pulse pressure is the difference between the systolic and diastolic blood pressure readings – in this case, 54.

23. Answer: D. Dehydration

A slightly elevated temperature in the immediate preoperative or post operative period may result from the lack of fluids before surgery rather than from infection. Anxiety will not cause an elevated temperature. Hypothermia is an abnormally low body temperature.

24 Answer D. All of the above

The quality and efficiency of the respiratory process can be determined by appraising the rate, rhythm, depth, ease, sound, and symmetry of respirations.

25. Answer: D. Temperature and respiratory rate

Under normal conditions, a healthy adult breathes in a smooth uninterrupted pattern 12 to 20 times a minute. Thus, a respiratory rate of 30 would be abnormal. A normal adult body temperature, as measured on an oral thermometer, ranges between 97° and 100°F (36.1° and 37.8°C); an axillary temperature is approximately one degree lower and a rectal temperature, one degree higher. Thus, an axillary temperature of 99.6°F (37.6°C) would be considered abnormal. The resting pulse rate in an adult ranges from 60 to 100 beats/minute, so a rate of 88 is normal.

26. Answer: D. Parasympathetic nervous system stimulation

Parasympathetic nervous system stimulation of the heart decreases the heart rate as well as the force of contraction, rate of impulse conduction and blood flow through the coronary vessels. Fever, exercise, and sympathetic stimulation all increase the heart rate.

27. Answer: D. Apical pulse

The apical pulse (the pulse at the apex of the heart) is located on the midclavicular line at the fourth, fifth, or sixth intercostal space. Base line vital signs include pulse rate, temperature, respiratory rate, and blood pressure. Blood pressure is typically assessed at the antecubital fossa, and respiratory rate is assessed best by observing chest movement with each inspiration and expiration.

28. Answer: C. Pedal

Because the pedal pulse cannot be detected in 10% to 20% of the population, its absence is not necessarily a significant finding. However, the presence or absence of the pedal pulse should be documented upon admission so that changes can be identified during the hospital stay. Absence of the apical, radial, or femoral pulse is abnormal and should be investigated.

29. Answer: B. An 88-year old incontinent patient with gastric cancer who is confined to his bed at home

Pressure ulcers are most likely to develop in patients with impaired mental status, mobility, activity level, nutrition, circulation and bladder or bowel control. Age is also a factor. Thus, the 88-year old incontinent patient who has impaired nutrition (from gastric cancer) and is confined to bed is at greater risk.

30. Answer: A. Encourage the patient to increase her fluid intake to 200 ml every 2 hours

Adequate hydration thins and loosens pulmonary secretions and also helps to replace fluids lost from elevated temperature, diaphoresis, dehydration and dyspnea. High-humidity air and chest physiotherapy help liquefy and mobilize secretions.

31. Answer: A. Thiamine

Chronic alcoholism commonly results in thiamine deficiency and other symptoms of malnutrition.

32. Answer: C. The patient should always feed himself

A patient with dysphagia (difficulty swallowing) requires assistance with feeding. Feeding himself is a long-range expected outcome. Soft foods, Fowler's or semi-Fowler's position, and oral hygiene before eating should be part of the feeding regimen.

33. Answer: A. Less than 30 ml/hour

A urine output of less than 30ml/hour indicates hypovolemia or oliguria, which is related to kidney function and inadequate fluid intake.

34. Answer: A. Caffeine-containing drinks, such as coffee and cola.

Fluids containing caffeine have a diuretic effect. Beets and urinary analgesics, such as Pyridium (Phenazopyridine), can color urine red. Kaopectate is an antidiarrheal medication.

35. Answer: C. Accompany the patient for his walk.

A hospitalized surgical patient leaving his room for the first time fears rejection and others staring at him, so he should not walk alone. Accompanying him will offer moral support, enabling him to face the rest of the world. Patients should begin ambulation as soon as possible after surgery to decrease complications and to regain strength and confidence. Waiting to consult a physical therapist is unnecessary.

36. Answer: A. Ineffective airway clearance related to thick, tenacious secretions.

Thick, tenacious secretions, a dry, hacking cough, orthopnea, and shortness of breath are signs of ineffective airway clearance. Ineffective airway clearance related to dry, hacking cough is incorrect because the cough is not the reason for the ineffective airway clearance. Ineffective individual coping related to COPD is wrong because the etiology for a nursing diagnosis should not be a medical diagnosis (COPD) and because no data indicate that the patient is coping ineffectively. Pain related to immobilization of affected leg would be an appropriate nursing diagnosis for a patient with a leg fracture.

37. Answer: D. "I know this will be difficult for you, but your hair will grow back after the completion of chemotherapy"

"I know this will be difficult" acknowledges the problem and suggests a resolution to it. "Don't worry.." offers some relief but doesn't recognize the patient's feelings. "..I didn't get to the bad news yet" would be inappropriate at any time. "Your hair is really pretty" offers no consolation or alternatives to the patient.

38. Answer: B. Young adulthood

Additional Vitamin C is needed in growth periods, such as infancy and childhood, and during pregnancy to supply demands for fetal growth and maternal tissues. Other conditions requiring extra vitamin C include wound healing, fever, infection and stress.

39. Answer: D. Inhibition of the respiratory hypoxic stimulus

Delivery of more than 2 liters of oxygen per minute to a patient with chronic obstructive pulmonary disease (COPD), who is usually in a state of compensated respiratory acidosis (retaining carbon dioxide (CO_2)), can inhibit the hypoxic stimulus for respiration. An increased partial pressure of carbon dioxide in arterial blood ($PACO_2$) would not initially result in cardiac arrest. Circulatory overload and respiratory excitement have no relevance to the question.

40. Answer: C. Muscle weakness

Presenting symptoms of hypokalemia (a serum potassium level below 3.5 mEq/liter) include muscle weakness, chronic fatigue, and cardiac dysrhythmias. The combined effects of inadequate food intake and prolonged diarrhea can deplete the potassium stores of a patient with GI problems.

41. Answer: D. All of the above

Assisting a patient with ambulation and transfer from a bed to a chair allows the nurse to evaluate the patient's ability to carry out these functions safely. Demonstrating the signal system and providing an opportunity for a return demonstration ensures that the patient knows how to operate the equipment and encourages him to call for assistance when needed. Checking the patient's identification band verifies the patient's identity and prevents identification mistakes in drug administration.

42. Answer: D. Side rails are a reminder to a patient not to get out of bed

Since about 40% of patients fall out of bed despite the use of side rails, side rails cannot be said to prevent falls; however, they do serve as a reminder that the patient should not get out of bed. The other answers are incorrect interpretations of the statistical data.

43. Answer: C. A patient who cannot care for himself at home

A patient who cannot care for himself at home does not necessarily have impaired awareness; he may simply have some degree of immobility.

44. Answer: D. Hip fracture

Hip fracture, the most common injury among elderly persons, usually results from osteoporosis. The other answers are diseases that can occur in the elderly from physiologic changes.

45. Answer: A. Depression

Sleep disturbances, inability to concentrate and decreased appetite are symptoms of depression, the most common psychogenic disorder among elderly persons. Other symptoms include diminished memory, apathy, disinterest in appearance, withdrawal, and irritability. Depression typically begins before the onset of old age and usually is caused by psychosocial, genetic, or biochemical factors

46. Answer: D. All of the above

Aging decreases elasticity of the blood vessels, which leads to increased peripheral resistance and decreased blood flow. These changes, in turn, increase the workload of the left ventricle.

47. Answer: D. Alzheimer's disease

Alzheimer;s disease, sometimes known as *senile dementia of the Alzheimer's type or primary degenerative dementia*, is an insidious; progressive, irreversible, and degenerative disease of the brain whose etiology is still unknown. *Parkinson's disease* is a neurologic disorder caused by lesions in the extrapyramidal system and manifested by tremors, muscle rigidity, hypokinesia, dysphagia, and dysphonia. *Multiple sclerosis,* a progressive, degenerative disease involving demyelination of the nerve fibers, usually begins in young adulthood and is marked by periods of remission and exacerbation. *Amyotrophic lateral sclerosis*, a disease marked by progressive

degeneration of the neurons, eventually results in atrophy of all the muscles; including those necessary for respiration.

48. ANswer: C. Labeling the corpse appropriately

The nurse is legally responsible for labeling the corpse when death occurs in the hospital. She may be involved in obtaining consent for an autopsy or notifying the coroner or medical examiner of a patient's death; however, she is not legally responsible for performing these functions. The attending physician may need information from the nurse to complete the death certificate, but he is responsible for issuing it.

49. Answer: B. Placing one pillow under the body's head and shoulders

The nurse must place a pillow under the decreased person's head and shoulders to prevent blood from settling in the face and discoloring it. She is required to bathe only soiled areas of the body since the mortician will wash the entire body. Before wrapping the body in a shroud, the nurse places a clean gown on the body and closes the eyes and mouth.

50. Answer: A. Protect the patient from injury

Ensuring the patient's safety is the most essential action at this time. The other nursing actions may be necessary but are not a major priority.

XXVI (26)

1. Which element in the circular chain of infection can be eliminated by preserving skin integrity?

A. Host
B. Reservoir
C. Mode of transmission
D. Portal of entry

2. Which of the following will probably result in a break in sterile technique for respiratory isolation?

A. Opening the patient's window to the outside environment
B. Turning on the patient's room ventilator
C. Opening the door of the patient's room leading into the hospital corridor
D. Failing to wear gloves when administering a bed bath

3. Which of the following patients is at greater risk for contracting an infection?

A. A patient with leukopenia
B. A patient receiving broad-spectrum antibiotics
C. A postoperative patient who has undergone orthopedic surgery
D. A newly diagnosed diabetic patient

4. Effective hand washing requires the use of:

A. Soap or detergent to promote emulsification
B. Hot water to destroy bacteria
C. A disinfectant to increase surface tension
D. All of the above

5. After routine patient contact, hand washing should last at least:
A. 30 seconds
B. 1 minute
C. 2 minute
D. 3 minutes

6. Which of the following procedures always requires surgical asepsis?
A. Vaginal instillation of conjugated estrogen
B. Urinary catheterization
C. Nasogastric tube insertion
D. Colostomy irrigation

7. Sterile technique is used whenever:
A. Strict isolation is required
B. Terminal disinfection is performed
C. Invasive procedures are performed
D. Protective isolation is necessary

8. Which of the following constitutes a break in sterile technique while preparing a sterile field for a dressing change?

A. Using sterile forceps, rather than sterile gloves, to handle a sterile item
B. Touching the outside wrapper of sterilized material without sterile gloves
C. Placing a sterile object on the edge of the sterile field
D. Pouring out a small amount of solution (15 to 30 ml) before pouring the solution into a sterile container

9. A natural body defense that plays an active role in preventing infection is:

A. Yawning
B. Body hair
C. Hiccupping
D. Rapid eye movements

10. All of the following statement are true about donning sterile gloves except:

A. The first glove should be picked up by grasping the inside of the cuff.
B. The second glove should be picked up by inserting the gloved fingers under the cuff outside the glove.
C. The gloves should be adjusted by sliding the gloved fingers under the sterile cuff and pulling the glove over the wrist
D. The inside of the glove is considered sterile

11. When removing a contaminated gown, the nurse should be careful that the first thing she touches is the:

A. Waist tie and neck tie at the back of the gown
B. Waist tie in front of the gown
C. Cuffs of the gown
D. Inside of the gown

12. Which of the following nursing interventions is considered the most effective form or universal precautions?

A. Cap all used needles before removing them from their syringes
B. Discard all used uncapped needles and syringes in an impenetrable protective container
C. Wear gloves when administering IM injections
D. Follow enteric precautions

13. All of the following measures are recommended to prevent pressure ulcers except:

A. Massaging the reddened area with lotion
B. Using a water or air mattress
C. Adhering to a schedule for positioning and turning
D. Providing meticulous skin care

14. Which of the following blood tests should be performed before a blood transfusion?

A. Prothrombin and coagulation time
B. Blood typing and cross-matching
C. Bleeding and clotting time
D. Complete blood count (CBC) and electrolyte levels.

15. The primary purpose of a platelet count is to evaluate the:

A. Potential for clot formation
B. Potential for bleeding
C. Presence of an antigen-antibody response
D. Presence of cardiac enzymes

16. Which of the following white blood cell (WBC) counts clearly indicates leukocytosis?

A. 4,500/mm^3
B. 7,000/mm^3
C. 10,000/mm^3
D. 25,000/mm^3

17. After 5 days of diuretic therapy with 20mg of furosemide (Lasix) daily, a patient begins to exhibit fatigue, muscle cramping and muscle weakness. These symptoms probably indicate that the patient is experiencing:

A. Hypokalemia
B. Hyperkalemia
C. Anorexia
D. Dysphagia

18. Which of the following statements about chest X-ray is false?

A. No contradictions exist for this test
B. Before the procedure, the patient should remove all jewelry, metallic objects, and buttons above the waist
C. A signed consent is not required
D. Eating, drinking, and medications are allowed before this test

19. The most appropriate time for the nurse to obtain a sputum specimen for culture is:

A. Early in the morning
B. After the patient eats a light breakfast
C. After aerosol therapy
D. After chest physiotherapy

20. A patient with no known allergies is to receive penicillin every 6 hours. When administering the medication, the nurse observes a fine rash on the patient's skin. The most appropriate nursing action would be to:

A. Withhold the moderation and notify the physician
B. Administer the medication and notify the physician

C. Administer the medication with an antihistamine
D. Apply corn starch soaks to the rash

21. All of the following nursing interventions are correct when using the Z-track method of drug injection except:

A. Prepare the injection site with alcohol
B. Use a needle that's a least 1" long
C. Aspirate for blood before injection
D. Rub the site vigorously after the injection to promote absorption

22. The correct method for determining the vastus lateralis site for I.M. injection is to:

A. Locate the upper aspect of the upper outer quadrant of the buttock about 5 to 8 cm below the iliac crest
B. Palpate the lower edge of the acromion process and the midpoint lateral aspect of the arm
C. Palpate a 1" circular area anterior to the umbilicus
D. Divide the area between the greater femoral trochanter and the lateral femoral condyle into thirds, and select the middle third on the anterior of the thigh

23. The mid-deltoid injection site is seldom used for I.M. injections because it:

A. Can accommodate only 1 ml or less of medication
B. Bruises too easily
C. Can be used only when the patient is lying down
D. Does not readily parenteral medication

24. The appropriate needle size for insulin injection is:

A. 18G, 1 ½" long
B. 22G, 1" long
C. 22G, 1 ½" long
D. 25G, 5/8" long

25. The appropriate needle gauge for intradermal injection is:

A. 20G
B. 22G
C. 25G
D. 26G

26. Parenteral penicillin can be administered as an:

A. IM injection or an IV solution
B. IV or an intradermal injection
C. Intradermal or subcutaneous injection
D. IM or a subcutaneous injection

27. The physician orders gr 10 of aspirin for a patient. The equivalent dose in milligrams is:

A. 0.6 mg
B. 10 mg
C. 60 mg
D. 600 mg

28. The physician orders an IV solution of dextrose 5% in water at 100ml/hour. What would the flow rate be if the drop factor is 15 gtt = 1 ml?

A. 5 gtt/minute
B. 13 gtt/minute
C. 25 gtt/minute
D. 50 gtt/minute

29. Which of the following is a sign or symptom of a hemolytic reaction to blood transfusion?

A. Hemoglobinuria
B. Chest pain
C. Urticaria
D. Distended neck veins

30. Which of the following conditions may require fluid restriction?

A. Fever
B. Chronic Obstructive Pulmonary Disease
C. Renal Failure
D. Dehydration

31. All of the following are common signs and symptoms of phlebitis except:

A. Pain or discomfort at the IV insertion site
B. Edema and warmth at the IV insertion site
C. A red streak exiting the IV insertion site
D. Frank bleeding at the insertion site

32. The best way of determining whether a patient has learned to instill ear medication properly is for the nurse to:

A. Ask the patient if he/she has used ear drops before
B. Have the patient repeat the nurse's instructions using her own words
C. Demonstrate the procedure to the patient and encourage to ask questions
D. Ask the patient to demonstrate the procedure

33. Which of the following types of medications can be administered via gastrostomy tube?

A. Any oral medications
B. Capsules whole contents are dissolve in water
C. Enteric-coated tablets that are thoroughly dissolved in water
D. Most tablets designed for oral use, except for extended-duration compounds

34. A patient who develops hives after receiving an antibiotic is exhibiting drug:

A. Tolerance
B. Idiosyncrasy
C. Synergism
D. Allergy

35. A patient has returned to his room after femoral arteriography. All of the following are appropriate nursing interventions except:

A. Assess femoral, popliteal, and pedal pulses every 15 minutes for 2 hours
B. Check the pressure dressing for sanguineous drainage
C. Assess a vital signs every 15 minutes for 2 hours
D. Order a hemoglobin and hematocrit count 1 hour after the arteriography

36. The nurse explains to a patient that a cough:

A. Is a protective response to clear the respiratory tract of irritants
B. Is primarily a voluntary action
C. Is induced by the administration of an antitussive drug
D. Can be inhibited by “splinting” the abdomen

37. An infected patient has chills and begins shivering. The best nursing intervention is to:

A. Apply iced alcohol sponges
B. Provide increased cool liquids
C. Provide additional bedclothes
D. Provide increased ventilation

38. A clinical nurse specialist is a nurse who has:

A. Been certified by the National League for Nursing
B. Received credentials from the Philippine Nurses’ Association
C. Graduated from an associate degree program and is a registered professional nurse
D. Completed a master’s degree in the prescribed clinical area and is a registered professional nurse.

39. The purpose of increasing urine acidity through dietary means is to:

A. Decrease burning sensations
B. Change the urine’s color
C. Change the urine’s concentration
D. Inhibit the growth of microorganisms

40. Clay colored stools indicate:

A. Upper GI bleeding
B. Impending constipation
C. An effect of medication
D. Bile obstruction

41. In which step of the nursing process would the nurse ask a patient if the medication she administered relieved his pain?

A. Assessment
B. Analysis
C. Planning
D. Evaluation

42. All of the following are good sources of vitamin A except:

A. White potatoes
B. Carrots
C. Apricots
D. Egg yolks

43. Which of the following is a primary nursing intervention necessary for all patients with a Foley Catheter in place?

A. Maintain the drainage tubing and collection bag level with the patient's bladder
B. Irrigate the patient with 1% Neosporin solution three times a daily
C. Clamp the catheter for 1 hour every 4 hours to maintain the bladder's elasticity
D. Maintain the drainage tubing and collection bag below bladder level to facilitate drainage by gravity

44. The ELISA test is used to:

A. Screen blood donors for antibodies to human immunodeficiency virus (HIV)
B. Test blood to be used for transfusion for HIV antibodies
C. Aid in diagnosing a patient with AIDS
D. All of the above

45. The two blood vessels most commonly used for TPN infusion are the:

A. Subclavian and jugular veins
B. Brachial and subclavian veins
C. Femoral and subclavian veins
D. Brachial and femoral veins

46. Effective skin disinfection before a surgical procedure includes which of the following methods?

A. Shaving the site on the day before surgery
B. Applying a topical antiseptic to the skin on the evening before surgery
C. Having the patient take a tub bath on the morning of surgery
D. Having the patient shower with an antiseptic soap on the evening before and the morning of surgery

47. When transferring a patient from a bed to a chair, the nurse should use which muscles to avoid back injury?

A. Abdominal muscles
B. Back muscles
C. Leg muscles
D. Upper arm muscles

48. Thrombophlebitis typically develops in patients with which of the following conditions?

A. Increases partial thromboplastin time
B. Acute pulsus paradoxus
C. An impaired or traumatized blood vessel wall
D. Chronic Obstructive Pulmonary Disease (COPD)

49. In a recumbent, immobilized patient, lung ventilation can become altered, leading to such respiratory complications as:

A. Respiratory acidosis, atelectasis, and hypostatic pneumonia
B. Apneustic breathing, atypical pneumonia and respiratory alkalosis
C. Cheyne-Stokes respirations and spontaneous pneumothorax
D. Kussmaul's respirations and hypoventilation

50. Immobility impairs bladder elimination, resulting in such disorders as

A. Increased urine acidity and relaxation of the perineal muscles, causing incontinence
B. Urine retention, bladder distention, and infection
C. Diuresis, natriuresis, and decreased urine specific gravity
D. Decreased calcium and phosphate levels in the urine

Answers and Rationale

1. Answer: D. Portal of entry

In the circular chain of infection, pathogens must be able to leave their reservoir and be transmitted to a susceptible host through a portal of entry, such as broken skin.

2. Answer: C. Opening the door of the patient's room leading into the hospital corridor

Respiratory isolation, like strict isolation, requires that the door to the door patient's room remain closed. However, the patient's room should be well ventilated, so opening the window or turning on the ventricular is desirable. The nurse does not need to wear gloves for respiratory isolation, but good hand washing is important for all types of isolation.

3. Answer: A. A patient with leukopenia

Leukopenia is a decreased number of leukocytes (white blood cells), which are important in resisting infection. None of the other situations would put the patient at risk for contracting an infection; taking broad-spectrum antibiotics might actually reduce the infection risk.

4. Answer: A. Soap or detergent to promote emulsification

Soaps and detergents are used to help remove bacteria because of their ability to lower the surface tension of water and act as emulsifying agents. Hot water may lead to skin irritation or burns.

5. Answer: A. 30 seconds

Depending on the degree of exposure to pathogens, hand washing may last from 10 seconds to 4 minutes. After routine patient contact, hand washing for 30 seconds effectively minimizes the risk of pathogen transmission.

6. Answer: B. Urinary catheterization

The urinary system is normally free of microorganisms except at the urinary meatus. Any procedure that involves entering this system must use surgically aseptic measures to maintain a bacteria-free state.

7. Answer: C. Invasive procedures are performed

All invasive procedures, including surgery, catheter insertion, and administration of parenteral therapy, require sterile technique to maintain a sterile environment. All equipment must be sterile, and the nurse and the physician must wear sterile gloves and maintain surgical asepsis. In the operating room, the nurse and physician are required to wear sterile gowns, gloves, masks, hair covers, and shoe covers for all invasive procedures. Strict isolation requires the use of clean gloves, masks, gowns and equipment to prevent the transmission of highly communicable diseases by contact or by airborne routes. Terminal disinfection is the disinfection of all contaminated supplies and equipment after a patient has been discharged to prepare them for reuse by another patient. The purpose of protective (reverse)isolation is to prevent a person with seriously impaired resistance from coming into contact who potentially pathogenic organisms.

8. Answer: C. Placing a sterile object on the edge of the sterile field

The edges of a sterile field are considered contaminated. When sterile items are allowed to come in contact with the edges of the field, the sterile items also become contaminated.

9. Answer: B. Body hair

Hair on or within body areas, such as the nose, traps and holds particles that contain microorganisms. Yawning and hiccupping do not prevent microorganisms from entering or leaving the body. Rapid eye movement marks the stage of sleep during which dreaming occurs.

10. Answer: D. The inside of the glove is considered sterile

The inside of the glove is always considered to be clean, but not sterile.

11. Answer: A. Waist tie and neck tie at the back of the gown

The back of the gown is considered clean, the front is contaminated. So, after removing gloves and washing hands, the nurse should untie the back of the gown; slowly move backward away from the gown, holding the inside of the gown and keeping the edges off the floor; turn and fold the gown inside out; discard it in a contaminated linen container; then wash her hands again.

12. Answer: B. Discard all used uncapped needles and syringes in an impenetrable protective container

According to the Centers for Disease Control (CDC), blood-to-blood contact occurs most commonly when a health care worker attempts to cap a used needle. Therefore, used needles should never be recapped; instead they should be inserted in a specially designed puncture resistant, labeled container. Wearing gloves is not always necessary when administering an I.M. injection. Enteric precautions prevent the transfer of pathogens via feces.

13. Answer: A. Massaging the reddened area with lotion

Nurses and other health care professionals previously believed that massaging a reddened area with lotion would promote venous return and reduce edema to the area. However, research has shown that massage only increases the likelihood of cellular ischemia and necrosis to the area.

14. Answer: B. Blood typing and cross-matching

Before a blood transfusion is performed, the blood of the donor and recipient must be checked for compatibility. This is done by blood typing (a test that determines a person's blood type) and cross-matching (a procedure that determines the compatibility of the donor's and recipient's blood after the blood types has been matched). If the blood specimens are incompatible, hemolysis and antigen-antibody reactions will occur.

15. Answer: A. Potential for clot formation

Platelets are disk-shaped cells that are essential for blood coagulation. A platelet count determines the number of thrombocytes in blood available for promoting hemostasis and assisting with blood coagulation after injury. It also is used to evaluate the patient's potential for bleeding; however, this is not its primary purpose. The normal count ranges from 150,000 to 350,000/mm3. A count of 100,000/mm3 or less indicates a potential for bleeding; count of less than 20,000/mm3 is associated with spontaneous bleeding.

16. Answer: D. 25,000/mm³

Leukocytosis is any transient increase in the number of white blood cells (leukocytes) in the blood. Normal WBC counts range from 5,000 to 100,000/mm3. Thus, a count of 25,000/mm3 indicates leukocytosis.

17. Answer: A. Hypokalemia

Fatigue, muscle cramping, and muscle weaknesses are symptoms of hypokalemia (an inadequate potassium level), which is a potential side effect of diuretic therapy. The physician usually orders supplemental potassium to prevent hypokalemia in patients receiving diuretics. Anorexia is another symptom of hypokalemia. Dysphagia means difficulty swallowing.

18. Answer: A. No contradictions exist for this test

Pregnancy or suspected pregnancy is the only contraindication for a chest X-ray. However, if a chest X-ray is necessary, the patient can wear a lead apron to protect the pelvic region from radiation. Jewelry, metallic objects, and buttons would interfere with the X-ray and thus should not be worn above the waist. A signed consent is not required because a chest X-ray is not an invasive examination. Eating, drinking and medications are allowed because the X-ray is of the chest, not the abdominal region.

19. Answer: A. Early in the morning

Obtaining a sputum specimen early in this morning ensures an adequate supply of bacteria for culturing and decreases the risk of contamination from food or medication.

20. Answer: A. Withhold the moderation and notify the physician

Initial sensitivity to penicillin is commonly manifested by a skin rash, even in individuals who have not been allergic to it previously. Because of the danger of anaphylactic shock, he nurse should withhold the drug and notify the physician, who may choose to substitute another drug. Administering an antihistamine is a dependent nursing intervention that requires a written physician's order. Although applying corn starch to the rash may relieve discomfort, it is not the nurse's top priority in such a potentially life-threatening situation.

21. Answer: D. Rub the site vigorously after the injection to promote absorption

The Z-track method is an I.M. injection technique in which the patient's skin is pulled in such a way that the needle track is sealed off after the injection. This procedure seals medication deep into the muscle, thereby minimizing skin staining and irritation. Rubbing the injection site is contraindicated because it may cause the medication to extravasate into the skin.

22. Answer: D. Divide the area between the greater femoral trochanter and the lateral femoral condyle into thirds, and select the middle third on the anterior of the thigh

The vastus lateralis, a long, thick muscle that extends the full length of the thigh, is viewed by many clinicians as the site of choice for I.M. injections because it has

relatively few major nerves and blood vessels. The middle third of the muscle is recommended as the injection site. The patient can be in a supine or sitting position for an injection into this site.

23. Answer: A. Can accommodate only 1 ml or less of medication

The mid-deltoid injection site can accommodate only 1 ml or less of medication because of its size and location (on the deltoid muscle of the arm, close to the brachial artery and radial nerve).

24. Answer: D. 25G, 5/8" long

A 25G, 5/8" needle is the recommended size for insulin injection because insulin is administered by the subcutaneous route. An 18G, 1 ½" needle is usually used for I.M. injections in children, typically in the vastus lateralis. A 22G, 1 ½" needle is usually used for adult I.M. injections, which are typically administered in the vastus lateralis or ventrogluteal site.

25. Answer: C. 25G

Because an intradermal injection does not penetrate deeply into the skin, a small-bore 25G needle is recommended. This type of injection is used primarily to administer antigens to evaluate reactions for allergy or sensitivity studies. A 20G needle is usually used for I.M. injections of oil-based medications; a 22G needle for I.M. injections; and a 25G needle, for I.M. injections; and a 25G needle, for subcutaneous insulin injections.

26. Answer: A. IM injection or an IV solution

Parenteral penicillin can be administered I.M. or added to a solution and given I.V. It cannot be administered subcutaneously or intradermally.

27. Answer: D. 600 mg

gr 10 x 60 mg/gr 1 = 600 mg

28. Answer: C. 25 gtt/minute

100ml/60 min X 15 gtt/ 1 ml = 25 gtt/minute

29. Answer: A. Hemoglobinuria

Hemoglobinuria, the abnormal presence of hemoglobin in the urine, indicates a hemolytic reaction (incompatibility of the donor's and recipient's blood). In this reaction, antibodies in the recipient's plasma combine rapidly with donor RBC's; the cells are hemolyzed in either circulatory or reticuloendothelial system. Hemolysis occurs more rapidly in ABO incompatibilities than in Rh incompatibilities. Chest pain and urticaria may be symptoms of impending anaphylaxis. Distended neck veins are an indication of hypervolemia.

30. Answer: C. Renal Failure

In real failure, the kidney loses their ability to effectively eliminate wastes and fluids. Because of this, limiting the patient's intake of oral and I.V. fluids may be necessary.

Fever, chronic obstructive pulmonary disease, and dehydration are conditions for which fluids should be encouraged.

31. Answer: D. Frank bleeding at the insertion site

Phlebitis, the inflammation of a vein, can be caused by chemical irritants (I.V. solutions or medications), mechanical irritants (the needle or catheter used during venipuncture or cannulation), or a localized allergic reaction to the needle or catheter. Signs and symptoms of phlebitis include pain or discomfort, edema and heat at the I.V. insertion site, and a red streak going up the arm or leg from the I.V. insertion site.

32. Answer: D. Ask the patient to demonstrate the procedure

Return demonstration provides the most certain evidence for evaluating the effectiveness of patient teaching.

33. Answer: D. Most tablets designed for oral use, except for extended-duration compounds

Capsules, enteric-coated tablets, and most extended duration or sustained release products should not be dissolved for use in a gastrostomy tube. They are pharmaceutically manufactured in these forms for valid reasons, and altering them destroys their purpose. The nurse should seek an alternate physician's order when an ordered medication is inappropriate for delivery by tube.

34. Answer: D. Allergy

A drug-allergy is an adverse reaction resulting from an immunologic response following a previous sensitizing exposure to the drug. The reaction can range from a rash or hives to anaphylactic shock. Tolerance to a drug means that the patient experiences a decreasing physiologic response to repeated administration of the drug in the same dosage. Idiosyncrasy is an individual's unique hypersensitivity to a drug, food, or other substance; it appears to be genetically determined. Synergism, is a drug interaction in which the sum of the drug's combined effects is greater than that of their separate effects.

35. Answer: D. Order a hemoglobin and hematocrit count 1 hour after the arteriography

A hemoglobin and hematocrit count would be ordered by the physician if bleeding were suspected. The other answers are appropriate nursing interventions for a patient who has undergone femoral arteriography.

36. Answer: A. Is a protective response to clear the respiratory tract of irritants

Coughing, a protective response that clears the respiratory tract of irritants, usually is involuntary; however it can be voluntary, as when a patient is taught to perform coughing exercises. An antitussive drug inhibits coughing. Splinting the abdomen supports the abdominal muscles when a patient coughs.

37. Answer: C. Provide additional bedclothes

In an infected patient, shivering results from the body's attempt to increase heat production and the production of neutrophils and phagocytic action through increased skeletal muscle tension and contractions. Initial vasoconstriction may cause skin to feel cold to the touch. Applying additional bed clothes helps to equalize the body temperature and stop the chills. Attempts to cool the body result in further shivering, increased metabolism, and thus increased heat production.

38. Answer: D. Completed a master's degree in the prescribed clinical area and is a registered professional nurse.

A clinical nurse specialist must have completed a master's degree in a clinical specialty and be a registered professional nurse. The National League of Nursing accredits educational programs in nursing and provides a testing service to evaluate student nursing competence but it does not certify nurses. The American Nurses Association identifies requirements for certification and offers examinations for certification in many areas of nursing., such as medical surgical nursing. These certification (credentialing) demonstrates that the nurse has the knowledge and the ability to provide high quality nursing care in the area of her certification. A graduate of an associate degree program is not a clinical nurse specialist: however, she is prepared to provide bed side nursing with a high degree of knowledge and skill. She must successfully complete the licensing examination to become a registered professional nurse.

39. Answer: D. Inhibit the growth of microorganisms

Microorganisms usually do not grow in an acidic environment.

40. Answer: D. Bile obstruction

Bile colors the stool brown. Any inflammation or obstruction that impairs bile flow will affect the stool pigment, yielding light, clay-colored stool. Upper GI bleeding results in black or tarry stool. Constipation is characterized by small, hard masses. Many medications and foods will discolor stool – for example, drugs containing iron turn stool black.; beets turn stool red.

41. Answer: D. Evaluation

In the evaluation step of the nursing process, the nurse must decide whether the patient has achieved the expected outcome that was identified in the planning phase.

42. Answer: A. White potatoes

The main sources of vitamin A are yellow and green vegetables (such as carrots, sweet potatoes, squash, spinach, collard greens, broccoli, and cabbage) and yellow fruits (such as apricots, and cantaloupe). Animal sources include liver, kidneys, cream, butter, and egg yolks.

43. Answer: D. Maintain the drainage tubing and collection bag below bladder level to facilitate drainage by gravity

Maintaining the drainage tubing and collection bag level with the patient's bladder could result in reflux of urine into the kidney. Irrigating the bladder with Neosporin and clamping the catheter for 1 hour every 4 hours must be prescribed by a physician.

44. Answer: D. All of the above

The ELISA test of venous blood is used to assess blood and potential blood donors to human immunodeficiency virus (HIV). A positive ELISA test combined with various signs and symptoms helps to diagnose acquired immunodeficiency syndrome (AIDS)

45. Answer: A. Subclavian and jugular veins

Total Parenteral Nutrition (TPN) requires the use of a large vessel, such as the subclavian or jugular vein, to ensure rapid dilution of the solution and thereby prevent complications, such as hyperglycemia. The brachial and femoral veins usually are contraindicated because they pose an increased risk of thrombophlebitis.

46. Answer: D. Having the patient shower with an antiseptic soap on the evening before and the morning of surgery

Studies have shown that showering with an antiseptic soap before surgery is the most effective method of removing microorganisms from the skin. Shaving the site of the intended surgery might cause breaks in the skin, thereby increasing the risk of infection; however, if indicated, shaving, should be done immediately before surgery, not the day before. A topical antiseptic would not remove microorganisms and would be beneficial only after proper cleaning and rinsing. Tub bathing might transfer organisms to another body site rather than rinse them away.

47. Answer: C. Leg muscles

The leg muscles are the strongest muscles in the body and should bear the greatest stress when lifting. Muscles of the abdomen, back, and upper arms may be easily injured.

48. Answer: C. An impaired or traumatized blood vessel wall

The factors, known as Virchow's triad, collectively predispose a patient to thrombophlebitis; impaired venous return to the heart, blood hypercoagulability, and injury to a blood vessel wall. Increased partial thromboplastin time indicates a prolonged bleeding time during fibrin clot formation, commonly the result of anticoagulant (heparin) therapy. Arterial blood disorders (such as pulsus paradoxus) and lung diseases (such as COPD) do not necessarily impede venous return of injure vessel walls.

49. Answer: A. Respiratory acidosis, atelectasis, and hypostatic pneumonia

Because of restricted respiratory movement, a recumbent, immobilize patient is at particular risk for respiratory acidosis from poor gas exchange; atelectasis from reduced

surfactant and accumulated mucus in the bronchioles, and hypostatic pneumonia from bacterial growth caused by stasis of mucus secretions.

50. Answer: B. Urine retention, bladder distention, and infection

The immobilized patient commonly suffers from urine retention caused by decreased muscle tone in the perineum. This leads to bladder distention and urine stagnation, which provide an excellent medium for bacterial growth leading to infection. Immobility also results in more alkaline urine with excessive amounts of calcium, sodium.

XXVIII (27)

Topics or concepts included in this exam are:

- Illness
- Infection
- Asepsis
- Stress

1. When the General adaptation syndrome is activated, FLIGHT OR FIGHT response sets in. Sympathetic nervous system releases norepinephrine while the adrenal medulla secretes epinephrine. Which of the following is true with regards to that statement?

A. Pupils will constrict
B. Client will be lethargic
C. Lungs will bronchodilate
D. Gastric motility will increase

2. Which of the following response is not expected to a person whose GAS is activated and the FIGHT OR FLIGHT response sets in?

A. The client will not urinate due to relaxation of the detrusor muscle
B. The client will be restless and alert
C. Clients BP will increase, there will be vasodilation
D. There will be increase glycogenolysis, Pancrease will decrease insulin secretion

3. State in which a person's physical, emotional, intellectual and social development or spiritual functioning is diminished or impaired compared with a previous experience.

A. Illness
B. Disease
C. Health
D. Wellness

4. This is the first stage of illness wherein, the person starts to believe that something is wrong. Also known as the transition phase from wellness to illness.

A. Symptom Experience
B. Assumption of sick role
C. Medical care contact
D. Dependent patient role

5. In this stage of illness, the person accepts or rejects a professionals suggestion. The person also becomes passive and may regress to an earlier

stage.

A. Symptom Experience
B. Assumption of sick role
C. Medical care contact
D. Dependent patient role

6. In this stage of illness, the person learns to accept the illness.

A. Symptom Experience
B. Assumption of sick role
C. Medical care contact
D. Dependent patient role

7. In this stage, the person tries to find answers for his illness. He wants his illness to be validated, his symptoms explained and the outcome reassured or predicted

A. Symptom Experience
B. Assumption of sick role
C. Medical care contact
D. Dependent patient role

8. The following are true with regards to aspect of the sick role except

A. One should be held responsible for his condition
B. One is excused from his societal role
C. One is obliged to get well as soon as possible
D. One is obliged to seek competent help

9. Refers to conditions that increases vulnerability of individual or group to illness or accident

A. Predisposing factor
B. Etiology
C. Risk factor
D. Modifiable Risks

10. Refers to the degree of resistance the potential host has against a certain pathogen

A. Susceptibility
B. Immunity
C. Virulence
D. Etiology

11. A group of symptoms that sums up or constitute a disease
A. Syndrome
B. Symptoms

C. Signs
D. Etiology

12. A woman undergoing radiation therapy developed redness and burning of the skin around the best. This is best classified as what type of disease?

A. Neoplastic
B. Traumatic
C. Nosocomial
D. Iatrogenic

13. The classification of CANCER according to its etiology Is best described as:

1. Nosocomial
2. Idiopathic
3. Neoplastic
4. Traumatic
5. Congenital
6. Degenrative

A. 5 and 2
B. 2 and 3
C. 3 and 4
D. 3 and 5

14. Term to describe the reactiviation and recurrence of pronounced symptoms of a disease

A. Remission
B. Emission
C. Exacerbation
D. Sub acute

15. A type of illness characterized by periods of remission and exacerbation

A. Chronic
B. Acute
C. Sub acute
D. Sub chronic

16. Diseases that results from changes in the normal structure, from recognizable anatomical changes in an organ or body tissue is termed as

A. Functional
B. Occupational
C. Inorganic
D. Organic

17. It is the science of organism as affected by factors in their environment. It deals with the relationship between disease and geographical environment.

A. Epidemiology
B. Ecology

C. Statistics
D. Geography

18. This is the study of the patterns of health and disease. Its occurrence and distribution in man, for the purpose of control and prevention of disease.

A. Epidemiology
B. Ecology
C. Statistics
D. Geography

19. Refers to diseases that produced no anatomic changes but as a result from abnormal response to a stimuli.

A. Functional
B. Occupational
C. Inorganic
D. Organic

20. In what level of prevention according to Leavell and Clark does the nurse support the client in obtaining OPTIMAL HEALTH STATUS after a disease or injury?

A. Primary
B. Secondary
C. Tertiary
D. None of the above

21. In what level of prevention does the nurse encourage optimal health and increases person's susceptibility to illness?

A. Primary
B. Secondary
C. Tertiary
D. None of the above

22. Also known as HEALTH MAINTENANCE prevention.

A. Primary
B. Secondary
C. Tertiary
D. None of the above

23. PPD In occupational health nursing is what type of prevention?

A. Primary
B. Secondary
C. Tertiary
D. None of the above

24. BCG in community health nursing is what type of prevention?

A. Primary
B. Secondary
C. Tertiary
D. None of the above

25. A regular pap smear for woman every 3 years after establishing normal pap smear for 3 consecutive years Is advocated. What level of prevention does this belongs?

A. Primary
B. Secondary
C. Tertiary
D. None of the above

26. Self monitoring of blood glucose for diabetic clients is on what level of prevention?

A. Primary
B. Secondary
C. Tertiary
D. None of the above

27. Which is the best way to disseminate information to the public?

A. Newspaper
B. School bulletins
C. Community bill boards
D. Radio and Television

28. Who conceptualized health as integration of parts and subparts of an individual?

A. Newman
B. Neuman
C. Watson
D. Rogers

29. The following are concept of health:

1. Health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity.
2. Health is the ability to maintain balance
3. Health is the ability to maintain internal milieu
4. Health is integration of all parts and subparts of an individual

A. 1,2,3
B. 1,3,4
C. 2,3,4
D. 1,2,3,4

30. The theorist the advocated that health is the ability to maintain dynamic equilibrium is

A. Bernard
B. Selye
C. Cannon
D. Rogers

31. Excessive alcohol intake is what type of risk factor?

A. Genetics
B. Age
C. Environment
D. Lifestyle

32. Osteoporosis and degenerative diseases like Osteoarthritis belongs to what type of risk factor?

A. Genetics
B. Age
C. Environment
D. Lifestyle

33. Also known as STERILE TECHNIQUE

A. Surgical Asepsis
B. Medical Asepsis
C. Sepsis
D. Asepsis

34. This is a person or animal, who is without signs of illness but harbors pathogen within his body and can be transferred to another

A. Host
B. Agent
C. Environment
D. Carrier

35. Refers to a person or animal, known or believed to have been exposed to a disease.

A. Carrier
B. Contact
C. Agent
D. Host

36. A substance usually intended for use on inanimate objects, that destroys pathogens but not the spores.

A. Sterilization
B. Disinfectant
C. Antiseptic
D. Autoclave

37. This is a process of removing pathogens but not their spores

A. Sterilization
B. Auto claving
C. Disinfection
D. Medical asepsis

38. The third period of infectious processes characterized by development of specific signs and symptoms

A. Incubation period
B. Prodromal period
C. Illness period
D. Convalescent period

39. A child with measles developed fever and general weakness after being exposed to another child with rubella. In what stage of infectious process does this child belongs?

A. Incubation period
B. Prodromal period
C. Illness period
D. Convalescent period

40. A 50 year old mailman carried a mail with anthrax powder in it. A minute after exposure, he still hasn't developed any signs and symptoms of anthrax. In what stage of infectious process does this man belongs?

A. Incubation period
B. Prodromal period
C. Illness period
D. Convalescent period

41. Considered as the WEAKEST LINK in the chain of infection that nurses can manipulate to prevent spread of infection and diseases

A. Etiologic/Infectious agent
B. Portal of Entry
C. Susceptible host
D. Mode of transmission

42. Which of the following is the exact order of the infection chain?

1. Susceptible host
2. Portal of entry
3. Portal of exit
4. Etiologic agent
5. Reservoir
6. Mode of transmission

A. 1, 2, 3, 4, 5, 6
B. 5, 4, 2, 3, 6, 1
C. 4, 5, 3, 6, 2, 1
D. 6, 5, 4, 3, 2, 1

43. Markee, A 15 year old high school student asked you. What is the mode of transmission of Lyme disease. You correctly answered him that Lyme disease is transmitted via

A. Direct contact transmission
B. Vehicle borne transmission
C. Air borne transmission
D. Vector borne transmission

44. The ability of the infectious agent to cause a disease primarily depends on all of the following except

A. Pathogenicity
B. Virulence
C. Invasiveness
D. Non Specificity

45. Contact transmission of infectious organism in the hospital is usually cause by

A. Urinary catheterization
B. Spread from patient to patient
C. Spread by cross contamination via hands of caregiver
D. Cause by unclean instruments used by doctors and nurses

46. Transmission occurs when an infected person sneezes, coughs or laugh that is usually projected at a distance of 3 feet.

A. Droplet transmission
B. Airborne transmission
C. Vehicle transmission
D. Vector borne transmission

47. Considered as the first line of defense of the body against infection

A. Skin
B. WBC

C. Leukocytes
D. Immunization

48. All of the following contributes to host susceptibility except

A. Creed
B. Immunization
C. Current medication being taken
D. Color of the skin

49. Graciel has been injected TT5, her last dosed for tetanus toxoid immunization. Graciel asked you, what type of immunity is TT Injections? You correctly answer her by saying Tetanus toxoid immunization is a/an

A. Natural active immunity
B. Natural passive immunity
C. Artificial active immunity
D. Artificial passive immunity

50. Agatha, was hacked and slashed by a psychotic man while she was crossing the railway. She suffered multiple injuries and was injected Tetanus toxoid Immunoglobulin. Agatha asked you, What immunity does TTIg provides? You best answered her by saying TTIg provides

A. Natural active immunity
B. Natural passive immunity
C. Artificial active immunity
D. Artificial passive immunity

51. This is the single most important procedure that prevents cross contamination and infection

A. Cleaning
B. Disinfecting
C. Sterilizing
D. Handwashing

52. This is considered as the most important aspect of handwashing

A. Time
B. Friction
C. Water
D. Soap

53. In handwashing by medical asepsis, hands are held…

A. Above the elbow, The hands must always be above the waist
B. Above the elbow, The hands are cleaner than the elbow
C. Below the elbow, Medical asepsis do not require hands to be above the waist
D. Below the elbow, Hands are dirtier than the lower arms

54. The suggested time per hand on handwashing using the time method is

A. 5 to 10 seconds each hand
B. 10 to 15 seconds each hand
C. 15 to 30 seconds each hand
D. 30 to 60 seconds each hand

55. The minimum time in washing each hand should never be below

A. 5 seconds
B. 10 seconds
C. 15 seconds
D. 30 seconds

56. How many ml of liquid soap is recommended for handwashing procedure?

A. 1-2 ml
B. 2-3 ml
C. 2-4 ml
D. 5-10 ml

57. Which of the following is not true about sterilization, cleaning and disinfection?

A. Equipment with small lumen are easier to clean
B. Sterilization is the complete destruction of all viable microorganism including spores
C. Some organism are easily destroyed, while other, with coagulated protein requires longer time
D. The number of organism is directly proportional to the length of time required for sterilization

58. Karlita asked you, How long should she boil her glass baby bottle in water? You correctly answered her by saying

A. The minimum time for boiling articles is 5 minutes
B. Boil the glass baby bottler and other articles for atleast 10 minutes
C. For boiling to be effective, a minimum of 15 minutes is required
D. It doesn't matter how long you boil the articles, as long as the water reached 100 degree Celsius

59. This type of disinfection is best done in sterilizing drugs, foods and other things that are required to be sterilized before taken in by the human body

A. Boiling Water
B. Gas sterilization
C. Steam under pressure
D. Radiation

60. A TB patient was discharged in the hospital. A UV Lamp was placed in the room where he stayed for a week. What type of disinfection is this?

A. Concurrent disinfection
B. Terminal disinfection
C. Regular disinfection
D. Routine disinfection

61. Which of the following is not true in implementing medical asepsis

A. Wash hand before and after patient contact
B. Keep soiled linens from touching the clothings
C. Shake the linens to remove dust
D. Practice good hygiene

62. Which of the following is true about autoclaving or steam under pressure?

A. All kinds of microorganism and their spores are destroyed by autoclave machine
B. The autoclaved instruments can be used for 1 month considering the bags are still intact
C. The instruments are put into unlocked position, on their hinge, during the autoclave
D. Autoclaving different kinds of metals at one time is advisable

63. Which of the following is true about masks?

A. Mask should only cover the nose
B. Mask functions better if they are wet with alcohol
C. Masks can provide durable protection even when worn for a long time and after each and every patient care
D. N95 Mask or particulate masks can filter organism as mall as 1 micromillimeter

64. Where should you put a wet adult diaper?

A. Green trashcan
B. Black trashcan
C. Orange trashcan
D. Yellow trashcan

65. Needles, scalpels, broken glass and lancets are considered as injurious wastes. As a nurse, it is correct to put them at disposal via a/an

A. Puncture proof container
B. Reused PET Bottles
C. Black trashcan
D. Yellow trashcan with a tag “INJURIOUS WASTES”

66. Miranda Priestly, An executive of RAMP magazine, was diagnosed with cancer of the cervix. You noticed that the radioactive internal implant protrudes to her vagina where supposedly, it should be in her cervix. What should be your initial action?

A. Using a long forceps, Push it back towards the cervix then call the physician
B. Wear gloves, remove it gently and place it on a lead container
C. Using a long forceps, Remove it and place it on a lead container
D. Call the physician, You are not allowed to touch, re insert or remove it

67. After leech therapy, Where should you put the leeches?

A. In specially marked BIO HAZARD Containers
B. Yellow trashcan
C. Black trashcan
D. Leeches are brought back to the culture room, they are not thrown away for they are reusable

68. Which of the following should the nurse AVOID doing in preventing spread of infection?

A. Recapping the needle before disposal to prevent injuries
B. Never pointing a needle towards a body part
C. Using only Standard precaution to AIDS Patients
D. Do not give fresh and uncooked fruits and vegetables to Mr. Gatchie, with Neutropenia

69. Where should you put Mr. Alejar, with Category II TB?

A. In a room with positive air pressure and atleast 3 air exchanges an hour
B. In a room with positive air pressure and atleast 6 air exchanges an hour
C. In a room with negative air pressure and atleast 3 air exchanges an hour
D. In a room with negative air pressure and atleast 6 air exchanges an hour

70. A client has been diagnosed with RUBELLA. What precaution is used for this patient?

A. Standard precaution
B. Airborne precaution
C. Droplet precaution
D. Contact precaution

71. A client has been diagnosed with MEASLES. What precaution is used for this patient?

A. Standard precaution
B. Airborne precaution
C. Droplet precaution
D. Contact precaution

72. A client has been diagnosed with IMPETIGO. What precaution is used for this patient?

A. Standard precaution
B. Airborne precaution
C. Droplet precaution
D. Contact precaution

73. The nurse is to insert an NG Tube when suddenly, she accidentally dip the end of the tube in the client's glass containing distilled drinking water which is definitely not sterile. As a nurse, what should you do?

A. Don't mind the incident, continue to insert the NG Tube
B. Obtain a new NG Tube for the client
C. Disinfect the NG Tube before reinserting it again
D. Ask your senior nurse what to do

74. All of the following are principle of SURGICAL ASEPSIS except

A. Microorganism travels to moist surfaces faster than with dry surfaces
B. When in doubt about the sterility of an object, consider it not sterile
C. Once the skin has been sterilized, considered it sterile
D. If you can reach the object by overreaching, just move around the sterile field to pick it rather than reaching for it

75. Which of the following is true in SURGICAL ASEPSIS?

A. Autoclaved linens and gowns are considered sterile for about 4 months as long as the bagging is intact
B. Surgical technique is a sole effort of each nurse
C. Sterile conscience, is the best method to enhance sterile technique
D. If a scrubbed person leaves the area of the sterile field, He/she must do handwashing and gloving again, but the gown need not be changed.

76. In putting sterile gloves, Which should be gloved first?

A. The dominant hand
B. The non dominant hand
C. The left hand
D. No specific order, Its up to the nurse for her own convenience

77. As the scrubbed nurse, when should you apply the goggles, shoe cap and mask prior to the operation?
A. Immediately after entering the sterile field
B. After surgical hand scrub
C. Before surgical hand scrub
D. Before entering the sterile field

78. Which of the following should the nurse do when applying gloves prior to a surgical procedure?
A. Slipping gloved hand with all fingers when picking up the second glove
B. Grasping the first glove by inserting four fingers, with thumbs up underneath the cuff
C. Putting the gloves into the dominant hand first
D. Adjust only the fitting of the gloves after both gloves are on

79. Which gloves should you remove first?
A. The glove of the non dominant hand
B. The glove of the dominant hand
C. The glove of the left hand
D. Order in removing the gloves Is unnecessary

80. Before a surgical procedure, Give the sequence on applying the protective items listed below

1. Eye wear or goggles
2. Cap
3. Mask
4. Gloves
5. Gown

A. 3, 2, 1, 5, 4
B. 3, 2, 1, 4, 5
C. 2, 3, 1, 5, 4
D. 2, 3, 1, 4, 5

81. In removing protective devices, which should be the exact sequence?

1. Eye wear or goggles
2. Cap
3. Mask
4. Gloves
5. Gown

A. 4, 3, 5, 1, 2
B. 2, 3, 1, 5, 4
C. 5, 4, 3, 2, 1
D. 1, 2, 3, 4, 5

82. In pouring a plain NSS into a receptacle located in a sterile field, how high should the nurse hold the bottle above the receptacle?

A. 1 inch
B. 3 inches
C. 6 inches
D. 10 inches

83. The tip of the sterile forceps is considered sterile. It is used to manipulate the objects in the sterile field using the non sterile hands. How should the nurse hold a sterile forceps?

A. The tip should always be lower than the handle
B. The tip should always be above the handle
C. The handle and the tip should be at the same level
D. The handle should point downward and the tip, always upward

84. The nurse enters the room of the client on airborne precaution due to tuberculosis. Which of the following are appropriate actions by the nurse?

1. She wears mask, covering the nose and mouth
2. She washes her hands before and after removing gloves, after suctioning the client's secretion
3. She removes gloves and hands before leaving the client's room
4. She discards contaminated suction catheter tip in trashcan found in the clients room

A. 1, 2
B. 1, 2, 3
C. 1, 2, 3, 4
D. 1, 3

85. When performing surgical hand scrub, which of the following nursing action is required to prevent contamination?

1. Keep fingernail short, clean and with nail polish
2. Open faucet with knee or foot control
3. Keep hands above the elbow when washing and rinsing
4. Wear cap, mask, shoe cover after you scrubbed

A. 1, 2
B. 2, 3
C. 1, 2, 3
D. 2, 3, 4

86. When removing gloves, which of the following is an inappropriate nursing action?

A. Wash gloved hand first
B. Peel off gloves inside out
C. Use glove to glove skin to skin technique
D. Remove mask and gown before removing gloves

87. Which of the following is TRUE in the concept of stress?

A. Stress is not always present in diseases and illnesses
B. Stress are only psychological and manifests psychological symptoms
C. All stressors evoke common adaptive response
D. Hemostasis refers to the dynamic state of equilibrium

88. According to this theorist, in his modern stress theory, Stress is the non specific response of the body to any demand made upon it.

A. Hans Selye
B. Walter Cannon
C. Claude Bernard
D. Martha Rogers

89. Which of the following is NOT TRUE with regards to the concept of Modern Stress Theory?

A. Stress is not a nervous energy
B. Man, whenever he encounters stresses, always adapts to it
C. Stress is not always something to be avoided
D. Stress does not always lead to distress

90. Which of the following is TRUE with regards to the concept of Modern Stress Theory?

A. Stress is essential
B. Man does not encounter stress if he is asleep
C. A single stress can cause a disease
D. Stress always leads to distress

91. Which of the following is TRUE in the stage of alarm of general adaptation syndrome?

A. Results from the prolonged exposure to stress
B. Levels or resistance is increased
C. Characterized by adaptation
D. Death can ensue

92. The stage of GAS where the adaptation mechanism begins

A. Stage of Alarm
B. Stage of Resistance
C. Stage of Homeostasis
D. Stage of Exhaustion

93. Stage of GAS Characterized by adaptation

A. Stage of Alarm
B. Stage of Resistance
C. Stage of Homeostasis
D. Stage of Exhaustion

94. Stage of GAS wherein, the Level of resistance are decreased

A. Stage of Alarm
B. Stage of Resistance
C. Stage of Homeostasis
D. Stage of Exhaustion

95. Where in stages of GAS does a person moves back into HOMEOSTASIS?

A. Stage of Alarm
B. Stage of Resistance
C. Stage of Homeostasis
D. Stage of Exhaustion

96. Stage of GAS that result from prolonged exposure to stress. Here, death will ensue unless extra adaptive mechanisms are utilized

A. Stage of Alarm
B. Stage of Resistance
C. Stage of Homeostasis
D. Stage of Exhaustion

97. All but one is a characteristic of adaptive response

A. This is an attempt to maintain homeostasis
B. There is a totality of response
C. Adaptive response is immediately mobilized, doesn't require time
D. Response varies from person to person

98. Andy, a newly hired nurse, starts to learn the new technology and electronic devices at the hospital. Which of the following mode of adaptation is Andy experiencing?

A. Biologic/Physiologic adaptive mode
B. Psychologic adaptive mode
C. Sociocultural adaptive mode
D. Technological adaptive mode

99. Andy is not yet fluent in French, but he works in Quebec where majority speaks French. He is starting to learn the language of the people. What type of adaptation is Andy experiencing?

A. Biologic/Physiologic adaptive mode
B. Psychologic adaptive mode

C. Sociocultural adaptive mode
D. Technological adaptive mode

100. Andy made an error and his senior nurse issued a written warning. Andy arrived in his house mad and kicked the door hard to shut it off. What adaptation mode is this?

A. Biologic/Physiologic adaptive mode
B. Psychologic adaptive mode
C. Sociocultural adaptive mode
D. Technological adaptive mode

Answers and Rationale

1. Answer: C. Lungs will bronchodilate

To better understand the concept, the autonomic nervous system is composed of the sympathetic and parasympathetic nervous system. It is called autonomic because it is involuntary and stimuli-based. You cannot dictate your heart to beat 60 per minute, nor tell your blood vessels when to constrict and dilate. Sympathetic nervous system is the “fight or flight” mechanism.

2. Answer: C. Clients BP will increase, there will be vasodilation

If vasodilation will occur, the BP will not increase but decrease.

3. Answer: A. Illness

Disease is a proven fact based on a medical theory, standards, diagnosis and clinical features. Illness, on the other hand, is a subjective state of not feeling well based on subjective appraisal, previous experience, peer advice and etc.

4. Answer: A. Symptom Experience

Assumption of the sick role is when a client accepts he is ill. Medical care contact is where the client asks someone to confirm what he is experiencing. During this stage, the client seeks professional advice for validation, reassurance clarification and explanation of the symptoms he is experiencing. Last stage of illness is the recovery stage where the patient gives up the sick role and assumes the previous normal functions.

5. Answer: D. Dependent patient role

In the dependent patient role stage, patients needs professionals for help. They have a choice either to accept or reject the professional’s decisions but patients are usually passive and accepting. Regression tends to occur more in this period.

6. Answer: B. Assumption of sick role

Acceptance of illness occurs in the assumption of sick role phase of illness.

7. Answer: C. Medical care contact

At this stage, The patient seeks for validation of his symptom experience. He wants to find out if what he feels are normal or not normal. He wants someone to explain why is he feeling these signs and symptoms and wants to know the probable outcome of this experience.

8. Answer: A. One should be held responsible for his condition

The nurse should not judge the patient and not view the patient as the cause or someone responsible for his illness. A sick client is excused from his societal roles, oblige to get well as soon as possible and obliged to seek competent help.

9. Answer: C. Risk factor

10. Answer: A. Susceptibility

Immunity is the absolute resistance to a pathogen considering that person has an intact immunity. Susceptibility is the degree of resistance or how well would the individual combat the pathogens and repel infection or invasion of these disease causing organisms. A susceptible person is someone who has a very low degree of resistance to combat pathogens. An immune person is someone that can easily repel specific pathogens.

11. Answer: A. Syndrome

Symptoms are individual manifestation of a certain disease (i.e., tics in Tourette syndrome) but a symptom alone is not enough to diagnose the patient as other diseases may have the symptom manifestation. Syndrome, on the other hand, means collection of these symptoms that occurs together and has a pattern that characterizes a certain disease.

12. Answer: D. Iatrogenic

Iatrogenic diseases refers to those that resulted from treatment of a certain disease. For example, a child develops redness and partial thickness burns over his chest area due to frequent exposure to X-ray. Neoplastic diseases are malignant diseases caused by proliferation of abnormally growing cells. Traumatic are brought about by injuries like vehicular accidents. Nosocomial are infections that are acquired inside the hospital.

13. Answer: B. 2 and 3 (Idiopathic and Neoplastic)

14. Answer: C. Exacerbation

15. Answer: A. Chronic

Chronic diseases are characterized by periods of remissions and exacerbations and persists longer than six (6) months that is why remissions and exacerbations are observable. The duration of acute and sub acute diseases are too short to manifest remissions.

16. Answer: D. Organic

Organic diseases are caused by a change in structure of a certain organ and organ systems. Inorganic diseases, on the other hand, are synonymous with functional diseases where there is no evident structural, anatomical or physical change in the structure of the organ or organ system but its function is altered due to other causes.

17. Answer: B. Ecology

Ecology is the science that deals with the ecosystem and its effects on living things in the biosphere. It deals with diseases in relationship with the environment. Epidemiology is simply the study of diseases and its occurrence and distribution in man for the purpose of controlling and preventing diseases.

18. Answer: A. Epidemiology

19. Answer: C. Inorganic

20. Answer: C. Tertiary

Primary refers to the measures that aim in preventing the diseases (i.e., healthy lifestyle, good nutrition, knowledge seeking behaviors, etc). Secondary prevention are those measures that deal with early diagnostics, case finding treatments (i.e, breast self exam, X-rays, antibiotic treatment to cure infection, iron therapy for anemia, etc). Tertiary prevention aims on maintaining optimum level of functioning during or after the impact of disease that threatens to alter the normal body functioning (i.e., prosthesis fitting for an amputated leg, glucose monitoring among diabetics, and TPA therapy after stroke).

21. Answer: D. None of the above.

The nurse never increases the person's susceptibility to illness but rather, LESSEN the person's susceptibility to illness.

22. Answer: B. Secondary

Secondary prevention is also known as health maintenance prevention.

23. Answer: A. Primary

Personal Protective Devices or PPD are worn by workers in a hazardous work environment to protect them from injuries. This is considered as primary prevention because the nurse prevents the occurrence of injuries.

24. Answer: A. Primary

25. Answer: B. Secondary

Pap-smear is a diagnostic procedure thus falls under the secondary level of prevention.

26. Answer: C. Tertiary

27. Answer: D. Radio and Television

The best way to disseminate information to the public is via television followed by radio. The two media outlets have the widest reach and this is how the Department of Health (DOH) establishes its IEC programs.

28. Answer: B. Neuman

The supra and subsystems are theories of Martha Rogers but the parts and subparts are Betty Neuman's. She stated that health is a state where in all parts and subparts of an individual are in harmony with the whole system. Margarex Newman defined health as an expanding consciousness.

29. Answer: D. 1,2,3,4

Rationale:All of the following are correct statement about health. The first one is the definition by World Health Organization (WHO). The second is taken from Walter Cannon's Homeostasis Theory. The third is from Claude Bernard's concept of Health as Internal Milieu. The last one is from Neuman's theory.

30. Answer: C. Cannon

Walter Cannon advocated health as homeostasis or the ability to maintain dynamic equilibrium. Hans Selye postulated concepts about stress and adaptation. Bernard defined health as the ability to maintain internal milieu and Rogers defined Health as Wellness that is influenced by individual's culture.

31. Answer: D. Lifestyle

32. Answer: B. Age

33. Answer: A. Surgical Asepsis

Surgical Asepsis is otherwise known as the "sterile technique," while Medical Asepsis is synonymous with the "clean technique."

34. Answer: D. Carrier

35. Answer: B. Contact

36. Answer: B. Disinfectant

Disinfectants are used on inanimate objects. Antiseptics are intended on persons and other living things. Both can kill and inhibit growth of microorganisms but cannot kill spores. Autoclaving or steam under pressure kills almost all types of microorganisms including their spores.

37. Answer: C. Disinfection

38. Answer: C. Illness period

In incubation period, the disease has been introduced to the body but no sign and symptom appear because the pathogen is not yet strong enough to cause it and may still need to multiply. The second period is called prodromal period where appearance of non-specific signs and symptoms sets in. Illness period is characterized by appearance of specific signs and symptoms. Acme is the peak of an illness while convalescent period is characterized by the abatement of the disease or its gradual dissipation.

39. Answer: B. Prodromal period

40. Answer: A. Incubation period

Anthrax can have an incubation period of hours to seven (7) days with an average of 48 (hours). Since the question stated exposure, we can assume that the mailman is in the incubation phase.

41. Answer: D. Mode of transmission

Mode of transmission is the weakest link in the chain of infection. It is easily manipulated by the nurses using the tiers of prevention, either by instituting transmission based precautions, universal precaution or isolation techniques.

42. Answer: C. 4,5,3,6,2,1

Source is the etiological agent itself, this is where the chain of infection starts. The source will first proliferate on a reservoir and will need a portal of exit to be able to transmit itself using a portal of entry to a susceptible host.

43. Answer: D. Vector borne transmission

Lyme's disease is caused by *borrelia burgdorferi* and is transmitted via a tick bite.

44. Answer: D. Non Specificity

To be able to cause a disease, a pathogen should have a target organ and should be specific to these organs to cause an infection.

45. Answer: C. Spread by cross contamination via hands of caregiver

A caregiver's hands like any other healthcare workers is the main cause of cross-contamination in a hospital setting. Handwashing is the single most important procedure to prevent the occurrence of cross-contamination and nosocomial infections.

46. Answer: A. Droplet transmission

47. Answer: A. Skin

Remember that intact skin and mucous membrane is our first line of defense against infection.

48. Answer: A. Creed

Creed, Faith or religious belief do not affect person's susceptibility to illness. Medication like corticosteroids could supress a person's immune system that will lead to increase susceptibility. Color of the skin could affect person's susceptibility to certain skin diseases. A dark skinned person has lower risk of skin cancer than a fair skinned person. Fair skinned person also has a higher risk for cholecystitis and cholelithiasis.

49. Answer: C. Artificial active immunity

TT1 and TT2 are considered the primary doses while TT3, TT4 and TT5 are booster doses. A woman with a complete immunization of DPT need not to receive the primary doses TT1 and TT2. Tetanus toxoid is an actual but weakened and inactivated toxin produced by *clostridium tetani.* It is artificial because it did not occur in the course of an actual illness or infection.

50. Answer: D. Artificial passive immunity

In this scenario, Agatha was already wounded and has injuries. Giving the Tetanus Toxoid vaccine itself would not be beneficial to her as it will take time before the body can produce antitoxins. What Agatha needs now is a ready made antitoxin in the form of ATS or TTIg which is considered artificial because her body did not produce it and passive because her immune system was not stimulated but rather, given a ready-made immunoglobulin to immediately suppress the infection.

51. Answer: D. Handwashing

TIP: Most of the time, when you see the word handwashing as one of the options, there is a big chance that it is the correct answer.

52. Answer: B. Friction

The most important aspect of handwashing is friction. The rest of the components will just enhance friction. Soap lowers the surface tension thereby increasing the effectiveness of friction. Water helps remove transient bacteria by working with soap to create lather that reduces surface tension. Time, on the other hand, is of the essence but friction is the most essential aspect of handwashing. It's friction whether you like it or not.

53. Answer: D. Below the elbow, Hands are dirtier than the lower arms

Hands are put below the elbow in medical asepsis in contrast with surgical asepsis where hands are required to be kept above the waist. In medical asepsis, hands are considered dirtier than the elbow and therefore, to limit contamination of the lower arm, the hands should always be below the elbow.

54. Answer: C. 15 to 30 seconds each hand

Each hand requires 15 to 30 seconds of hand washing as a minimum to effectively remove transient germs.

55. Answer: B. 10 seconds

According to Kozier, the minimum time required for watching each hands is 10 seconds and should not be lower than that. The recommended time, again, is 15 to 30 seconds.

56. Answer: C. 2-4 ml

If a liquid soap is to be used, 1 tsp (5 ml) of liquid soap is recommended for handwashing procedure.

57. Answer: A. Equipment with small lumen are easier to clean

Equipment with large lumen are easier to clean compared to those with small lumen. Other choices are correct.

58. Answer: C. For boiling to be effective, a minimum of 15 minutes is required

Boiling is the most common and least expensive method of sterilization used in home. For it to be effective, you should boil articles for at least 15 minutes.

59. Answer: D. Radiation

If food and drugs are to be sterilized by boiling water, ethylene oxide gas and autoclave, most probably they'll be ineffective after the process. Ethylene oxide gas is toxic to humans, boiling food will alter its consistency and lower it nutritional value. Autoclaving food may sound fun but it is the dumbest thing to do. Radiation using a microwave oven or an ionization penetrate foods and drugs thus, sterilizing them.

60. Answer: B. Terminal disinfection

Terminal disinfection refers to practices to remove pathogens that stayed in the belongings or immediate environment of an infected client who has been discharged. Concurrent disinfection refers to ongoing efforts implemented during the client's stay to remove or limit pathogens in his supplies, belongings, immediate environment in order to control the spread of the disease.

61. Answer: C. Shake the linens to remove dust

Never shake soiled linens. Once soiled fold it inwards with the clean surface facing out. Shaking the linen can dislodge and further spread pathogens harbored in its fabric.

62. Answer: C. The instruments are put into unlocked position, on their hinge, during the autoclave

Metals with locks, like clamps and scissors should be unlocked in order to minimize stiffening caused by autoclaving the hinges. Not all microorganisms are destroyed by autoclaving, there are still microorganisms that are invulnerable to extreme heat. Autoclaved instruments are to be used within two (2) weeks. Only the same type of metals should be autoclaved as this will alteration in plating of these metals.

63. Answer: D. N95 Mask or particulate masks can filter organism as mall as 1 micromillimeter

Mask should cover both nose and mouth and will not function optimally when wet. They should never be worn greater than four (4) hours and will gradually lose its effectiveness after four (4) horus. N95 masks or particulate masks can filter organisms as small as one (1) micromillimeter.

64. Answer: D. Yellow trashcan

Infectious waste like blood and blood products, wet diapers and dressings are thrown in yellow-colored trashbins.

65. Answer: A. Puncture proof container

Needles, scalpels and other sharps are to be disposed in a puncture proof container.

66. Answer: C. Using a long forceps, Remove it and place it on a lead container

A dislodged radioactive cervical implant in brachytherapy are to be picked by a long forceps and to be stored in a lead container in order to prevent damage on the client's normal tissue. Calling the physician is the most appropriate action among the choices, a nurse should never attempt to put it back nor touch it with her bare or even gloved hands.

67. Answer: A. In specially marked BIO HAZARD Containers

Leeches, in leech therapy or leech phlebotomy are to be disposed on a BIOHAZARD container. They are never re used as this could cause transfer of infection. These leeches are hospital grown and not the usual leeches found in swamps because that would just be disgusting.

68. Answer: A. Recapping the needle before disposal to prevent injuries

Never recap needles. After using, they are directly disposed in a puncture proof container after used. Recapping could cause injury to the nurse and spread infection. Choices B, C and D are all appropriate. Standard precaution is sufficient for a patient with HIV. A client with neutropenia are not given fresh and uncooked fruits and vegetables as it may cause severe infection due to immunosuppression.

69. Answer: D. In a room with negative air pressure and atleast 6 air exchanges an hour

Patients with tuberculosis should have a private room with a negative air pressure and at least 6 to 12 air exchanges per hour. Negative pressure rooms will prevent air inside from escaping. Air exchanges are necessary since the client's room do not allow air to get out of the room.

70. Answer: C. Droplet precaution

Droplet precaution is sufficient on client's with RUBELLA or german measles.

71. Answer: B. Airborne precaution

Measles is highly communicable and more contagious than Rubella. It requires airborne precaution as it is spread by small particle droplets that remains suspended in air and dispersed by air movements.

72. Answer: D. Contact precaution

Impetigo causes blisters or sores in the skin. It is generally caused by GABS or Staph Aureaus. It is spread by skin to skin contact or by scratching the lesions and touching another person's skin.

73. Answer: A. Don't mind the incident, continue to insert the NG Tube

The digestive tract is not sterile, and therefore, simple errors like this would not cause harm to the patient. NGT tube need not be sterile, and so is colostomy and rectal tubes. Clean technique is sufficient during NGT and colostomy care.

74. Answer: C. Once the skin has been sterilized, considered it sterile

Human skin is impossible to be sterilized. It contains normal flora of microorganism. A, B and D are all correct.

75. Answer: C. Sterile conscience, is the best method to enhance sterile technique

Sterile conscience, or the moral imperative of a nurse to be honest in practicing sterile technique, is the best method to enhance sterile technique. Autoclaved linens are considered sterile only within two (2) weeks even if the bagging is intact. Surgical technique is a team effort of each nurse. If a scrubbed person leave the sterile field and area, he must do the process all over again.

76. Answer: B. The non dominant hand

Gloves are put on the non dominant hands first and then, the dominant hand. The rationale is simply because humans tend to use the dominant hand first before the non dominant hand. Out of 10 humans that will put on their sterile gloves, 8 of them will put the gloves on their non dominant hands first.

77. Answer: C. Before surgical hand scrub

The nurse should put his goggles, cap and mask prior to washing the hands. If he wash his hands prior to putting all these equipments, he must wash his hands again as these equipments are said to be unsterile.

78. Answer: D. Adjust only the fitting of the gloves after both gloves are on

The nurse should only adjust fitting of the gloves when they are both on the hands. Not doing so will break the sterile technique. Only 4 fingers are slipped when picking up the second gloves. You cannot slip all of your fingers as the cuff is limited and the thumb would not be able to enter the cuff. The first glove is grasp by simply picking it up with the first 2 fingers and a thumb in a pinching motion. Gloves are put on the non dominant hands first.

79. Answer: A. The glove of the non dominant hand

Gloves are worn in the non dominant hand first, and is removed also from the non dominant hand first. Rationale is simply because in 10 people removing gloves, 8 of them will use the dominant hand first and remove the gloves of the non dominant hand.

80. Answer: D. 2,3,1,4,5

81. Answer: A. 4,3,5,1,2

When removing protective devices, one must remove the gloves first, followed by the mask and gown, then other devices like cap, shoe cover, and etc. Doing it in this manner will prevent contamination of hair, neck and face area. Go ahead, try removing your mask, hair cap and others before removing your soiled and bloodied gloves.

82. Answer: C. 6 inches

Even if you do not know the answer to this question, you can answer it correctly by imagining. If you pour the NSS into a receptacle 1 to 3 inch above it, chances are, the mouth of the NSS bottle would dip into the receptacle as you fill it, making it contaminated. If you pour the NSS bottle into a receptacle 10 inches above it, that is too high, chances are, as you pour the NSS, most will spill out because the force will be too much for the buoyant force to handle. It will also be difficult to pour something precisely into a receptacle as the height increases between the receptacle and the bottle. 6 inches is the correct answer. It is not too low nor too high.

83. Answer: A. The tip should always be lower than the handle

Sterile forceps are usually dipped into a disinfectant or germicidal solution. If the tip is higher than the handle, the solution will flow down into the handle and into your hands,

and as you use the forceps, you'll eventually lower its tip making the solution in your hand flow to the tip thus contaminating the sterile area of the forceps. To prevent this, the tip should always be lower than the handle.

84. Answer: C. 1,2,3,4

All soiled equipment used in an infectious patient are disposed inside the client's room to prevent contamination outside the room. Using the mask to cover both nose and mouth is correct. Hands are washed before removing the gloves and before and after your enter the client's room. Gloves and contaminated suction tip are thrown in the trash found in the client's room.

85. Answer: C. 1,2,3

Caps, masks and shoe covers are worn before scrubbing in.

86. Answer: D. Remove mask and gown before removing gloves

Gloves are the dirtiest personal protective device used and therefore, should be the first to be removed to prevent spread of microorganisms as you remove your masks and gown.

87. Answer: C. All stressors evoke common adaptive response

All stressors evoke common adaptive response. A psychologic fear like nightmare and a real fear or real perceive threat evokes common manifestation like tachycardia, tachypnea, sweating, increase muscle tension etc. ALL diseases and illness causes stress. Stress can be both real or imaginary. Hemostasis refers to the arrest of blood flowing abnormally through a damage vessel. Homeostasis is the one that refers to dynamic state of equilibrium according to Walter Cannon.

88. Answer: A. Hans Selye

Hans Selye is the only theorist who proposed an intriguing theory about stress that has been widely used and accepted by professionals today. He conceptualized two types of human response to stress, The GAS or general adaptation syndrome which is characterized by stages of ALARM, RESISTANCE and EXHAUSTION. The local adaptation syndrome controls stress through a particular body part.

89. Answer: B. Man, whenever he encounters stresses, always adapts to it

Man do not always adapt to stress. Sometimes, stress can lead to exhaustion and eventually, death. Choices A, C and D are all correct.

90. Answer: A. Stress is essential

Stress is ESSENTIAL. No man can live normally without stress. It is essential because it is evoked by the body's normal pattern of response and leads to a favorable adaptive mechanism that are utilized in the future when more stressors are encountered by the body. Man can encounter stress even while asleep (i.e., nightmares).

Disease are multifactorial and are not caused by a single stressor. Stress is sometimes favorable and are not always a cause for distress.

91. Answer: D. Death can ensue

Death can ensue as early as the stage of alarm. Exhaustion results to a prolonged exposure to stress. Resistance is when the levels of resistance increases and characterized by being able to adapt.

92. Answer: A. Stage of Alarm

Adaptation mechanisms begin in the stage of alarm. This is when the adaptive mechanism are mobilized.

93. Answer: B. Stage of Resistance

94. Answer: A. Stage of Alarm

Resistance are decreased in the stage of alarm. Resistance is absent in the stage of exhaustion. Resistance is increased in the stage of resistance.

95. Answer: B. Stage of Resistance

96. Answer: D. Stage of Exhaustion

97. Answer: C. Adaptive response is immediately mobilized, doesn't require time

Aside from having limits that leads to exhaustion, adaptive response requires time for it to act. It requires energy, physical and psychological taxes that needs time for our body to mobilize and utilize.

98. Answer: D. Technological adaptive mode

99. Answer: C. Sociocultural adaptive mode

Sociocultural adaptive modes include language, communication, dressing, acting and socializing in line with the social and cultural standard of the people around the adapting individual.

100. Answer: B. Psychologic adaptive mode

XXIX (28)

Topics or concepts included in this exam are:

- Stress and response to stress
- Crisis Intervention
- Communication
- Documentation
- Learning

1. The coronary vessels, unlike any other blood vessels in the body, respond to sympathetic stimulation by

A. Vasoconstriction
B. Vasodilatation

C. Decreases force of contractility
D. Decreases cardiac output

2. What stress response can you expect from a patient with blood sugar of 50 mg / dl?

A. Body will try to decrease the glucose level
B. There will be a halt in release of sex hormones
C. Client will appear restless
D. Blood pressure will increase

3. All of the following are purpose of inflammation except

A. Increase heat, thereby produce abatement of phagocytosis
B. Localized tissue injury by increasing capillary permeability
C. Protect the issue from injury by producing pain
D. Prepare for tissue repair

4. The initial response of tissue after injury is

A. Immediate Vasodilation
B. Transient Vasoconstriction
C. Immediate Vasoconstriction
D. Transient Vasodilation

5. The last expected process in the stages of inflammation is characterized by

A. There will be sudden redness of the affected part
B. Heat will increase on the affected part
C. The affected part will lose its normal function
D. Exudates will flow from the injured site

6. What kind of exudates is expected when there is an antibody-antigen reaction as a result of microorganism infection?

A. Serous
B. Serosanguinous
C. Purulent
D. Sanguinous

7. The first manifestation of inflammation is

A. Redness on the affected area
B. Swelling of the affected area
C. Pain, which causes guarding of the area
D. Increase heat due to transient vasodilation

8. The client has a chronic tissue injury. Upon examining the client's antibody for a particular cellular response, Which of the following WBC component is responsible for phagocytosis in chronic tissue injury?

A. Neutrophils
B. Basophils
C. Eosinophils
D. Monocytes

9. Which of the following WBC component proliferates in cases of Anaphylaxis?

A. Neutrophils
B. Basophils
C. Eosinophil
D. Monocytes

10. Icheanne, ask you, her Nurse, about WBC Components. She got an injury yesterday after she twisted her ankle accidentally at her gymnastic class. She asked you, which WBC Component is responsible for proliferation at the injured site immediately following an injury. You answer:

A. Neutrophils
B. Basophils
C. Eosinophils
D. Monocytes

11. Icheanne then asked you, what is the first process that occurs in the inflammatory response after injury, You tell her:

A. Phagocytosis
B. Emigration
C. Pavementation
D. Chemotaxis

12. Icheanne asked you again, What is that term that describes the magnetic attraction of injured tissue to bring phagocytes to the site of injury?
A. Icheanne, you better sleep now, you asked a lot of questions
B. It is Diapedesis
C. We call that Emigration
D. I don't know the answer, perhaps I can tell you after I find it out later
13. This type of healing occurs when there is a delayed surgical closure of infected wound
A. First intention
B. Second intention
C. Third intention
D. Fourth intention
14. Type of healing when scars are minimal due to careful surgical incision and good healing
A. First intention
B. Second intention
C. Third intention
D. Fourth intention

15. Imelda, was slashed and hacked by an unknown suspects. She suffered massive tissue loss and laceration on her arms and elbow in an attempt to evade the criminal. As a nurse, you know that the type of healing that will most likely occur to Miss Imelda is

A. First intention
B. Second intention
C. Third intention
D. Fourth intention

16. Imelda is in the recovery stage after the incident. As a nurse, you know that the diet that will be prescribed to Miss Imelda is

A. Low calorie, High protein with Vitamin A and C rich foods
B. High protein, High calorie with Vitamin A and C rich foods
C. High calorie, Low protein with Vitamin A and C rich foods
D. Low calorie, Low protein with Vitamin A and C rich foods

17. Miss Imelda asked you, What is WET TO DRY Dressing method? Your best response is

A. It is a type of mechanical debridement using Wet dressing that is applied and left to dry to remove dead tissues
B. It is a type of surgical debridement with the use of Wet dressing to remove the necrotic tissues
C. It is a type of dressing where in, The wound is covered with Wet or Dry dressing to prevent contamination
D. It is a type of dressing where in, A cellophane or plastic is placed on the wound over a wet dressing to stimulate healing of the wound in a wet medium

18. The primary cause of pain in inflammation is

A. Release of pain mediators
B. Injury to the nerve endings
C. Compression of the local nerve endings by the edema fluids
D. Circulation is lessen, Supply of oxygen is insufficient

19. The client is in stress because he was told by the physician he needs to undergo surgery for removal of tumor in his bladder. Which of the following are effects of sympatho-adreno-medullary response by the client?

1. Constipation
2. Urinary frequency
3. Hyperglycemia
4. Increased blood pressure

A. 3,4
B. 1,3,4
C.1,2,4
D.1,4

20. The client is on NPO post midnight. Which of the following, if done by the client, is sufficient to cancel the operation in the morning?

A. Eat a full meal at 10:00 P.M
B. Drink fluids at 11:50 P.M
C. Brush his teeth the morning before operation
D. Smoke cigarette around 3:00 A.M

21. The client place on NPO for preparation of the blood test. Adreno-cortical response is activated and which of the following below is an expected response?

A. Low BP
B. Decrease Urine output
C. Warm, flushed, dry skin
D. Low serum sodium levels

22. Which of the following is true about therapeutic relationship?

A. Directed towards helping an individual both physically and emotionally
B. Bases on friendship and mutual trust
C. Goals are set by the solely nurse
D. Maintained even after the client doesn't need anymore of the Nurse's help

23. According to her, A nurse patient relationship is composed of 4 stages : Orientation, Identification, Exploitation and Resolution

A. Roy
B. Peplau
C. Rogers
D. Travelbee

24. In what phase of Nurse patient relationship does a nurse review the client's medical records thereby learning as much as possible about the client?

A. Pre Orientation
B. Orientation
C. Working
D. Termination

25. Nurse Aida has seen her patient, Roger for the first time. She establish a contract about the frequency of meeting and introduce to Roger the expected termination. She started taking baseline assessment and set interventions and outcomes. On what phase of NPR Does Nurse Aida and Roger belong?

A. Pre Orientation
B. Orientation
C. Working
D. Termination

26. Roger has been seen agitated, shouting and running. As Nurse Aida approaches, he shouts and swear, calling Aida names. Nurse Aida told Roger "That is an unacceptable behavior Roger, Stop and go to your room now." The situation is most likely in what phase of NPR?

A. Pre Orientation
B. Orientation
C. Working
D. Termination

27. Nurse Aida, in spite of the incident, still consider Roger as worthwhile simply because he is a human being. What major ingredient of a therapeutic communication is Nurse Aida using?

A. Empathy
B. Positive regard
C. Comfortable sense of self
D. Self awareness

28. Nurse Irma saw Roger and told Nurse Aida " Oh look at that psychotic patient " Nurse Aida should intervene and correct Nurse Irma because her statement shows that she is lacking?

A. Empathy
B. Positive regard
C. Comfortable sense of self
D. Self awareness

29. Which of the following statement is not true about stress?

A. It is a nervous energy
B. It is an essential aspect of existence
C. It has been always a part of human experience
D. It is something each person has to cope

30. Martina, a tennis champ was devastated after many new competitors outpaced her in the Wimbledon event.She became depressed and always seen crying. Martina is clearly on what kind of situation?

A. Martina is just stressed out
B. Martina is Anxious
C. Martina is in the exhaustion stage of GAS
D. Martina is in Crisis

31. Which of the following statement is not true with regards to anxiety?

A. It has physiologic component
B. It has psychologic component
C. The source of dread or uneasiness is from an unrecognized entity
D. The source of dread or uneasiness is from a recognized entity

32. Lorraine, a 27 year old executive was brought to the ER for an unknown reason. She is starting to speak but her speech is disorganized and cannot be understood. On what level of anxiety does this features belongs?

A. Mild
B. Moderate
C. Severe
D. Panic

33. Elton, 21 year old nursing student is taking the board examination. She is sweating profusely, has decreased awareness of his environment and is purely focused on the exam questions characterized by his selective attentiveness. What anxiety level is Elton exemplifying?

A. Mild
B. Moderate
C. Severe
D. Panic

34. You noticed the patient chart : ANXIETY +3 What will you expect to see in this client?

A. An optimal time for learning, hearing and perception is greatly increased
B. Dilated pupils
C. Unable to communicate
D. Palliative Coping Mechanism

35. When should the nurse starts giving XANAX?

A. When anxiety is +1
B. When the client starts to have a narrow perceptual field and selective inattentiveness
C. When problem solving is not possible
D. When the client is immobile and disorganized

36. Which of the following behavior is not a sign or a symptom of Anxiety?

A. Frequent hand movement
B. Somatization
C. The client asks a question
D. The client is acting out

37. Which of the following intervention is inappropriate for client's with anxiety?

A. Offer choices
B. Provide a quiet and calm environment
C. Provide detailed explanation on each and every procedures and equipments
D. Bring anxiety down to a controllable level

38. Which of the following statement, if made by the nurse, is considered not therapeutic?

A. “How did you deal with your anxiety before?”
B. “It must be awful to feel anxious.”
C. “How does it feel to be anxious?”
D. “What makes you feel anxious?”

39. Marissa Salva, Uses Benson’s relaxation. How is it done?

A. Systematically tensing muscle groups from top to bottom for 5 seconds, and then releasing them
B. Concentrating on breathing without tensing the muscle, Letting go and repeating a word or sound after each exhalation
C. Using a strong positive, feeling-rich statement about a desired change
D. Exercise combined with meditation to foster relaxation and mental alacrity

40. What type of relaxation technique does Lyza uses if a machine is showing her pulse rate, temperature and muscle tension which she can visualize and assess?
A. Biofeedback
B. Massage
C. Autogenic training
D. Visualization and Imagery

41. This is also known as Self-suggestion or Self-hypnosis
A. Biofeedback
B. Meditation
C. Autogenic training
D. Visualization and Imagery

42. Which among these drugs is NOT an anxiolytic?

A. Valium
B. Ativan
C. Milltown
D. Luvox

43. Kenneth, 25 year old diagnosed with HIV felt that he had not lived up with God’s expectation. He fears that in the course of his illness, God will be punitive and not be supportive. What kind of spiritual crisis is Kenneth experiencing?

1. Spiritual Pain
2. Spiritual Anxiety
3. Spiritual Guilt
4. Spiritual Despair

A. 1,2
B. 2,3
C. 3,4
D. 1,4

44. Grace, believes that her relationship with God is broken. She tried to go to church to ask forgiveness everyday to remedy her feelings. What kind of spiritual distress is Grace experiencing?

A. Spiritual Pain
B. Spiritual Alienation
C. Spiritual Guilt
D. Spiritual Despair

45. Remedios felt "EMPTY" She felt that she has already lost God's favor and love because of her sins. This is a type of what spiritual crisis?

A. Spiritual Anger
B. Spiritual Loss
C. Spiritual Despair
D. Spiritual Anxiety

46. Blake is working with a schizophrenic patient. He noticed that the client is agitated, pacing back and forth, restless and experiencing Anxiety +3. Blake said "You appear restless" What therapeutic technique did Blake used?

A. Offering general leads
B. Seeking clarification
C. Making observation
D. Encouraging description of perception

47. Ronny told Blake "I see dead people." Blake responded, "You see dead people?" This exchange is an example of what therapeutic communication technique?

A. Reflecting
B. Restating
C. Exploring
D. Seeking clarification

48. Ronny told Blake, "Do you think I'm crazy?" Blake responded, "Do you think you're crazy?" Blake uses what example of therapeutic communication?

A. Reflecting
B. Restating
C. Exploring
D. Seeking clarification

49. Myra, 21 year old nursing student has difficulty sleeping. She told Nurse Blake "I really think a lot about my ex-boyfriend recently." Blake told Myra "And that causes you difficulty sleeping?" Which therapeutic technique is used in this situation?

A. Reflecting
B. Restating
C. Exploring
D. Seeking clarification

50. Myra told Blake "I cannot sleep, I stay away all night." Blake told her "You have difficulty sleeping?" This is what type of therapeutic communication technique?

A. Reflecting
B. Restating
C. Exploring
D. Seeking clarification

51. Myra said "I saw my dead grandmother here at my bedside a while ago." Blake responded "Really? That is hard to believe. How do you feel about it?" What technique did Blake used?

A. Disproving
B. Disagreeing
C. Voicing Doubt
D. Presenting Reality

52. Which of the following is a therapeutic communication in response to "I am a GOD, bow before me or ill summon the dreaded thunder to burn you and purge you to pieces!"

A. "You are not a GOD, you are Professor Tadle and you are a PE Teacher, not a Nurse. I am Glen, your nurse."
B. "Oh hail GOD Tadle, everyone bow or face his wrath!"
C. "Hello Mr. Tadle, You are here in the hospital, I am your nurse and you are a patient here"
D. "How can you be a GOD Mr. Tadle? Can you tell me more about it?"

53. Erik John Senna, Told Nurse Blake " I don't want to that, I don't want that thing.. that's too painful!" Which of the following response is NON THERAPEUTIC?

A. "This must be difficult for you, but I need to inject you this for your own good"
B. "You sound afraid"
C. "Are you telling me you don't want this injection?"
D. "Why are you so anxious? Please tell me more about your feelings Erik"

54. Mr. Poncho was caught by the police because of his illegal activities. When he got home after paying for the bail, he shouted at his son. What defense mechanism did Mr. Poncho used?

A. Restitution
B. Projection
C. Displacement
D. Undoing

55. Later that day, he bought his son ice cream and food. What defense mechanism is Mr. Poncho unconsciously doing?

A. Restitution
B. Conversion
C. Redoing
D. Reaction formation

56. Crisis is a sudden event in ones life that disturbs a person's homeostasis. Which of the following is NOT TRUE in crisis?

A. The person experiences heightened feeling of stress
B. Inability to function in the usual organized manner
C. Lasts for 4 months
D. Indicates unpleasant emotional feelings

57. Which of the following is a characteristic of crisis?

A. Lasts for an unlimited period of time
B. There is a triggering event
C. Situation is not dangerous to the person
D. Person totality is not involved

58. Levito Devin, the Italian prime minister, is due to retire next week. He feels depressed due to the enormous loss of influence, power, fame and fortune. What type of crisis is Devin experiencing?

A. Situational
B. Maturational
C. Social
D. Phenomenal

59. Tstrada, the USA president, has been unexpectedly impeached and was out of office before the end of his term. He is in what type of crisis?

A. Situational
B. Maturational
C. Social
D. Phenomenal

60. The tsunami in Thailand and Indonesia took thousands of people and change million lives. The people affected by the tsunami are saddened and do not know how to start all over again. What type of crisis is this?

A. Situational
B. Maturational
C. Social
D. Phenomenal

61. Which of the following is the BEST goal for crisis intervention?

A. Bring back the client in the pre crisis state
B. Make sure that the client becomes better
C. Achieve independence
D. Provide alternate coping mechanism

62. What is the best intervention when the client has just experienced the crisis and still at the first phase of the crisis?

A. Behavior therapy
B. Gestalt therapy
C. Cognitive therapy
D. Milieu Therapy

63. Therapeutic nurse client relationship is describes as follows

1. Based on friendship and mutual interest
2. It is a professional relationship
3. It is focused on helping the patient solve problems and achieve health-related goals
4. Maintained only as long as the patient requires professional help

A. 1,2,3
B. 1,2,4
C. 2,3,4
D. 1,3,4

64. The client is scheduled to have surgical removal of the tumor on her left breast. Which of the following manifestation indicates that she is experiencing Mild Anxiety?

A. She has increased awareness of her environmental details
B. She focused on selected aspect of her illness
C. She experiences incongruence of action, thoughts and feelings
D. She experiences random motor activities

65. Which of the following nursing intervention would least likely be effective when dealing with a client with aggressive behavior?

A. Approach him in a calm manner
B. Provide opportunities to express feelings
C. Maintain eye contact with the client
D. Isolate the client from others

66. Whitney, a patient of nurse Blake, verbalizes… "I have nothing, nothing… nothing! Don't make me close one more door, I don't wanna hurt anymore!" Which of the following is the most appropriate response by Blake?

A. Why are you singing?
B. What makes you say that?
C. Ofcourse you are everything!
D. What is that you said?

67. Whitney verbalizes that she is anxious that the diagnostic test might reveal laryngeal cancer. Which of the following is the most appropriate nursing intervention?

A. Tell the client not to worry until the results are in
B. Ask the client to express feelings and concern
C. Reassure the client everything will be alright
D. Advice the client to divert his attention by watching television and reading newspapers

68. Considered as the most accurate expression of person's thought and feelings

A. Verbal communication
B. Non verbal communication
C. Written communication
D. Oral communication

69. Represents inner feeling that a person do not like talking about.

A. Overt communication
B. Covert communication
C. Verbal communication
D. Non verbal communication

70. Which of the following is NOT a characteristic of an effective Nurse-Client relationship?

A. Focused on the patient
B. Based on mutual trust
C. Conveys acceptance
D. Discourages emotional bond

71. A type of record wherein each person or department makes notation in separate records. A nurse will use the nursing notes, the doctor will use the Physician's order sheet etc. Data is arranged according to information source.

A. POMR
B. POR
C. Traditional
D. Resource oriented

72. Type of recording that integrates all data about the problem, gathered by members of the health team.

A. POMR
B. Traditional
C. Resource oriented
D. Source oriented

73. These are data that are monitored by using graphic charts or graphs that indicated the progression or fluctuation of client's Temperature and Blood pressure.

A. Progress notes
B. Kardex
C. Flow chart
D. Flow sheet

74. Provides a concise method of organizing and recording data about the client. It is a series of flip cards kept in portable file used in change of shift reports.

A. Kardex
B. Progress Notes
C. SOAPIE
D. Change of shift report

75. You are about to write an information on the Kardex. There are four (4) available writing instruments to use. Which of the following should you use?

A. Mongol #2
B. Permanent Ink
C. A felt or fountain pen
D. Pilot Pentel Pen marker

76. The client has an allergy to Iodine-based dye. Where should you put this vital information in the client's chart?

A. In the first page of the client's chart
B. At the last page of the client's chart
C. At the front metal plate of the chart
D. In the Kardex

77. Which of the following is NOT TRUE about the Kardex

A. It provides readily available information
B. It is a tool of end of shift reports
C. The primary basis of endorsement
D. Where Allergies information are written

78. Which of the following, if seen on the Nurses notes, violates characteristic of good recording?

A. The client has a blood pressure of 120/80, Temperature of 36.6 C, Pulse rate of 120 and Respiratory rate of 22
B. Ate 50% of food served
C. Refused administration of betaxolol
D. Visited and seen by Dr. Santiago

79. The physician ordered: Mannerix a.c , what does a.c means?

A. As desired
B. Before meals
C. After meals
D. Before bed time

80. The physician ordered, Maalox, 2 hours p.c, what does p.c means?

A. As desired
B. Before meals
C. After meals
D. Before bedtime

81. The physician ordered, Maxitrol, Od. What does Od means?

A. Left eye
B. Right eye
C. Both eye
D. Once a day

82. The physician ordered, Magnesium Hydroxide cc Aluminum Hydroxide. What does cc means?

A. without
B. with
C. one half
D. With one half dose

83. Physician ordered, Paracetamol tablet ss. What does ss means?

A. without
B. with
C. one half
D. With one half dose

84. Which of the following indicates that learning has been achieved?

A. Martin starts exercising every morning and eating a balance diet after you taught her mag HL tayo program
B. Donya Delilah has been able to repeat the steps of insulin administration after you taught it to her
C. Marsha said " I understand " after you a health teaching about family planning
D. John rated 100% on your given quiz about smoking and alcoholism

85. In his theory of learning as a BEHAVIORISM, he stated that transfer of knowledge occurs if a new situation closely resembles an old one.

A. Bloom
B. Lewin
C. Thorndike
D. Skinner

86. Which of the following is TRUE with regards to learning?

A. Start from complex to simple
B. Goals should be hard to achieve so patient can strive to attain unrealistic goals
C. Visual learning is the best for every individual
D. Do not teach a client when he is in pain

87. According to Bloom, there are 3 domains in learning. Which of these domains is responsible for the ability of Donya Delilah to inject insulin?

A. Cognitive
B. Affective
C. Psychomotor
D. Motivative

88. Which domains of learning is responsible for making John and Marsha understand the different kinds of family planning methods?

A. Cognitive
B. Affective
C. Psychomotor
D. Motivative

89. Which of the following statement clearly defines therapeutic communication?

A. Therapeutic communication is an interaction process which is primarily directed by the nurse
B. It conveys feeling of warmth, acceptance and empathy from the nurse to a patient in relaxed atmosphere
C. Therapeutic communication is a reciprocal interaction based on trust and aimed at identifying patient needs and developing mutual goals
D. Therapeutic communication is an assessment component of the nursing process

90. Which of the following concept is most important in establishing a therapeutic nurse patient relationship?

A. The nurse must fully understand the patient's feelings, perception and reactions before goals can be established
B. The nurse must be a role model for health fostering behavior
C. The nurse must recognize that the patient may manifest maladaptive behavior after illness
D. The nurse should understand that patients might test her before trust is established

91. Which of the following communication skill is most effective in dealing with covert communication?

A. Validation
B. Listening
C. Evaluation
D. Clarification

92. Which of the following are qualities of a good recording?

1. Brevity
2. Completeness and chronology
3. Appropriateness
4. Accuracy

A. 1,2
B. 3,4
C. 1,2,3
D. 1,2,3,4

93. All of the following chart entries are correct except

A. V/S 36.8 C,80,16,120/80
B. Complained of chest pain
C. Seems agitated
D. Able to ambulate without assistance

94. Which of the following teaching method is effective in client who needs to be educated about self injection of insulin?

A. Detailed explanation
B. Demonstration
C. Use of pamphlets
D. Film showing

95. What is the most important characteristic of a nurse patient relationship?

A. It is growth facilitating
B. Based on mutual understanding
C. Fosters hope and confidence
D. Involves primarily emotional bond

96. Which of the following nursing intervention is needed before teaching a client post spleenectomy deep breathing and coughing exercises?

A. Tell the patient that deep breathing and coughing exercises is needed to promote good breathing, circulation and prevent complication
B. Tell the client that deep breathing and coughing exercises is needed to prevent Thrombophlebitis, hydrostatic pneumonia and atelectasis
C. Medicate client for pain
D. Tell client that cooperation is vital to improve recovery

97. The client has an allergy with penicillin. What is the best way to communicate this information?

A. Place an allergy alert in the Kardex
B. Notify the attending physician
C. Write it on the patient's chart
D. Take note when giving medications

98. An adult client is on extreme pain. He is moaning and grimacing. What is the best way to assess the client's pain?

A. Perform physical assessment
B. Have the client rate his pain on the smiley pain rating scale
C. Active listening on what the patient says
D. Observe the client's behavior

99. Therapeutic communication begins with?

A. Knowing your client
B. Knowing yourself
C. Showing empathy
D. Encoding

100. The PCS gave new guidelines including leaflets to educate cancer patients. As a nurse, When using materials like this, what is your responsibility?

A. Read it for the patient
B. Give it for the patient to read himself
C. Let the family member read the material for the patient
D. Read it yourself then, Have the client read the material

Answers and Rationale

1. Answer: B. Vasodilatation

Sympathetic activation to the heart results in coronary vasodilation and increased coronary flow due to increased metabolic activity (increased heart rate, contractility) despite direct vasoconstrictor effects of sympathetic activation on the coronaries. This is termed “functional sympatholysis.”

2. Answer: D. Blood pressure will increase

Blood pressure elevation secondary to hypoglycemia has been demonstrated in human experimentation through the activation of the sympathoadrenal system.

3. Answer: A. Increase heat, thereby produce abatement of phagocytosis

The inflammatory response is a defense mechanism that evolved in higher organisms to protect them from infection and injury. Its purpose is to localize and eliminate the injurious agent and to remove damaged tissue components so that the body can begin to heal. The response consists of changes in blood flow, an increase in permeability of blood vessels, and the migration of fluid, proteins, and white blood cells (leukocytes) from the circulation to the site of tissue damage. An inflammatory response that lasts only a few days is called acute inflammation, while a response of longer duration is referred to as chronic inflammation.

4. Answer: C. Immediate Vasoconstriction

Inflammation can be divided into several phases. The earliest, gross event of an inflammatory response is temporary vasoconstriction, i.e. narrowing of blood vessels caused by contraction of smooth muscle in the vessel walls, which can be seen as blanching (whitening) of the skin.

5. Answer: C. The affected part will lose its normal function

A fifth consequence of inflammation is the loss of function of the inflamed area, a feature noted by German pathologist Rudolf Virchow in the 19th century. Loss of function may result from pain that inhibits mobility or from severe swelling that prevents movement in the area.

6. Answer: C. Purulent

Purulent effluent refers to a thick yellow, gray or green drainage that comes out of a wound when infection invades the area. The fluid contains pathogenic microorganisms

along with white cells, inflammatory cells and dead or dying bacteria. When the wound is infected, the volume of the purulent exudate increases.

7. Answer: A. Redness on the affected area

Vasodilation occurs first at the arteriole level, progressing to the capillary level, and brings about a net increase in the amount of blood present, causing the redness and heat of inflammation.

8. Answer: D. Monocytes

Monocytes and their macrophage and dendritic-cell progeny serve three main functions in the immune system. These are phagocytosis, antigen presentation, and cytokine production. Phagocytosis is the process of uptake of microbes and particles followed by digestion and destruction of this material. Monocytes can perform phagocytosis using intermediary (opsonising) proteins such as antibodies or complement that coat the pathogen, as well as by binding to the microbe directly via pattern-recognition receptors that recognize pathogens.

9. Answer: C. Eosinophil

It is known that eosinophils appear as an aftermath of anaphylaxis in sensitized tissues that are reexposed to specific antigens.

10. Answer: A. Neutrophils

Activated neutrophils are capable of presenting antigens via MHCII, thereby stimulating T-cell activation and proliferation.

11. Answer: C. Pavementation

Pavementation or the sticking of white blood cells to the linings of the finest blood vessels (capillaries) when inflammation occurs is the first process that occurs in the inflammatory response after injury.

12. Answer: D. I don't know the answer, perhaps I can tell you after I find it out later

13. Answer: C. Third intention

Healing by third intention is a method of closing a grossly contaminated wound in which the wound is left open until contamination has been markedly reduced and inflammation has subsided and then is closed by first intention. Also called delayed primary closure.

14. Answer: A. First intention

Healing by first intention aka. primary wound healing or primary closure describes a wound closed by approximation of wound margins or by placement of a graft or flap, or wounds created and closed in the operating room.

15. Answer: B. Second intention

Healing by second intention aka. secondary wound healing or spontaneous healing Describes a wound left open and allowed to close by epithelialization and contraction.

16. Answer: B. High protein, High calorie with Vitamin A and C rich foods

Even if you do not currently have any aches or pains, adding these foods into your diet can help prepare your body for healing if you should happen to get hurt.

17. Answer: A. It is a type of mechanical debridement using Wet dressing that is applied and left to dry to remove dead tissues

This type of mechanical debridement is done by placing a wet (or moist) gauze dressing on your wound and allowing it to dry, wound drainage and dead tissue can be removed when you take off the old dressing.

18. Answer: C. Compression of the local nerve endings by the edema fluids

Chemicals that stimulate nerve endings are released, making the area much more sensitive and the inflamed area is likely to be painful, especially when touched.

19. Answer: B. 1,3,4

20. Answer: D. Smoke cigarette around 3:00 A.M

The phrase “NPO After Midnight” is one of the most common in medicine. It is present not only in physician’s pre-operative orders, but repeated by nurses, ward secretaries and dietary workers. The goal of “NPO after midnight” was to ensure an empty stomach for the morning procedure.

21. Answer: B. Decrease Urine output

22. Answer: A. Directed towards helping an individual both physically and emotionally

Therapeutic nurse-patient communication helps nurses to build positive relationships with patients by showing warmth, respect, and empathy. It also increases confidence of the nurse by enabling nurses to ask for support, open up for feedbacks, and overcome anxiety. Therefore allows nurses to provide the best possible care for patients. Effective nurse-healthcare provider communications assure optimal patient-centered care.

23. Answer: B. Peplau

Peplau published her Theory of Interpersonal Relations in 1952, and in 1968, interpersonal techniques became the crux of psychiatric nursing. The nursing model identifies four sequential phases in the interpersonal relationship: orientation, identification, exploitation, and resolution.

24. Answer: A. Pre Orientation

Pre-orientation phase begins when the nurse is assigned to the patient. It includes all that the nurse thinks and does before interacting with the patient such as when the nurse review the client’s medical records.

25. Answer: B. Orientation

Orientation Phase begins when the nurse and the patient meet for the patient. In this phase, parameters of the relationship is done. Explanation of roles is also done during this phase which includes the responsibilities and expectation of the patient and nurse, with the expectations of both parties of what they can and can't do. It is during the orientation phase when the nurse begins to know the patient.

26. Answer: C. Working

The working phase is highly individualized. it is more structured than the orientation phase- meaning most of the therapeutic work is done during this phase.

27. Answer: B. Positive regard

Unconditional positive regard often described as acceptance is the third core condition and this involves taking a non-judgemental attitude towards the client accepting and respecting them for who and what they are.

28. Answer: B. Positive regard

Refer to #27

29. Answer: A. It is a nervous energy

Stress is a normal physical response to events that make you feel threatened or upset your balance in some way. A nervous energy is more part of anxiety.

30. Answer: D. Martina is in Crisis

Martina is in Crisis. She feels sad and down during this tough time. She can have intense negative feelings for weeks, months or more.

31. Answer: D. The source of dread or uneasiness is from a recognized entity

Anxiety is a general term for several disorders that cause nervousness, fear, apprehension, and worrying. These disorders affect how we feel and behave, and they can manifest real physical symptoms. Mild anxiety is vague and unsettling, while severe anxiety can be extremely debilitating, having a serious impact on daily life.

32. Answer: D. Panic

Panic is the highest level of anxiety and is associated with dread, terror and a sense of impending doom. You may not be able to communicate, function or concentrate because you are unable to think rationally. You may start uncontrollably pacing and become increasingly active without absolute purpose.

33. Answer: B. Moderate

At this level, you lose the broader picture and focus only on the cause of the anxiety. You may not be able to pay attention like usual, and even though your perceptual field is narrowed, you are still able to solve a problem. Mild and moderate levels of anxiety are considered normal.

34. Answer: B. Dilated pupils

35. Answer: B. When the client starts to have a narrow perceptual field and selective inattentiveness

36. Answer: C. The client asks a question

37. Answer: A. Offer choices

38. Answer: D. "What makes you feel anxious?"

39. Answer: B. Concentrating on breathing without tensing the muscle, Letting go and repeating a word or sound after each exhalation

The Relaxation Response is essentially the opposite reaction to the "fight or flight" response. According to Dr. Benson, using the Relaxation Response is beneficial as it counteracts the physiological effects of stress and the fight or flight response.

40. Answer: A. Biofeedback

Biofeedback is a technique you can use to learn to control your body's functions, such as your heart rate. With biofeedback, you're connected to electrical sensors that help you receive information (feedback) about your body (bio). This feedback helps you focus on making subtle changes in your body, such as relaxing certain muscles, to achieve the results you want, such as reducing pain.

In essence, biofeedback gives you the power to use your thoughts to control your body, often to help with a health condition or physical performance. Biofeedback is often used as a relaxation technique.

41. Answer: C. Autogenic training

Autogenic Therapy (AT) is a powerful mind and body technique involving simple relaxation and body awareness exercises. These reduce the intensity of the body's stress response, and replace it with a calmer physiological state in which self-healing naturally begins to occur.

42. Answer: D. Luvox

Luvox (fluvoxamine) is a selective serotonin reuptake inhibitor (SSRI) antidepressant.Fluvoxamine affects chemicals in the brain that may become unbalanced and cause obsessive-compulsive symptoms. It is frequently used along with benzodiazepine anxiolytics in clinics.

43: Answer: B. 2,3

Spiritual anxiety is the expression of fear of God's wrath and punishment; fear that God might not take care of one, either immediately or in the future; and/or worry that God is displeased with one's behavior. Spiritual guilt is an expression suggesting that one has failed to do the things which he should have done in life and/or done things which were not pleasing to God; articulation of concerns about the "kind" of life one has lived. Spiritual pain is the expression of discomfort of suffering relative to one's relationship with God, verbalization of feelings of having a void or lack of spiritual fulfillment, and/or a lack of peace in terms of one's relationship to one's creator. And spiritual despair is

the expression suggesting that there is no hope of ever having a relationship with God or of pleasing Him and/or a feeling that God no longer can or does care for one.

44. Answer: B. Spiritual Alienation

Spiritual alienation is the expressions of loneliness or the feeling that God seems very far away and remote from one's everyday life, verbalization that one has to depend upon one's self in times of trial or need, and/or a negative attitude toward receiving any comfort or help from God.

45. Answer: B. Spiritual Loss

Spiritual loss is the expression of feelings of having temporarily lost or terminated the love of God, fear that one's relationship with God has been threatened, and/or a feeling of emptiness with regard to spiritual things.

46. Answer: C. Making observation

Making observation is a therapeutic observation that is verbalizing what is observed or perceived.

47. Answer: B. Restating

Restating lets client know whether an expressed statement has or has not been understood.

48. Answer: A. Reflecting

Reflecting directs questions or feelings back to client so that they may be recognized and accepted.

49. Answer: A. Reflecting

Reflecting is directing back to the patient questions, feelings, and ideas.

50. Answer: B. Restating

Restating is repeating the main idea expressed.

51. Answer: C. Voicing Doubt

Voicing doubt is expressing uncertainty as to the reality of client's perception.

52. Answer: C. "Hello Mr. Tadle, You are here in the hospital, I am your nurse and you are a patient here"

This is an example of presenting reality. It is clarifying misconceptions that client may be expressing.

53. Answer: D. "Why are you so anxious? Please tell me more about your feelings Erik"

Requesting an explanation is an ineffective behavior and response.

54. Answer: C. Displacement

Displacement is the redirecting of thoughts feelings and impulses directed at one person or object, but taken out upon another person or object. People often use displacement when they cannot express their feelings in a safe manner to the person they are directed at.

55. Answer: A. Restitution

Restitution is the mechanism of relieving the mind of a load of guilt by making up or reparation (paying up with interest).

56. Answer: C. Lasts for 4 months

57: Answer: B. There is a triggering event

Crisis is any event that is, or is expected to lead to, an unstable and dangerous situation affecting an individual, group, community, or whole society.

58. Answer: B. Maturational

Maturational crisis a life crisis in which usual coping mechanisms are inadequate in dealing with a stress common to a particular stage in the life cycle or with stress caused by a transition from one stage to another.

59. Answer: A. Situational

Situational crisis is an unexpected crisis that arises suddenly in response to an external event or a conflict concerning a specific circumstance.

60. Answer: C. Social

Social Crisis is the crisis which hampers the social life of an individual. It can include recession, World War, terrorism etc., these are the major factor which is responsible for social crisis.

61. Answer: D. Provide alternate coping mechanism

One of the goals for crisis intervention is that the victim and the counselor begin to collaboratively generate and explore alternatives for coping. Although this situation will be unlike any other experience before, the counselor should assist the individual in looking at what has worked in the past for other situations; this is typically the most difficult to achieve in crisis counseling.

62. Answer D. Milieu Therapy

The goal of milieu therapy is to manipulate the environment so that all aspects of the client's hospital experience are considered therapeutic.

63. Answer: C. 2,3,4

A therapeutic nurse-client relationship is established for the benefit of the client. It includes nurses working with the client to create goals directed at improving their health status. Goals are centered on the client's values, beliefs and needs. A partnership is formed between nurse and client. The nurse empowers patient and families to get involved in their health. This relationship has three phases, a beginning (first time

contact/introduction), a middle (develop a relationship to deliver care) and an end (the patient is no longer dependant on the nurse).

64. Answer: A. She has increased awareness of her environmental details

Mild anxiety is anxiety that is manageable without any additional techniques. Mild anxiety tends to be when you have irritating symptoms that don't seem to go away, but otherwise don't control you.

65. Answer: B. Provide opportunities to express feelings

Providing opportunities for the client to express his or her feelings will likely trigger his or her aggressiveness more.

66. Answer: D. What is that you said?

Clarification should be sought at each step of the way. The patient is usually quite aware when he is not being understood. Eventually he may cease trying to communicate. Peplau states that it is always possible to ask: What is that you said?

67. Answer: B. Ask the client to express feelings and concern

Asking the client to verbalize what she or he perceives may relieve the tension the client is feeling and he or she might be less likely to take action on ideas that are harmful or frightening.

68. Answer: B. Non verbal communication

Non verbal communication is considered as the most accurate expression of person's thought and feelings. Nonverbal communication represents two-thirds of all communication.

69. Answer: B. Covert communication

"Overt" means "done or shown openly or plainly apparent" in the Oxford English dictionary. This can refer to all sorts of actions which are done in plain sight or with clear manifestations. "Covert," on the other hand, means the exact opposite of overt – not openly acknowledged or displayed.

70. Answer: D. Discourages emotional bond

Emotional support is important in order for a nurse-client relationship to be effective. It is giving and receiving reassurance and encouragement done through understanding.

71. Answer: D. Resource oriented

72. Answer: A. POMR

Problem-oriented medical record (POMR) is a method of recording data about the health status of a patient in a problem-solving system. The POMR preserves the data in an easily accessible way that encourages ongoing assessment and revision of the health care plan by all members of the health care team.

73. Answer: D. Flow sheet

Flowsheet (in a patient record) is a graphic summary of several changing factors, especially the patient's vital signs or weight and the treatments and medications given.

74. Answer: A. Kardex

The Kardex is a trademark for a card-filing system that allows quick reference to the particular needs of each patient for certain aspects of nursing care.

75. Answer: A. Mongol #2

Kardexes are a huge risk factor for med errors that is why they are written in pencil. They are not legal documents and are discarded when the patient is transferred out. And they are only as good as the nurse responsible for checking the orders

76. Answer: C. At the front metal plate of the chart

77. Answer: C. The primary basis of endorsement

Refer to #75.

78. Answer: A. The client has a blood pressure of 120/80, Temperature of 36.6 C Pulse rate of 120 and Respiratory rate of 22

Shortcuts would be safe to use on records when commenting on blood pressure, temperature, pulse rate, and respiratory rate respectively. Do not use an abbreviation unless you are sure that it is commonly understood and in general use.

79. Answer: B. Before meals

80. Answer: C. After meals

81. Answer: D. Once a day

82. Answer: B. with

83. Answer: C. one half

84. Answer: A. Martin starts exercising every morning and eating a balance diet after you taught her mag HL tayo program

Learning has been achieved by the patient if he or she applies and acts upon the teachings of the health care provider or the nurse. Verbalizing such learning does not guarantee an effective nurse teaching.

85. Answer: C. Thorndike

After several experiments on animals and learning development, Thorndike posited that learning was actually merely a change in behavior as a result of a consequence. Furthermore, if an action brought a reward, it was stamped into the mind and available for recall later. These two suppositions together came to be known as the Law of Effect, and now inform much of what we know about operant conditioning and behaviorism.

86. Answer: D. Do not teach a client when he is in pain

Pain tells us something is wrong. Pain does not suggest that the patient is ready to listen and perceive properly the teaching that the nurse may impart.

87. Answer: C. Psychomotor

Bloom's Taxonomy model is in three parts, or 'overlapping domains'. Again, Bloom used rather academic language, but the meanings are simple to understand: The learner should benefit from development of knowledge and intellect (Cognitive Domain); attitude and beliefs (Affective Domain); and the ability to put physical and bodily skills into effect – to act (Psychomotor Domain).

88. Answer: A. Cognitive

Refer to #87.

89. Answer: C. Therapeutic communication is a reciprocal interaction based on trust and aimed at identifying patient needs and developing mutual goals

Therapeutic communication is a process in which the nurse consciously influences a client or helps the client to a better understanding through verbal or nonverbal communication. Therapeutic communication involves the use of specific strategies that encourage the patient to express feelings and ideas and that convey acceptance and respect.

The goal of therapeutic communication is to increase self-worth or decrease psychological distress by collecting information to determine the illness, assessing and modifying the behavior, and providing health education.

90. Answer: D. The nurse should understand that patients might test her before trust is established

A therapeutic nurse-patient relationship is defined as a helping relationship that's based on mutual trust and respect, the nurturing of faith and hope, being sensitive to self and others, and assisting with the gratification of your patient's physical, emotional, and spiritual needs through your knowledge and skill.

91. Answer: A. Validation

92. Answer: D. 1,2,3,4

Documentation in nursing is also an integral part of providing quality and safe care to patients. Qualities of a good recording include Brevity, Completeness and chronology, Appropriateness and Accuracy.

93. Answer: C. Seems agitated

Being accurate is very important. For example, do not use vague terms such as "good urine output." How many cc's are "good?" Chart the specific amount and be accurate on things that you see and observe.

94. Answer: B. Demonstration

In teaching through demonstration, patients are set up to potentially conceptualize material more effectively.

95. Answer: A. It is growth facilitating

You can help your patient achieve harmony in mind, body, and spirit when engaging in a therapeutic relationship based on effective communication that incorporates caring behaviors. It's a win-win situation in which you and your patient can experience growth by sharing "the moment" with each other.

96. Answer: A. Tell the patient that deep breathing and coughing exercises is needed to promote good breathing, circulation and prevent complication

Deep breathing and coughing will decrease your risk for a lung infection. Take a deep breath and hold it for as long as you can. Let the air out and then cough strongly. Deep breaths help open your airway. You may be given an incentive spirometer to help you take deep breaths. Put the plastic piece in your mouth and take a slow, deep breath. Then let the air out and cough. Repeat these steps 10 times every hour.

97. Answer: B. Notify the attending physician

98. Answer: C. Active listening on what the patient says

Assessment of the patient experiencing pain is the cornerstone to optimal pain management. However, the quality and utility of any assessment tool is only as good as the clinician's ability to thoroughly focus on the patient. This means listening empathically, believing and legitimizing the patient's pain, and understanding, to the best of his or her capability, what the patient may be experiencing. A health care professional's empathic understanding of the patient's pain experience and accompanying symptoms confirms that there is genuine interest in the patient as a person. This can influence a positive pain management outcome.

99. Answer: B. Knowing yourself

It is important for the nurse to know herself to identify kinds of behavior of ideas that make her anxious and to seed help for her problems. Otherwise, she is likely to add new problems to those with which the patient is already struggling.

100. Answer: D. Read it yourself then, Have the client read the material

XXX (29)

Topics or concepts included in this exam are:

- Physical assessment
- Vital signs
- Routine proceures
- Specimen Collection
- Nursing Process
- Nursing Diagnoses

1. She is the first one to coin the term "NURSING PROCESS." She introduced three (3) steps of nursing process which are: Observation, Ministration and Validation.

A. Nightingale
B. Johnson
C. Rogers
D. Hall

2. The American Nurses Association formulated an innovation of the Nursing process. Today, how many distinct steps are there in the nursing process?

A. APIE – 4
B. ADPIE – 5
C. ADOPIE – 6
D. ADOPIER – 7

3. They are the first ones to suggest a four (4) step nursing process called APIE or assessment, planning, implementation, and evaluation.

1. Yura
2. Walsh
3. Roy
4. Knowles

A. 1,2
B. 1,3
C. 3,4
D. 2,3

4. Which characteristic of nursing process is responsible for proper utilization of human resources, time and cost resources?

A. Organized and Systematic
B. Humanistic
C. Efficient
D. Effective

5. Which characteristic of nursing process addresses the INDIVIDUALIZED care a client must receive?

A. Organized and Systematic
B. Humanistic
C. Efficient
D. Effective

6. A characteristic of the nursing process that is essential to promote client satisfaction and progress. The care should also be relevant with the client's needs.

A. Organized and Systematic
B. Humanistic
C. Efficient
D. Effective

7. Rhina, who has Menieres disease, said that her environment is moving. Which of the following is a valid assessment?

1. Rhina is giving an objective data
2. Rhina is giving a subjective data
3. The source of the data is primary
4. The source of the data is secondary

A. 1,3
B. 2,3
C. 2.4
D. 1,4

8. Nurse Angela, observe Joel who is very apprehensive over the impending operation. The client is experiencing dyspnea, diaphoresis and asks lots of questions. Angela made a diagnosis of ANXIETY R/T INTRUSIVE PROCEDURE. This is what type of Nursing Diagnosis?

A. Actual
B. Probable
C. Possible
D. Risk

9. Nurse Angela diagnosed Mrs. Delgado, who have undergone a BKA. Her diagnosis is SELF ESTEEM DISTURBANCE R/T CHANGE IN BODY IMAGE. Although the client has not yet seen her lost leg, Angela already anticipated the diagnosis. This is what type of Diagnosis?

A. Actual
B. Probable
C. Possible
D. Risk

10. Nurse Angela is about to make a diagnosis but very unsure because the S/S the client is experiencing is not specific with her diagnosis of POWERLESSNESS R/T DIFFICULTY ACCEPTING LOSS OF LOVED ONE. She then focus on gathering

data to refute or prove her diagnosis but her plans and interventions are already ongoing for the diagnosis. Which type of Diagnosis is this?

A. Actual
B. Probable
C. Possible
D. Risk

11. Nurse Angela knew that Stephen Lee Mu Chin, has just undergone an operation with an incision near the diaphragm. She knew that this will contribute to some complications later on. She then should develop what type of Nursing diagnosis?

A. Actual
B. Probable
C. Possible
D. Risk

12. Which of the following Nursing diagnosis is INCORRECT?

A. Fluid volume deficit R/T Diarrhea
B. High risk for injury R/T Absence of side rails
C. Possible ineffective coping R/T Loss of loved one
D. Self esteem disturbance R/T Effects of surgical removal of the leg

13. Among the following statements, which should be given the HIGHEST priority?

A. Client is in extreme pain
B. Client's blood pressure is 60/40
C. Client's temperature is 40 deg. Centigrade
D. Client is cyanotic

14. Which of the following need is given a higher priority among others?

A. The client has attempted suicide and safety precaution is needed
B. The client has disturbance in his body image because of the recent operation
C. The client is depressed because her boyfriend left her all alone
D. The client is thirsty and dehydrated

15. Which of the following is TRUE with regards to Client Goals?

A. They are specific, measurable, attainable and time bounded
B. They are general and broadly stated
C. They should answer for WHO, WHAT ACTIONS, WHAT CIRCUMSTANCES, HOW WELL and WHEN.
D. Example is : After discharge planning, Client demonstrated the proper psychomotor skills for insulin injection.

16. Which of the following is a NOT a correct statement of an Outcome criteria?

A. Ambulates 30 feet with a cane before discharge
B. Discusses fears and concerns regarding the surgical procedure

C. Demonstrates proper coughing and breathing technique after a teaching session
D. Reestablishes a normal pattern of elimination

17. Which of the following is a OBJECTIVE data?

A. Dizziness
B. Chest pain
C. Anxiety
D. Blue nails

18. A patient's chart is what type of data source?

A. Primary
B. Secondary
C. Tertiary
D. Can be A and B

19. All of the following are characteristic of the Nursing process except

A. Dynamic
B. Cyclical
C. Universal
D. Intrapersonal

20. Which of the following is true about the NURSING CARE PLAN?

A. It is nursing centered
B. Rationales are supported by interventions
C. Verbal
D. At least 2 goals are needed for every nursing diagnosis

21. A framework for health assessment that evaluates the effects of stressors to the mind, body and environment in relation with the ability of the client to perform ADL.

A. Functional health framework
B. Head to toe framework
C. Body system framework
D. Cephalocaudal framework

22. Client has undergone Upper GI and Lower GI series. Which type of health assessment framework is used in this situation?

A. Functional health framework
B. Head to toe framework
C. Body system framework
D. Cephalocaudal framework

23. Which of the following statement is true regarding temperature?

A. Oral temperature is more accurate than rectal temperature
B. The bulb used in Rectal temperature reading is pear shaped or round

C. The older the person, the higher his BMR
D. When the client is swimming, BMR Decreases

24. A type of heat loss that occurs when the heat is dissipated by air current

A. Convection
B. Conduction
C. Radiation
D. Evaporation

25. Which of the following is TRUE about temperature?

A. The highest temperature usually occurs later in a day, around 8 P.M to 12 M.N
B. The lowest temperature is usually in the Afternoon, Around 12 P.M
C. Thyroxin decreases body temperature
D. Elderly people are risk for hyperthermia due to the absence of fats, Decreased thermoregulatory control and sedentary lifestyle.

26. Hyperpyrexia is a condition in which the temperature is greater than

A. 40 degree Celsius
B. 39 degree Celsius
C. 100 degree Fahrenheit
D. 105.8 degree Fahrenheit

27. Tympanic temperature is taken from John, A client who was brought recently into the ER due to frequent barking cough. The temperature reads 37.9 Degrees Celsius. As a nurse, you conclude that this temperature is

A. High
B. Low
C. At the low end of the normal range
D. At the high end of the normal range

28. John has a fever of 38.5 Deg. Celsius. It surges at around 40 Degrees and go back to 38.5 degrees 6 times today in a typical pattern. What kind of fever is John having?

A. Relapsing
B. Intermittent
C. Remittent
D. Constant

29. John has a fever of 39.5 degrees 2 days ago, But yesterday, he has a normal temperature of 36.5 degrees. Today, his temperature surges to 40 degrees. What type of fever is John having?

A. Relapsing
B. Intermittent

C. Remittent
D. Constant

30. John's temperature 10 hours ago is a normal 36.5 degrees. 4 hours ago, He has a fever with a temperature of 38.9 Degrees. Right now, his temperature is back to normal. Which of the following best describe the fever john is having?

A. Relapsing
B. Intermittent
C. Remittent
D. Constant

31. The characteristic fever in Dengue Virus is characterized as:

A. Tricyclic
B. Bicyclic
C. Biphasic
D. Triphasic

32. When John has been given paracetamol, his fever was brought down dramatically from 40 degrees Celsius to 36.7 degrees in a matter of 10 minutes. The nurse would assess this event as:

A. The goal of reducing john's fever has been met with full satisfaction of the outcome criteria
B. The desired goal has been partially met
C. The goal is not completely met
D. The goal has been met but not with the desired outcome criteria

33. What can you expect from Marianne, who is currently at the ONSET stage of fever?

A. Hot, flushed skin
B. Increase thirst
C. Convulsion
D. Pale,cold skin

34. Marianne is now at the Defervescence stage of the fever, which of the following is expected?

A. Delirium
B. Goose flesh
C. Cyanotic nail beds
D. Sweating

35. Considered as the most accessible and convenient method for temperature taking

A. Oral
B. Rectal
C. Tympanic
D. Axillary

36. Considered as Safest and most non invasive method of temperature taking

A. Oral
B. Rectal
C. Tympanic
D. Axillary

37. Which of the following is NOT a contraindication in taking ORAL temperature?

A. Quadriplegic
B. Presence of NGT
C. Dyspnea
D. Nausea and Vomitting

38. Which of the following is a contraindication in taking RECTAL temperature?

A. Unconscious
B. Neutropenic
C. NPO
D. Very young children

39. How long should the Rectal Thermometer be inserted to the clients anus?

A. 1 to 2 inches
B. .5 to 1.5 inches
C. 3 to 5 inches
D. 2 to 3 inches

40. In cleaning the thermometer after use, The direction of the cleaning to follow Medical Asepsis is :

A. From bulb to stem
B. From stem to bulb
C. From stem to stem
D. From bulb to bulb

41. How long should the thermometer stay in the Client's Axilla?

A. 3 minutes
B. 4 minutes
C. 7 minutes
D. 10 minutes

42. Which of the following statement is TRUE about pulse?

A. Young person have higher pulse than older persons
B. Males have higher pulse rate than females after puberty
C. Digitalis has a positive chronotropic effect
D. In lying position, Pulse rate is higher

43. The following are correct actions when taking radial pulse except:

A. Put the palms downward
B. Use the thumb to palpate the artery
C. Use two or three fingers to palpate the pulse at the inner wrist
D. Assess the pulse rate, rhythm, volume and bilateral quality

44. The difference between the systolic and diastolic pressure is termed as

A. Apical rate
B. Cardiac rate
C. Pulse deficit
D. Pulse pressure

45. Which of the following completely describes PULSUS PARADOXICUS?

A. A greater-than-normal increase in systolic blood pressure with inspiration
B. A greater-than-normal decrease in systolic blood pressure with inspiration
C. Pulse is paradoxically low when client is in standing position and high when supine.
D. Pulse is paradoxically high when client is in standing position and low when supine.

46. Which of the following is TRUE about respiration?

A. I:E 2:1
B. I:E : 4:3
C I:E 1:1
D. I:E 1:2

47. Contains the pneumotaxic and the apneustic centers

A. Medulla oblongata
B. Pons
C. Carotid bodies
D. Aortic bodies

48. Which of the following is responsible for deep and prolonged inspiration

A. Medulla oblongata
B. Pons
C. Carotid bodies
D. Aortic bodies

49. Which of the following is responsible for the rhythm and quality of breathing?

A. Medulla oblongata
B. Pons
C. Carotid bodies
D. Aortic bodies

50. The primary respiratory center

A. Medulla oblongata
B. Pons
C. Carotid bodies
D. Aortic bodies

51. Which of the following is TRUE about the mechanism of action of the Aortic and Carotid bodies?

A. If the BP is elevated, the RR increases
B. If the BP is elevated, the RR decreases
C. Elevated BP leads to Metabolic alkalosis
D. Low BP leads to Metabolic acidosis

52. All of the following factors correctly influence respiration except one. Which of the following is incorrect?

A. Hydrocodone decreases RR
B. Stress increases RR
C. Increase temperature of the environment, Increase RR
D. Increase altitude, Increase RR

53. When does the heart receives blood from the coronary artery?

A. Systole
B. Diastole
C. When the valves opens
D. When the valves closes

54. Which of the following is more life threatening?

A. BP = 180/100
B. BP = 160/120
C. BP = 90/60
D. BP = 80/50

55. Refers to the pressure when the ventricles are at rest

A. Diastole
B. Systole
C. Preload
D. Pulse pressure

56. Which of the following is TRUE about the blood pressure determinants?

A. Hypervolemia lowers BP
B. Hypervolemia increases GFR
C. HCT of 70% might decrease or increase BP
D. Epinephrine decreases BP

57. Which of the following do not correctly correlates the increase BP of Ms. Aida, a 70 year old diabetic?

A. Females, after the age 65 tends to have lower BP than males
B. Disease process like Diabetes increase BP
C. BP is highest in the morning, and lowest during the night
D. Africans, have a greater risk of hypertension than Caucasian and Asians.

58. How many minutes are allowed to pass if the client had engaged in strenuous activities, smoked or ingested caffeine before taking his/her BP?

A. 5
B. 10
C. 15
D. 30

59. Too narrow cuff will cause what change in the Client's BP?

A. True high reading
B. True low reading
C. False high reading
D. False low reading

60. Which is a preferable arm for BP taking?

A. An arm with the most contraptions
B. The left arm of the client with a CVA affecting the right brain
C. The right arm
D. The left arm

61. Which of the following is INCORRECT in assessing client's BP?

A. Read the mercury at the upper meniscus, preferably at the eye level to prevent error of parallax
B. Inflate and deflate slowly, 2-3 mmHg at a time
C. The sound heard during taking BP is known as KOROTKOFF sound
D. If the BP is taken on the left leg using the popliteal artery pressure, a BP of 160/80 is normal.

62. Which of the following is the correct interpretation of the ERROR OF PARALLAX

A. If the eye level is higher than the level of the meniscus, it will cause a false high reading
B. If the eye level is higher than the level of the meniscus, it will cause a false low reading
C. If the eye level is lower than the level of the meniscus, it will cause a false low reading
D. If the eye level is equal to that of the level of the upper meniscus, the reading is accurate

63. How many minute/s is/are allowed to pass before making a re-reading after the first one?

A. 1
B. 5
C. 15
D. 30

64. Which of the following is TRUE about the auscultation of blood pressure?

A. Pulse + 4 is considered as FULL
B. The bell of the stethoscope is use in auscultating BP
C. Sound produced by BP is considered as HIGH frequency sound
D. Pulse +1 is considered as NORMAL

65. In assessing the abdomen, Which of the following is the correct sequence of the physical assessment?

A. Inspection, Auscultation, Percussion, Palpation
B. Palpation, Auscultation, Percussion, Inspection
C. Inspection, Palpation, Auscultation, Percussion
D. Inspection, Auscultation, Palpation, Percussion

66. The sequence in examining the quadrants of the abdomen is:

A. RUQ, RLQ, LUQ, LLQ
B. RLQ, RUQ, LLQ, LUQ
C. RUQ, RLQ, LLQ, LUQ
D. RLQ, RUQ, LUQ, LLQ

67. In inspecting the abdomen, which of the following is NOT DONE?

A. Ask the client to void first
B. Knees and legs are straighten to relax the abdomen
C. The best position in assessing the abdomen is Dorsal recumbent
D. The knees and legs are externally rotated

68. Dr. House is about to conduct an ophthalmoscope examination. Which of the following, if done by a nurse, is a correct preparation before the procedure?

A. Provide the necessary draping to ensure privacy
B. Open the windows, curtains and light to allow better illumination
C. Pour warm water over the ophthalmoscope to ensure comfort
D. Darken the room to provide better illumination

69. If the client is female, and the doctor is a male and the patient is about to undergo a vaginal and cervical examination, why is it necessary to have a female nurse in attendance?

A. To ensure that the doctor performs the procedure safely
B. To assist the doctor

C. To assess the client's response to examination
D. To ensure that the procedure is done in an ethical manner

70. In palpating the client's breast, which of the following position is necessary for the patient to assume before the start of the procedure?
A. Supine
B. Dorsal recumbent
C. Sitting
D. Lithotomy

71. When is the best time to collect urine specimen for routine urinalysis and C/S?
A. Early morning
B. Later afternoon
C. Midnight
D. Before breakfast

72. Which of the following is among an ideal way of collecting a urine specimen for culture and sensitivity?

A. Use a clean container
B. Discard the first flow of urine to ensure that the urine is not contaminated
C. Collect around 30-50 ml of urine
D. Add preservatives, refrigerate the specimen or add ice according to the agency's protocol

73. In a 24 hour urine specimen started Friday, 9:00 A.M, which of the following if done by a Nurse indicate a NEED for further procedural debriefing?

A. The nurse ask the client to urinate at 9:00 A.M, Friday and she included the urine in the 24 hour urine specimen
B. The nurse discards the Friday 9:00 A M urine of the client
C. The nurse included the Saturday 9:00 A.M urine of the client to the specimen collection
D. The nurse added preservatives as per protocol and refrigerates the specimen

74. This specimen is required to assess glucose levels and for the presence of albumin the the urine
A. Midstream clean catch urine
B. 24 hours urine collection
C. Postprandial urine collection
D. Second voided urine

75. When should the client test his blood sugar levels for greater accuracy?
A. During meals
B. In between meals
C. Before meals
D. 2 Hours after meals

76. In collecting a urine from a catheterized patient, Which of the following statement indicates an accurate performance of the procedure?

A. Clamp above the port for 30 to 60 minutes before drawing the urine from the port
B. Clamp below the port for 30 to 60 minutes before drawing the urine from the port
C. Clamp above the port for 5 to 10 minutes before drawing the urine from the port
D. Clamp below the port for 5 to 10 minutes before drawing the urine from the port

77. A community health nurse should be resourceful and meet the needs of the client. A villager ask him, "Can you test my urine for glucose?" Which of the following technique allows the nurse to test a client's urine for glucose without the need for intricate instruments.

A. Acetic Acid test
B. Nitrazine paper test
C. Benedict's test
D. Litmus paper test

78. A community health nurse is assessing client's urine using the Acetic Acid solution. Which of the following, if done by a nurse, indicates lack of correct knowledge with the procedure?

A. The nurse added the Urine as the 2/3 part of the solution
B. The nurse heats the test tube after adding 1/3 part acetic acid
C. The nurse heats the test tube after adding 2/3 part of Urine
D. The nurse determines abnormal result if she noticed that the test tube becomes cloudy

79. Which of the following is incorrect with regards to proper urine testing using Benedict's Solution?

A. Heat around 5ml of Benedict's solution together with the urine in a test tube
B. Add 8 to 10 drops of urine
C. Heat the Benedict's solution without the urine to check if the solution is contaminated
D. If the color remains BLUE, the result is POSITIVE

80. "+++ Positive" result after Benedicts test is depicted by what color?

A. Blue
B. Green
C. Yellow
D. Orange

81. Clinitest is used in testing the urine of a client for glucose. Which of the following, if committed by a nurse, indicates error?

A. Specimen is collected after meals
B. The nurse puts 1 clinitest tablet into a test tube
C. She added 5 drops of urine and 10 drops of water
D. If the color becomes orange or red, It is considered postitive

82. Which of the following nursing intervention is important for a client scheduled to have a Guaiac Test?

A. Avoid turnips, radish and horseradish 3 days before procedure
B. Continue iron preparation to prevent further loss of Iron
C. Do not eat read meat 12 hours before procedure
D. Encourage caffeine and dark colored foods to produce accurate results

83. In collecting a routine specimen for fecalysis, which of the following, if done by a nurse, indicates inadequate knowledge and skills about the procedure?

A. The nurse scoop the specimen specifically at the site with blood and mucus
B. She took around 1 inch of specimen or a teaspoonful
C. Ask the client to call her for the specimen after the client wiped off his anus with a tissue
D. Ask the client to defecate in a bedpan, Secure a sterile container

84. In a routine sputum analysis, which of the following indicates proper nursing action before sputum collection?

A. Secure a clean container
B. Discard the container if the outside becomes contaminated with the sputum
C. Rinse the client's mouth with Listerine after collection
D. Tell the client that 4 tablespoon of sputum is needed for each specimen for a routine sputum analysis

85. Who collects blood specimen?

A. The nurse
B. Medical technologist
C. Physician
D. Physical therapist

86. David, 68 year old male client is scheduled for Serum Lipid analysis. Which of the following health teaching is important to ensure accurate reading?
A. Tell the patient to eat fatty meals 3 days prior to the procedure
B. NPO for 12 hours pre procedure
C. Ask the client to drink 1 glass of water 1 hour prior to the procedure
D. Tell the client that the normal serum lipase level is 50 to 140 U/L

87. The primary factor responsible for body heat production is the
A. Metabolism
B. Release of thyroxin
C. Muscle activity
D. Stress

88. The heat regulating center is found in the
A. Medulla oblongata
B. Thalamus
C. Hypothalamus
D. Pons

89. A process of heat loss which involves the transfer of heat from one surface to another is

A. Radiation
B. Conduction
C. Convection
D. Evaporation

90. Which of the following is a primary factor that affects the BP?

A. Obesity
B. Age
C. Stress
D. Gender

91. The following are social data about the client except

A. Patient's lifestyle
B. Religious practices
C. Family home situation
D. Usual health status

92. The best position for any procedure that involves vaginal and cervical examination is

A. Dorsal recumbent
B. Side lying
C. Supine
D. Lithotomy

93. Measure the leg circumference of a client with bipedal edema is best done in what position?

A. Dorsal recumbent
B. Sitting
C. Standing
D. Supine

94. In palpating the client's abdomen, Which of the following is the best position for the client to assume?

A. Dorsal recumbent
B. Side lying
C. Supine
D. Lithotomy

95. Rectal examination is done with a client in what position?

A. Dorsal recumbent
B. Sims position
C. Supine
D. Lithotomy

96. Which of the following is a correct nursing action when collecting urine specimen from a client with an Indwelling catheter?

A. Collect urine specimen from the drainage bag
B. Detach catheter from the connecting tube and draw the specimen from the port
C. Use sterile syringe to aspirate urine specimen from the drainage port
D. Insert the syringe straight to the port to allow self sealing of the port

97. Which of the following is inappropriate in collecting mid stream clean catch urine specimen for urine analysis?

A. Collect early in the morning, First voided specimen
B. Do perineal care before specimen collection
C. Collect 5 to 10 ml for urine
D. Discard the first flow of the urine

98. When palpating the client's neck for lymphadenopathy, where should the nurse position himself?

A. At the client's back
B. At the client's right side
C. At the client's left side
D. In front of a sitting client

99. Which of the following is the best position for the client to assume if the back is to be examined by the nurse?

A. Standing
B. Sitting
C. Side lying
D. Prone

100. In assessing the client's chest, which position best show chest expansion as well as its movements?

A. Sitting
B. Prone
C. Sidelying
D. Supine

Answers

1. Answer: D. Hall

The term Nursing Process was first used by Lydia E. Hall where she introduced the 3 steps: observation, administration of care and validation.Florence Nightingale introduced the Environmental Theory. Dorothy Johnson is known for her Behavioral Systems Model while Martha Rogers introduced the Theory of Unitary Human Beings.

2. Answer: C. ADOPIE – 6

ADOPIE stands for: Assessment, Diagnosis, Outcome Identification, Planning, Intervention and Evaluation.

3. Answer: A. 1,2

Helen Yura and Mary B. Walsh are the first ones to suggest a four step nursing process.

4. Answer: C. Efficient

Other than being **efficient**, a nursing process should also be **effective** in planning care, and utilization of resources.

5. Answer: B. Humanistic

In the humanistic approach, a plan to care is developed and implemented by taking into consideration the unique needs of the individual client. It also states that no two person has the same health needs even if they have the same health condition or illness.

6. Answer: D. Effective

See rationale for #4.

7. Answer: B. 2,3

The data is subjective and primary since it was said by the client herself. Objective data are observable by the nurse.

8. Answer: A. Actual

An actual nursing diagnosis describes a clinical judgement that the nurse has validated because of the presence of major defining characteristics.

9. Answer: D. Risk

A risk nursing diagnosis describes a clinical judgement that an individual or group is more vulnerable to develop the problem than others in the same or a similar situation because of risk factors.

10. Answer: C. Possible

Possible nursing diagnosis is not a type of diagnosis as are actual, risk, and syndrome. These are the diagnostician option to indicate that some data are present to confirm a diagnosis but are insufficient at this time.

11. Answer: D. Risk

See rationale for #9.

12. Answer: B. High risk for injury R/T Absence of side rails

13. Answer: D. Client is cyanotic

Cyanosis (cyanotic) is the appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen saturation. Following the principles of Airway, Breathing, and Circulation, the first priority should be option D.

14. Answer: D. The client is thirsty and dehydrated

Based on Abraham Maslow's Hierarchy of Needs, physiological needs should be prioritized first. The other options are not physiological needs.

15. Answer: B. They are general and broadly stated

16. Answer: D. Reestablishes a normal pattern of elimination

17. Answer: D. Blue nails

18. Answer: B. Secondary

19. Answer: D. Intrapersonal

20. Answer: A. It is nursing centered

21. Answer: A. Functional health framework

22. Answer: C. Body system framework

23. Answer: B. The bulb used in Rectal temperature reading is pear shaped or round

24. Answer: A. Convection

25. Answer: A. The highest temperature usually occurs later in a day, around 8 P.M to 12 M.N

26. Answer: D. 105.8 degree Fahrenheit

27. Answer: D. At the high end of the normal range

28. Answer: C. Remittent

29. Answer: A. Relapsing

30. Answer: B. Intermittent

31. Answer: C. Biphasic

32. Answer: D. The goal has been met but not with the desired outcome criteria

33. Answer: D. Pale,cold skin

34. Answer: D. Sweating
35. Answer: A. Oral
36. Answer: D. Axillary
37. Answer: A. Quadriplegic
38. Answer: B. Neutropenic
39. Answer: B. .5 to 1.5 inches
40. Answer: B. From stem to bulb
41. Answer: C. 7 minutes
42. Answer: A. Young person have higher pulse than older persons
43. Answer: B. Use the thumb to palpate the artery
44. Answer: D. Pulse pressure
45. Answer: B. A greater-than-normal decrease in systolic blood pressure with inspiration
46. Answer: D. I:E 1:2
47. Answer: B. Pons
48. Answer: B. Pons
49. Answer: B. Pons
50. Answer: A. Medulla oblongata
51. Answer: B. If the BP is elevated, the RR decreases
52. Answer: C. Increase temperature of the environment, Increase RR
53. Answer: B. Diastole

54. Answer: B. BP = 160/120
55. Answer: A. Diastole
56. Answer: D. Epinephrine decreases BP
57. Answer: A. Females, after the age 65 tends to have lower BP than males
58. Answer: D. 30
59. Answer: C. False high reading
60. Answer: D. The left arm
61. Answer: A. Read the mercury at the upper meniscus, preferably at the eye level to prevent error of parallax
62. Answer: B. If the eye level is higher than the level of the meniscus, it will cause a false low reading
63. Answer: A. 1
64. Answer: B. The bell of the stethoscope is use in auscultating BP
65. Answer: A. Inspection, Auscultation, Percussion, Palpation
66. Answer: D. RLQ,RUQ,LUQ,LLQ
67. Answer: B. Knees and legs are straighten to relax the abdomen
68. Answer: D. Darken the room to provide better illumination
69. Answer: D. To ensure that the procedure is done in an ethical manner
70. Answer: A. Supine
71. Answer: A. Early morning
72. Answer: B. Discard the first flow of urine to ensure that the urine is not contaminated
73. Answer: A. The nurse ask the client to urinate at 9:00 A.M, Friday and she included the urine in the 24 hour urine specimen
74. Answer: D. Second voided urine
75. Answer: C. Before meals
76. Answer: B. Clamp below the port for 30 to 60 minutes before drawing the urine from the port
77. Answer: C. Benedict's test
78. Answer: B. The nurse heats the test tube after adding 1/3 part acetic acid
79. Answer: D. If the color remains BLUE, the result is POSITIVE
80. Answer: D. Orange
81. Answer: Specimen is collected after meals
82. Answer: A. Avoid turnips, radish and horseradish 3 days before procedure
83. Answer: C. Ask the client to call her for the specimen after the client wiped off his anus with a tissue
84. Answer: C. Rinse the client's mouth with Listerine after collection
85. Answer: B. Medical technologist
86. Answer: B. NPO for 12 hours pre procedure
87. Answer: A. Metabolism
88. Answer: C. Hypothalamus
89. Answer: B. Conduction
90. Answer: C. Stress
91. Answer: A. Patient's lifestyle

92. Answer: D. Lithotomy
93. Answer: A. Dorsal recumbent
94. Answer: A. Dorsal recumbent
95. Answer: B. Sims position
96. Answer: C. Use sterile syringe to aspirate urine specimen from the drainage port
97. Answer: C. Collect 5 to 10 ml for urine
98. Answer: A. At the client's back
99. Answer: A. Standing
100. Answer: A. Sitting

XXXi (30)

Topics or concepts included in this exam are:

- Nutrition
- Supplementation (Vitamins, Minerals)
- Oxygenation
- Respiratory System

1. Which one of the following is NOT a function of the Upper airway?

A. For clearance mechanism such as coughing
B. Transport gases to the lower airways
C. Warming, Filtration and Humidification of inspired air
D. Protect the lower airway from foreign mater

2. It is the hair that lines the vestibule which function as a filtering mechanism for foreign objects

A. Cilia
B. Nares
C. Carina
D. Vibrissae

3. This is the paranasal sinus found between the eyes and the nose that extends backward into the skull

A. Ehtmoid
B. Sphenoid
C. Maxillary
D. Frontal

4. Which paranasal sinus is found over the eyebrow?

A. Ehtmoid
B. Sphenoid
C. Maxillary
D. Frontal

5. Gene De Vonne Katrouchuacheulujiki wants to change her surname to something shorter, The court denied her request which depresses her and find herself binge eating. She accidentally aspirate a large piece of nut and it passes the carina. Probabilty wise, Where will the nut go?

A. Right main stem bronchus
B. Left main stem bronchus
C. Be dislodged in between the carina
D. Be blocked by the closed epiglottis

6. Which cell secretes mucus that help protect the lungs by trapping debris in the respiratory tract?

A. Type I pneumocytes
B. Type II pneumocytes
C. Goblet cells
D. Adipose cells

7. How many lobes are there in the RIGHT LUNG?

A. One
B. Two
C. Three
D. Four

8. The presence of the liver causes which anatomical difference of the Kidneys and the Lungs?

A. Left kidney slightly lower, Left lung slightly shorter
B. Left kidney slightly higher, Left lung slightly shorter
C. Right kidney lower, Right lung shorter
D. Right kidney higher, Right lung shorter

9. Surfactant is produced by what cells in the alveoli?

A. Type I pneumocytes
B. Type II pneumocytes
C. Goblet cells
D. Adipose cells

10. The normal L:S Ratio to consider the newborn baby viable is

A. 1:2
B. 2:1
C. 3:1
D. 1:3

11. Refers to the extra air that can be inhaled beyond the normal tidal volume

A. Inspiratory reserve volume
B. Expiratory reserve volume
C. Functional residual capacity
D. Residual volume

12. This is the amount of air remained in the lungs after a forceful expiration

A. Inspiratory reserve volume
B. Expiratory reserve volume
C. Functional residual capacity
D. Residual volume

13. Casssandra, A 22 year old grade Agnostic, Asked you, how many spikes of bones are there in my ribs? Your best response is which of the following?

A. We have 13 pairs of ribs Cassandra
B. We have 12 pairs of ribs Cassandra
C. Humans have 16 pairs of ribs, and that was noted by Vesalius in 1543
D. Humans have 8 pairs of ribs. 4 of which are floating

14. Which of the following is considered as the main muscle of respiration?

A. Lungs
B. Intercostal Muscles
C. Diaphragm
D. Pectoralis major

15. Cassandra asked you : How many air is there in the oxygen and how many does human requires? Which of the following is the best response :

A. God is good, Man requires 21% of oxygen and we have 21% available in our air
B. Man requires 16% of oxygen and we have 35% available in our air
C. Man requires 10% of oxygen and we have 50% available in our air
D. Human requires 21% of oxygen and we have 21% available in our air

16. Which of the following is TRUE about Expiration?

A. A passive process
B. The length of which is half of the length of Inspiration
C. Stridor is commonly heard during expiration
D. Requires energy to be carried out

17. Which of the following is TRUE in postural drainage?

A. Patient assumes position for 10 to 15 minutes
B. Should last only for 60 minutes
C. Done best P.C
D. An independent nursing action

18. All but one of the following is a purpose of steam inhalation

A. Mucolytic
B. Warm and humidify air
C. Administer medications
D. Promote bronchoconstriction

19. Which of the following is NOT TRUE in steam inhalation?

A. It is a dependent nursing action
B. Spout is put 12-18 inches away from the nose
C. Render steam inhalation for atleast 60 minutes
D. Cover the client’s eye with wash cloth to prevent irritation

20. When should a nurse suction a client?

A. As desired
B. As needed
C. Every 1 hour
D. Every 4 hours

21. Ernest Arnold Hamilton, a 60 year old American client was mobbed by teen gangsters near New york, Cubao. He was rushed to John John Hopio Medical Center and was Unconscious. You are his nurse and you are to suction his secretions. In which position should you place Mr. Hamilton?

A. High fowlers
B. Semi fowlers
C. Prone
D. Side lying

22. You are about to set the suction pressure to be used to Mr. Hamilton. You are using a Wall unit suction machine. How much pressure should you set the valve before suctioning Mr. Hamilton?

A. 50-95 mmHg
B. 200-350 mmHg
C. 100-120 mmHg
D. 10-15 mmHg

23. The wall unit is not functioning; You then try to use the portable suction equipment available. How much pressure of suction equipment is needed to prevent trauma to mucus membrane and air ways in case of portable suction units?

A. 2-5 mmHg
B. 5-10 mmHg
C. 10-15 mmHg
D. 15-25 mmHg

24. There are four catheter sizes available for use, which one of these should you use for Mr. Hamilton?

A. Fr. 18
B. Fr. 12
C. Fr. 10
D. Fr. 5

25. Which of the following, if done by the nurse, indicates incompetence during suctioning an unconscious client?

A. Measure the length of the suction catheter to be inserted by measuring from the tip of the nose, to the earlobe, to the xiphoid process
B. Use KY Jelly if suctioning nasopharyngeal secretion
C. The maximum time of suctioning should not exceed 15 seconds
D. Allow 30 seconds interval between suctioning

26. Which of the following is the initial sign of hypoxemia in an adult client?

1. Tachypnea
2. Tachycardia
3. Cyanosis
4. Pallor
5. Irritability
6. Flaring of Nares

A. 1,2
B. 2,5
C. 2,6
D. 3,4

27. Which method of oxygenation least likely produces anxiety and apprehension?

A. Nasal Cannula
B. Simple Face mask
C. Non Rebreather mask
D. Partial Rebreather mask

28. Which of the following oxygen delivery method can deliver 100% Oxygen at 15 LPM?

A. Nasal Cannula
B. Simple Face mask
C. Non Rebreather mask
D. Partial Rebreather mask

29. Which of the following is not true about OXYGEN?

A. Oxygen is odorless, tasteless and colorless gas.
B. Oxygen can irritate mucus membrane
C. Oxygen supports combustion
D. Excessive oxygen administration results in respiratory acidosis

30. Roberto San Andres, A new nurse in the hospital is about to administer oxygen on patient with Respiratory distress. As his senior nurse, you should intervene if Roberto will:

A. Uses venture mask in oxygen administration
B. Put a non rebreather mask in the patient before opening the oxygen source

C. Use a partial rebreather mask to deliver oxygen
D. Check for the doctor's order for Oxygen administration

31. Which of the following will alert the nurse as an early sign of hypoxia?

A. Client is tired and dyspneic
B. The client is coughing out blood
C. The client's heart rate is 50 BPM
D. Client is frequently turning from side to side

32. Miguelito de balboa, An OFW presents at the admission with an A:P Diameter ratio of 2:1, Which of the following associated finding should the nurse expect?

A. Pancytopenia
B. Anemia
C. Fingers are Club-like
D. Hematocrit of client is decreased

33. The best method of oxygen administration for client with COPD uses:

A. Cannula
B. Simple Face mask
C. Non rebreather mask
D. Venturi mask

34. Mang Dagul, a 50 year old chronic smoker was brought to the E.R because of difficulty in breathing. Pleural effusion was the diagnosis and CTT was ordered. What does C.T.T Stands for?

A. Chest tube thoracotomy
B. Chest tube thoracostomy
C. Closed tube thoracotomy
D. Closed tube thoracostmy

35. Where will the CTT be inserted if we are to drain fluids accumulated in Mang dagul's pleura?

A. 2nd ICS
B. 4th ICS
C. 5th ICS
D. 8th ICS

36. There is a continuous bubbling in the water sealed drainage system with suction. And oscillation is observed. As a nurse, what should you do?

A. Consider this as normal findings
B. Notify the physician
C. Check for tube leak
D. Prepare a petrolatum gauze dressing

37. Which of the following is true about nutrition?

A. It is the process in which food are broken down, for the body to use in growth and development
B. It is a process in which digested proteins, fats, minerals, vitamins and carbohydrates are transported into the circulation
C. It is a chemical process that occurs in the cell that allows for energy production, energy use, growth and tissue repair
D. It is the study of nutrients and the process in which they are use by the body

38. The majority of the digestion processes take place in the

A. Mouth
B. Small intestine
C. Large intestine
D. Stomach

39. All of the following is true about digestion that occurs in the Mouth except

A. It is where the digestion process starts
B. Mechanical digestion is brought about by mastication
C. The action of ptyalin or the salivary trypsin breaks down starches into maltose
D. Deglutition occurs after food is broken down into small pieces and well mixed with saliva

40. Which of the following foods lowers the cardiac sphincter pressure?

A. Roast beef, Steamed cauliflower and Rice
B. Orange juice, Non fat milk, Dry crackers
C. Decaffeinated coffee, Sky flakes crackers, Suman
D. Coffee with coffee mate, Bacon and Egg

41. Where does the digestion of carbohydrates start?

A. Mouth
B. Esophagus
C. Small intestine
D. Stomach

42. Protein digestion begins where?

A. Mouth
B. Esophagus
C. Small intestine
D. Stomach

43. All but one is true about digestion that occurs in the Stomach

A. Carbohydrates are the fastest to be digested, in about an hour
B. Fat is the slowest to be digested, in about 5 hours
C. HCl inhibits absorption of Calcium in the gastric mucosa
D. HCl converts pepsinogen to pepsin, which starts the complex process of protein digestion

44. Which of the following is NOT an enzyme secreted by the small intestine?

A. Sucrase
B. Enterokinase
C. Amylase
D. Enterokinase

45. The hormone secreted by the Small intestine that stimulates the production of pancreatic juice which primarily aids in buffering the acidic bolus passed by the Stomach

A. Enterogastrone
B. Ghrelin
C. Pancreozymin
D. Enterokinase

46. When the duodenal enzyme sucrase acts on SUCROSE, which 2 monosaccharides are formed?

A. Galactose + Galactose
B. Glucose + Fructose
C. Glucose + Galactose
D. Fructose + Fructose

47. This is the enzyme secreted by the pancrease that completes the protein digestion

A. Trypsin
B. Enterokinase
C. Enterogastrone
D. Amylase

48. The end product of protein digestion or the "Building blocks of Protein" is what we call

A. Nucleotides
B. Fatty acids
C. Glucose
D. Amino Acids

49. Enzyme secreted by the small intestine after it detects a bolus of fatty food. This will contract the gallbladder to secrete bile and relax the sphincter of Oddi to aid in the emulsification of fats and its digestion.

A. Lipase
B. Amylase
C. Cholecystokinin
D. Pancreozymin

50. Which of the following is not true about the Large Intestine?

A. It absorbs around 1 L of water making the feces around 75% water and 25% solid
B. The stool formed in the transverse colon is not yet well formed
C. It is a sterile body cavity
D. It is called large intestine because it is longer than the small intestine

51. This is the amount of heat required to raise the temperature of 1 kg water to 1 degree Celsius

A. Calorie
B. Joules
C. Metabolism
D. Basal metabolic rate

52. Assuming a cup of rice provides 50 grams of carbohydrates. How many calories are there in that cup of rice?

A. 150 calories
B. 200 calories
C. 250 calories
D. 400 calories

53. An average adult Filipino male requires how many calories in a day?

A. 1,000 calories
B. 1,500 calories
C. 2,000 calories
D. 2,500 calories

54. Which of the following is true about an individual's caloric needs?

A. All individual have the same caloric needs
B. Females in general have higher BMR and therefore, require more calories
C. During cold weather, people need more calories due to increase BMR
D. Dinner should be the heaviest meal of the day

55. Among the following people, who requires the greatest caloric intake?

A. An individual in a long state of gluconeogenesis
B. An individual in a long state of glycogenolysis
C. A pregnant individual
D. An adolescent with a BMI of 25

56. Which nutrient deficiency is associated with the development of Pellagra, Dermatitis and Diarrhea?

A. Vitamin B1
B. Vitamin B2
C. Vitamin B3
D. Vitamin B6

57. Which Vitamin is not given in conjunction with the intake of LEVODOPA in cases of Parkinson's Disease due to the fact that levodopa increases its level in the body?

A. Vitamin B1
B. Vitamin B2
C. Vitamin B3
D. Vitamin B6

58. A vitamin taken in conjunction with ISONIAZID to prevent peripheral neuritis

A. Vitamin B1
B. Vitamin B2
C. Vitamin B3
D. Vitamin B6

59. The inflammation of the Lips, Palate and Tongue is associated in the deficiency of this vitamin

A. Vitamin B1
B. Vitamin B2
C. Vitamin B3
D. Vitamin B6

60. Beri beri is caused by the deficiency of which Vitamin?

A. Vitamin B1
B. Vitamin B2
C. Vitamin B3
D. Vitamin C

61. Which of the following is the best source of Vitamin E?

A. Green leafy vegetables
B. Vegetable oil
C. Fortified Milk
D. Fish liver oil

62. Among the following foods, which food should you emphasize giving on an Alcoholic client?

A. Pork liver and organ meats, Pork
B. Red meat, Eggs and Dairy products
C. Green leafy vegetables, Yellow vegetables, Cantaloupe and Dairy products
D. Chicken, Peanuts, Bananas, Wheat germs and yeasts

63. Which food group should you emphasize giving on a pregnant mother in first trimester to prevent neural tube defects?

A. Broccoli, Guava, Citrus fruits, Tomatoes
B. Butter, Sardines, Tuna, Salmon, Egg yolk
C. Wheat germ, Vegetable Oil, soybeans, corn, peanuts
D. Organ meats, Green leafy vegetables, Liver, Eggs

64. A client taking Coumadin is to be educated on his diet. As a nurse, which of the following food should you instruct the client to avoid?

A. Spinach, Green leafy vegetables, Cabbage, Liver
B. Salmon, Sardines, Tuna
C. Butter, Egg yolk, breakfast cereals
D. Banana, Yeast, Wheat germ, Chicken

65. Vitamin E plus this mineral works as one of the best anti oxidant in the body according to the latest research. They are combined with 5 Alpha reductase inhibitor to reduce the risk of acquiring prostate cancer

A. Zinc
B. Iron
C. Selenium
D. Vanadium

66. Incident of prostate cancer is found to have been reduced on a population exposed in tolerable amount of sunlight. Which vitamin is associated with this phenomenon?

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

67. Micronutrients are those nutrients needed by the body in a very minute amount. Which of the following vitamin is considered as a MICRONUTRIENT

A. Phosphorous
B. Iron
C. Calcium
D. Sodium

68. Deficiency of this mineral results in tetany, osteomalacia, osteoporosis and rickets.

A. Vitamin D
B. Iron
C. Calcium
D. Sodium

69. Among the following foods, which has the highest amount of potassium per serving?

A. Cantaloupe
B. Avocado
C. Raisin
D. Banana

70. A client has HEMOSIDEROSIS. Which of the following drug would you expect to be given to the client?

A. Acetazolamide
B. Deferoxamine
C. Calcium EDTA
D. Activated charcoal

71. Which of the following provides the richest source of Iron per area of their meat?

A. Pork meat
B. Lean red meat
C. Pork liver
D. Green mongo

72. Which of the following is considered the best indicator of nutritional status of an individual?

A. Height
B. Weight
C. Arm muscle circumference
D. BMI

73. Jose Miguel, a 50 year old business man is 6'0 Tall and weights 179 lbs. As a nurse, you know that Jose Miguel is :

A. Overweight
B. Underweight
C. Normal
D. Obese

74. Jose Miguel is a little bit nauseous. Among the following beverages, Which could help relieve JM's nausea?

A. Coke
B. Sprite
C. Mirinda
D. Orange Juice or Lemon Juice

75. Which of the following is the first sign of dehydration?

A. Tachycardia
B. Restlessness
C. Thirst
D. Poor skin turgor

76. What Specific gravity lab result is compatible with a dehydrated client?

A. 1.007
B. 1.020
C. 1.039
D. 1.029

77. Which hematocrit value is expected in a dehydrated male client?

A. 67%
B. 50%
C. 36%
D. 45%

78. Which of the following statement by a client with prolonged vomiting indicates the initial onset of hypokalemia?

A. My arm feels so weak
B. I felt my heart beat just right now
C. My face muscle is twitching
D. Nurse, help! My legs are cramping

79. Which of the following is not an anti-emetic?

A. Marinol
B. Dramamine
C. Benadryl
D. Alevaire

80. Which is not a clear liquid diet?

A. Hard candy
B. Gelatin
C. Coffee with Coffee mate
D. Bouillon

81. Which of the following is included in a full liquid diet?

A. Popsicles
B. Pureed vegetable meat
C. Pineapple juice with pulps
D. Mashed potato

82. Which food is included in a BLAND DIET?

A. Steamed broccoli
B. Creamed potato
C. Spinach in garlic
D. Sweet potato

83. Which of the following if done by the nurse, is correct during NGT Insertion?

A. Use an oil based lubricant
B. Measure the amount of the tube to be inserted from the Tip of the nose, to the earlobe, to the xiphoid process
C. Soak the NGT in a basin of ice water to facilitate easy insertion
D. Check the placement of the tube by introducing 10 cc of sterile water and auscultating for bubbling sound

84. Which of the following is the BEST method in assessing for the correct placement of the NGT?

A. X-Ray
B. Immerse tip of the tube in water to check for bubbles produced
C. Aspirating gastric content to check if the content is acidic
D. Instilling air in the NGT and listening for a gurgling sound at the epigastric area

85. A terminally ill cancer patient is scheduled for an NGT feeding today. How should you position the patient?

A. Semi fowlers in bed
B. Bring the client into a chair
C. Slightly elevated right side lying position
D. Supine in bed

86. A client is scheduled for NGT Feeding. Checking the residual volume, you determined that he has 40 cc residual from the last feeding. You reinstill the 40 cc of residual volume and added the 250 cc of feeding ordered by the doctor. You then instill 60 cc of water to clear the lumen and the tube. How much will you put in the client's chart as input?

A. 250 cc
B. 290 cc
C. 350 cc
D. 310 cc

87. Which of the following if done by a nurse indicates deviation from the standards of NGT feeding?

A. Do not give the feeding and notify the doctor of residual of the last feeding is greater than or equal to 50 ml
B. Height of the feeding should be 12 inches about the tube point of insertion to allow slow introduction of feeding
C. Ask the client to position in supine position immediately after feeding to prevent dumping syndrome
D. Clamp the NGT before all of the water is instilled to prevent air entry in the stomach

88. What is the most common problem in TUBE FEEDING?

A. Diarrhea
B. Infection
C. Hyperglycemia
D. Vomiting

89. Which of the following is TRUE in colostomy feeding?

A. Hold the syringe 18 inches above the stoma and administer the feeding slowly
B. Pour 30 ml of water before and after feeding administration

C. Insert the ostomy feeding tube 1 inch towards the stoma
D. A Pink stoma means that circulation towards the stoma is all well

90. A client with TPN suddenly develops tremors, dizziness, weakness and diaphoresis. The client said "I feel weak" You saw that his TPN is already empty and another TPN is scheduled to replace the previous one but its provision is already 3 hours late. Which of the following is the probable complication being experienced by the client?

A. Hyperglycemia
B. Hypoglycemia
C. Infection
D. Fluid overload

91. To assess the adequacy of food intake, which of the following assessment parameters is best used?

A. Food likes and dislikes
B. Regularity of meal times
C. 3 day diet recall
D. Eating style and habits

92. The vomiting center is found in the

A. Medulla Oblongata
B. Pons
C. Hypothalamus
D. Cerebellum

93. The most threatening complication of vomiting in client's with stroke is

A. Aspiration
B. Dehydration
C. Fluid and electrolyte imbalance
D. Malnutrition

94. Which among this food is the richest source of Iron?

A. Ampalaya
B. Broccoli
C. Mongo
D. Malunggay leaves

95. Which of the following is a good source of Vitamin A?

A. Egg yolk
B. Liver
C. Fish
D. Peanuts

96. The most important nursing action before gastrostomy feeding is

A. Check V/S
B. Assess for patency of the tube

C. Measure residual feeding
D. Check the placement of the tube

97. The primary advantage of gastrostomy feeding is

A. Ensures adequate nutrition
B. It prevents aspiration
C. Maintains Gastro esophageal sphincter integrity
D. Minimizes fluid-electrolyte imbalance

98. What is the BMI Of Budek, weighing 120 lbs and has a height of 5 feet 7 inches.

A. 20
B. 19
C. 15
D. 25

99. Which finding is consistent with PERNICIOUS ANEMIA?

A. Strawberry tongue
B. Currant Jelly stool
C. Beefy red tongue
D. Pale [HYPOCHROMIC] RBC

100. The nurse is browsing the chart of the patient and notes a normal serum lipase level. Which of the following is a normal serum lipase value?

A. 10 U/L
B. 100 U/L
C. 200 U/L
D. 350 U/L

Answers and Rationale

1. Answer: A. For clearance mechanism such as coughing

The the function of the cough reflex is to dislodge foreign substances from the trachea. The upper respiratory tract refers to the external nose, nasal cavity, pharynx and associated structures while the lower respiratory tract includes the larynx, trachea, bronchi, and lungs. However, there are alternative definitions just like the larynx being placed on the upper respiratory tract.

2. Answer: D. Vibrissae

Vibrissae are the thick hairs which grow inside the nostrils to help keep large particles from entering the nasal passages. Cilia are hair-like projection lining the bronchus that move microbes and debris up and out of the airways.

3. Answer: A. Ehtmoid

The ethmoidal sinuses are formed from several discrete air cells within the ethmoid bone between the nose and the eyes. The maxillary sinuses, also called the maxillary antrechea and the largest of the paranasal sinuses, are under the eyes, in the maxillary

bones. The frontal sinuses, superior to the eyes, are in the frontal bone, which forms the hard part of the forehead. The sphenoidal sinuses are in the sphenoid bone.

4. Answer: D. Frontal

The frontal sinuses are found superior to the eyes and eyebrows in the frontal bone, which forms the hard part of the forehead.

5. Answer: A. Right main stem bronchus

Foreign objects that enter the trachea usually lodge in the right main bronchus, because it is more vertical than the left main bronchus and therefore for in direct line with the trachea.

6. Answer: C. Goblet cells

Goblet cells are found scattered among the epithelial lining of organs, such as the intestinal and respiratory tracts. They are found inside the trachea, bronchus, and larger bronchioles in respiratory tract. The main role of goblet cells is to secrete mucus in order to protect the mucosae where they are found.

7. Answer: C. Three

The right lung has three lobes called the superior, middle and inferior lobes. the left lung, on the other hand, has only two lobes namely the superior and inferior lobes.

8. Answer: C. Right kidney lower, Right lung shorter

The kidneys are paired retroperitoneal structures that are normally located between the transverse processes of T12-L3 vertebrae, with the left kidney typically somewhat more superior in position than the right. The right lung, meanwhile, has a higher volume, total capacity and weight, than that of the left lung. Although it is 5 cm shorter due to the diaphragm rising higher on the right side to accommodate the liver, it is broader than the left lung due to the cardiac notch of the left lung.

9. Answer: B. Type II pneumocytes

Pulmonary surfactant is a surface-active lipoprotein complex (phospho lipoprotein) formed by type II alveolar cells.

10. Answer: B. 2:1

An L–S ratio of 2 or more indicates fetal lung maturity and a relatively low risk of infant respiratory distress syndrome, and an L/S ratio of less than 1.5 is associated with a high risk of infant respiratory distress syndrome.

11. Answer: A. Inspiratory reserve volume

Inspiratory reserve volume is the maximal amount of additional air that can be drawn into the lungs by determined effort after normal inspiration. Average inspiratory reserve volumes in healthy adults are 3.0 L in men and 1.9 L in women.

12. Answer: D. Residual volume

Residual volume is the volume of air remaining in the lungs after a maximal exhalation. Average residual volumes in healthy adults are 1.2 L in men and 1.1 L in women.

13. Answer: B. We have 12 pairs of ribs Cassandra

Humans have 24 ribs (12 pairs). The first seven sets of ribs, known as “true ribs” (costae verae), are directly attached to the sternum through the costal cartilage. The following five sets are known as “false ribs” (costae spuriae), three of these sharing a common cartilaginous connection to the sternum, while the last two (eleventh and twelfth ribs) are termed floating ribs (costae fluctuantes) or vertebral ribs.

14. Answer: C. Diaphragm

The main muscle of breathing is the diaphragm, therefore it gets its own page. The muscles of inspiration elevate the ribs and sternum, and the muscles of expiration depress them. The primary inspiratory muscles are the external intercostals and the diaphragm.

15. Answer: D. Human requires 21% of oxygen and we have 21% available in our air

Air is a mixture of 21% oxygen, 78% nitrogen, and approximately 1% other trace gases, primarily argon; to simplify calculations this last 1% is usually treated as if it were nitrogen. The gas is essential for living, but only up to a point. Humans can only breathe 21 percent oxygen.

16. Answer: A. A passive process

Expiration is a passive process. That means that we don’t have to expend any energy to exhale. When our diaphragm has stopped contracting for inspiration, it can now begin to relax.

17. Answer: A. Patient assumes position for 10 to 15 minutes

Postural drainage is the positioning techniques that drain secretions from specific segments of the lugs and bronchi into the trachea. The client is instructed to remain in each position for 10 to 15 minutes. During this time, perform percussion and vibration, as ordered.

18. Answer: D. Promote bronchoconstriction

Steam inhalation is a method of introducing warm, moist air into the lungs via the nose and throat for therapeutic benefit. Essential oils are often added to provide additional relief. Inhaling steam is a great treatment for respiratory complications and is recommended for dealing with common cold, flu, bronchitis, sinusitis, asthma, and allergies. Dry air passages are moistened, and mucus is loosened/eliminated easier by coughing or blowing the nose. The moist air also alleviates difficulty breathing, throat irritation and inflammation.

19. Answer: C. Render steam inhalation for atleast 60 minutes

A common method of inhaling steam is to boil a few cups of filtered water and then pour the steaming water into a large bowl. Essential oils can be added at this point if desired. Next, a towel can be placed over the head, while leaning over the bowl of water, breathing deeply through the nose for approximately 15 minutes. Humidifiers also provide a gentle form of steam inhalation.

20. Answer: B. As needed

A nurse should suction a patient as needed and indicated to maintain patency and integrity of airway.

21. Answer: D. Side lying

Position the unconscious client in a side-lying position facing you. A side-lying position facilitates drainage of secretions by gravity and prevents aspiration.

22. Answer: C. 100-120 mmHg

Turn on suction device and adjust pressure: infants and children, 50 to 75 mm Hg; adults, 100 to 120 mm Hg. Excessive negative pressure traumatizes mucosa and can induce hypoxia.

23. Answer: C. 10-15 mmHg

The pressure for a portable suction equipment depends on the age of the patient. For adults (10-15 mmHg), for children (5-10 mmHg) and for infants (2-5 mmHg).

24. Answer: A. Fr. 18

Appropriate-sized catheter: infants, 5 to 8 Fr; children, 8 to 10 Fr; adults, 12 to 18 Fr.

25. Answer: A. Measure the length of the suction catheter to be inserted by measuring from the tip of the nose, to the earlobe, to the xiphoid process

Determine the depth the suction device will be inserted, by measuring the device against the distance from the corner of the patient's mouth to the tip of the earlobe on the same side.

26. Answer: B. 2,5

Restlessness, irritability and tachycardia are early signs of hypoxia. Chronic hypoxemia may result in cognitive changes, such as memory changes.

27. Answer: A. Nasal Cannula

Among the methods of oxygenation, nasal cannulas least likely produce anxiety and apprehension. However, patients with nasal cannulas sometimes complain of nasal dryness, particularly when receiving oxygen at high levels. New devices can help with this by adding moisture and warmth to the delivery process.

28. Answer: C. Non Rebreather mask

A non rebreather mask has a reservoir bag that is inflated with pure oxygen. Between the mask and the bag is another one-way valve that allows the patient to breathe in the oxygen supplied by the source as well as oxygen from the reservoir. This provides the patient with an oxygen concentration of nearly 100%. A piece of tubing, usually connected to extension tubing, connects the mask to the oxygen source.

29. Answer: D. Excessive oxygen administration results in respiratory acidosis

Oxygen, in its natural state, is a colorless, odorless, and tasteless gas. Oxygen is considered to be the most important of all the elements to life. Oxygen does not burn, but it does support combustion. Oxygen may also dry out the nasal mucosa and can irritate the nares.

30. Answer: B. Put a non rebreather mask in the patient before opening the oxygen source

In using a non rebreather mask, nurses should connect oxygen flow meter to an oxygen source first and preset the oxygen flow to 15 liters per minute and check the system before placing the mask over patient's face covering the nose and mouth.

31. Answer: D. Client is frequently turning from side to side

Restlessness, irritability and tachycardia are early signs of hypoxia.

32. Answer: C. Fingers are Club-like

The normal AP to Lateral diameter in normal adult is 1:2. Signs of possible chronic pulmonary disease include clubbing, barrel chest (the increased anterior-posterior diameter of the chest present in some patients with emphysema), and pursed lip breathing. Clubbing is enlargement of the fingertips (or toes) due to proliferation of connective tissue between the fingernail and the bone.

33. Answer: A. Cannula

The nasal cannula is used when a low-flow oxygen is indicated. The room air mixes with the oxygen from the tank. It can deliver 24-40 percent of oxygen at 2-6 liters per minute. The cannula is used for patients with COPD, asthma, emphysema, and uncomplicated heart attack.

34. Answer: B. Chest tube thoracostomy

CTT stands for Chest tube thoracostomy. It is done to drain fluid, blood, or air from the space around the lungs. Some diseases, such as pneumonia and cancer, can cause an excess amount of fluid or blood to build up in the space around the lungs (called a pleural effusion).

35. Answer: D. 8th ICS

Chest tubes are indicated when the normally airtight pleural space has been penetrated through surgery or trauma, when a defect in the alveoli allows air to enter the intrapleural space, and when there is an accumulation of fluid, as from pleural effusion. In some cases one tube is inserted higher in the thorax (usually in the 2nd intercostal

space) to remove air, and a second tube is placed lower (in the 8th or 9th intercostal space) to drain off fluids.

36. Answer: C. Check for tube leak

Intermittent bubbling in water seal chamber with forced expiration or cough is okay. Continuous bubbling in the water seal is abnormal and indicates an air leak. IF the nurse notes that there is CONTINUOUS bubbling in the water seal chamber, check for leaks in the system. With physician's order, RN places padded clamp closest to dressing. If leak stops, air leak is at insertion site. If bubbling continues, leak is between clamp and drainage system.

37. Answer: D. It is the study of nutrients and the process in which they are use by the body

The science or study that deals with food and nourishment, especially in humans. It is the process of nourishing or being nourished, especially the process by which a living organism assimilates food and uses it for growth and for replacement of tissues.

38. Answer: B. Small intestine

Chemical processes that contribute to digestion begin in the mouth with action of saliva on food. However, most of the chemical digestive processes occur in the stomach and small intestine – where the partly-digested materials are subjected to gastric juices, pancreatic juice, succus entericus and so on. To be slightly more detailed, most digestion takes place in the duodenum section of the small intestine.

39. Answer: C. The action of ptyalin or the salivary trypsin breaks down starches into maltose

Salivary amylase (ptyalin) starts the breakdown of high-molecular-weight carbohydrates while trypsin breaks down proteins.

40. Answer: D. Coffee with coffee mate, Bacon and Egg

Certain foods and drinks loosen the lower esophageal sphincter. These include chocolate, peppermint, caffeine-containing beverages (such as coffee, tea, and soft drinks), fatty foods, and alcohol.

41. Answer: A. Mouth

Chemical processes that contribute to digestion begin in the mouth with action of saliva on food.

42. Answer: D. Stomach

Protein digestion occurs in the stomach and duodenum in which 3 main enzymes, pepsin secreted by the stomach and trypsin and chymotrypsin secreted by the pancreas, break down food proteins into polypeptides that are then broken down by various exopeptidases and dipeptidases into amino acids.

43. Answer: C. HCl inhibits absorption of Calcium in the gastric mucosa

Hydrochloric acid, or HCL, is secreted in the stomach during digestion to begin breakdown of dietary fats. HCL is needed for absorption of calcium in the duodenum, which is the first part of small intestine. The duodenum is where calcium is actively absorbed from food into the body through the intestinal wall into the bloodstream.

44. Answer: C. Amylase

Amylase is an enzyme that helps digest carbohydrates. It is produced in the pancreas and the glands that make saliva.

45. Answer: C. Pancreozymin

Pancreozymin is a hormone of the duodenal mucosa that stimulates the external secretory activity of the pancreas, especially its production of amylase; identical with cholecystokinin.

46. Answer: B. Glucose + Fructose

Sucrose is a disaccharide combination of the monosaccharides glucose and fructose with the formula C12H22O11.

47. Answer: A. Trypsin

In the duodenum, trypsin catalyzes the hydrolysis of peptide bonds, breaking down proteins into smaller peptides. The peptide products are then further hydrolyzed into amino acids via other proteases, rendering them available for absorption into the blood stream. Tryptic digestion is a necessary step in protein absorption as proteins are generally too large to be absorbed through the lining of the small intestine.

48. Answer: D. Amino Acids

Twenty percent of the human body is made up of protein. Protein plays a crucial role in almost all biological processes and amino acids are the building blocks of it.

49. Answer: C. Cholecystokinin

CCK mediates a number of physiological processes, including digestion and satiety. It is released by I cells located in the mucosal epithelium of the small intestine (mostly in the duodenum and jejunum). CCK also causes the increased production of hepatic bile, and stimulates the contraction of the gall bladder and the relaxation of the Sphincter of Oddi (Glisson's sphincter), resulting in the delivery of bile into the duodenal part of the small intestine. Bile salts form amphipathic micelles that emulsify fats, aiding in their digestion and absorption.

50. Answer: C. It is a sterile body cavity

The large intestine is the end section of the intestine. It is about 5 ft (1.5 m) long, is wider than the small intestine, and has a smooth inner wall. In the first half, enzymes from the small intestine complete digestion, and bacteria produce many B vitamins and vitamin K. Over 24–30 hours, churning movements break down tough cellulose fibres and expose chyme to the colon's walls, which absorb water and electrolytes; absorption is its main function, along with storing fecal matter for expulsion.

51. Answer: A. Calorie

Calorie, a unit of energy or heat variously defined. The calorie was originally defined as the amount of heat required at a pressure of 1 standard atmosphere to raise the temperature of 1 gram of water 1° Celsius.

52. Answer: B. 200 calories

Determine if your food is a carbohydrate, protein, or fat. The conversion multiple is different for each type of food. 1 gram of carbohydrate is equal to 4 calories. Therefore, a cup of rice having 50 grams of carbohydrates contains 200 calories.

53. Answer: C. 2,000 calories

The Department of Health consultant on non-communicable diseases, noted that the recommended calorie intake for women is 1,500 and 2,000 for men daily. It is advisable that Filipinos should aim for 500 calories a meal only.

54. Answer: C. During cold weather, people need more calories due to increase BMR

Temperature affects how many calories we burn. According to the American Dietetic Association Complete Food and Nutrition Guide, both the heat and cold raise the BMR. If we are too cold we shiver. Shivering burns up much energy from the constant contraction and relaxation of muscle cells trying to produce heat to maintain body temperature. When we are hot we also burn more energy through the process of sweating.

55. Answer: A. An individual in a long state of gluconeogenesis

The human body requires glucose for the brain and nervous system, and a diet that has very few or no dietary carbohydrates forces it to generate this glucose from protein through gluconeogenesis, with an efficiency of approximately 57% (protein and carbohydrate are approximately equal in calorific value; each has about four kilocalories per gram, but gluconeogenesis can produce only 57g of glucose from 100g of protein). This could be a significant contributor to metabolic advantage.

56. Answer: C. Vitamin B3

Also known as vitamin B3 or nicotinic acid, Niacin deficiency is a condition that occurs when a person doesn't get enough or can't absorb niacin or tryptophan. Severe deficiency, called pellagra, can cause symptoms related to the skin, digestive system, and nervous system.

57. Answer: D. Vitamin B6

Vitamin B6 reduces the effectiveness of levodopa, a medication used to treat Parkinson's disease. However, your doctor may be able to determine a dose of B6 that can help reduce side effects of levodopa without interfering with the drug's action. Taking vitamin B6 along with levodopa should be done only under the strict guidance of a physician.

58. Answer: D. Vitamin B6

Vitamin B6 (pyridoxine) supplementation during isoniazid (INH) therapy is necessary in some patients to prevent the development of peripheral neuropathy. In vivo pyridoxine is converted into coenzymes which play an essential role in the metabolism of protein, carbohydrates, fatty acids, and several other substances, including brain amines, INH apparently competitively inhibits the action of pyridoxine in these metabolic functions. The reported frequency of INH-induced neuropathy in various studies is reviewed and population groups at relatively high risk of developing this complication are identified. The routine use of pyridoxine supplementation to prevent peripheral neuropathy in high risk populations is recommended.

59. Answer: B. Vitamin B2

Riboflavin deficiency is also called ariboflavinosis. In humans the classical syndrome affects the mouth (sore throat, inflammation of the lining of mouth and tongue), angular cheilitis), the eyes (photophobia with bloodshot, itchy, watery eyes), the skin (moist, scaly skin particularly affecting the scrotum or labia majora and the nasolabial folds) and the blood (decreased red blood cell count with normal cell size and hemoglobin content i.e. normochromic normocytic anemia). In children it also results in reduced growth.

60. Answer: A. Vitamin B1

Beriberi is a disease brought on by a Vitamin B-1 (thiamine) deficiency. There are two types of the disease: wet beriberi and dry beriberi. Wet beriberi can effect heart function and, in the most extreme cases, heart failure. Dry beriberi damages the nerves and can lead to a loss of muscle strength and, eventually, muscle paralysis. If left unchecked and untreated, beriberi will cause death.

61. Answer: B. Vegetable oil

Because vitamin E is naturally present in plant-based diets and animal products and is often added by manufacturers to vegetable oils and processed foods, intakes are probably adequate to avoid overt deficiency in most situations.

62. Answer: A. Pork liver and organ meats, Pork

It is important for alcoholics to avoid refined sugars and caffeine, as they stress blood sugar control mechanisms and may increase the craving for alcohol. In one study, excluding caffeine, junk food, dairy products, and peanut butter was compared to a control diet for six months. Excellent food sources of thiamine include asparagus, mushrooms, peanuts, pork, soybeans, sunflower seeds, and yeast.

63. Answer: D. Organ meats, Green leafy vegetables, Liver, Eggs

Foods rich in folic acid such as leafy green vegetable, yeast, wheat germ, nuts, eggs, bananas, oranges, and organ meats taken during the first trimester of pregnancy can help prevent spina bifida.

64. Answer: A. Spinach, Green leafy vegetables, Cabbage, Liver

Certain foods and beverages can make it so warfarin doesn't effectively prevent blood clots. In order to maintain stable PT/INR levels one should not eat more than 1 serving of a high vitamin K food, and no more than 3 servings of a food with moderate amounts of vitamin K. What is important is that your intake of vitamin K stays consistent. The nurse must instruct the client to avoid eating or drinking large amounts of Kale, Spinach, Brussels sprouts, Parsley, Collard greens, Mustard greens, Chard, and Green tea.

65. Answer: C. Selenium

Lycopene (as beta-carotene) and selenium supplementation have been associated with a reduced risk of prostate cancer in nested case-control studies, but only in subgroups of men with low baseline plasma lycopene (or beta-carotene) and selenium levels respectively. The Prostate Cancer Prevention Trial prospectively evaluated finasteride, a 5-alpha-reductase inhibitor, as chemoprevention.

66. Answer: D. Vitamin D

Vitamin D is made naturally by the body when exposed to sunlight. A study in patients with prostate cancer suggested that medium or high levels of vitamin D in the blood may be linked with better outcomes than lower levels. These findings indicate that vitamin D levels may play a role in whether or not the disease will worsen and may be a factor in predicting outcome in prostate cancer patients.

67. Answer: B. Iron

Micronutrients are nutrients for humans required in small quantities throughout life. The microminerals or trace elements include at least iron, cobalt, chromium, copper, iodine, manganese, selenium, zinc and molybdenum. Micronutrients also include vitamins, which are organic compounds required as nutrients in tiny amounts by an organism.

68. Answer: C. Calcium

Calcium and phosphorus are needed to keep bones healthy and strong. A mild lack it may not cause symptoms but can cause tiredness and general aches and pains. A more severe lack can cause serious problems such as rickets (in children) and osteomalacia (in adults). Vitamin D is also important because it increases the rate at which calcium is absorbed into your blood.

69. Answer: B. Avocado

Cantaloupe: 267 mg Potassium, Avocado: 485 mg Potassium, Banana: 358 mg Potassium

70. Answer: B. Deferoxamine

Combined therapy with deferoxamine and hemofiltration offers promises as an effective means of iron mobilization in dialysis patients with hemosiderosis.

71. Answer: C. Pork liver

Pork liver has 23 mg of iron in every 100 g while lean red meat only has 3.7 mg of iron in every 100 g.

72. Answer: D. BMI

Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.

73. Answer: C. Normal

$$BMI = \frac{mass\,(kg)}{height^2(m)} = \frac{mass\,(lb)}{height^2(in)} \times 703$$

$$BMI = \frac{81.36\,(kg)}{1.83^2(m)}$$

$$BMI = 24.29 = normal$$

74. Answer: A. Coke

One of the ingredients in coke is sodium bicarbonate, or baking soda. This is an alkaline substance, and therefore can help balance the pH level in the stomach. So, if the cause of the nausea has to do with too much acid in the stomach, or acid rising from the stomach into the esophagus, coke can have a relieving effect on the condition. Doctors recommend letting the soda go flat before drinking, or adding a pinch of salt over the top.

75. Answer: C. Thirst

Dehydration can be mild, moderate or severe, depending on how much of your body weight is lost through fluids. Two early signs of dehydration are thirst and dark colored urine. This is the body's way of trying to increase water intake and decrease water loss.

76. Answer: C. 1.039

Adults generally have a specific gravity in the range of 1.000 to 1.030. Increases in specific gravity (hypersthenuria, i.e. increased concentration of solutes in the urine) may be associated with dehydration, diarrhea, emesis, excessive sweating, urinary tract/bladder infection, glucosuria, renal artery stenosis, hepatorenal syndrome, decreased blood flow to the kidney (especially as a result of heart failure), and excess of anti-diuretic hormone caused by Syndrome of inappropriate anti-diuretic hormone. A specific gravity greater than 1.035 is consistent with frank dehydration.

77. Answer: A. 67%

Higher than normal hematocrit levels represent abnormally elevated red blood cell counts. High hematocrits can be seen in people living at high altitudes and in chronic smokers. Dehydration produces a falsely high hematocrit that disappears when proper fluid balance is restored. Some other infrequent causes of an elevated hematocrit are lung disease, certain tumors, a disorder of the bone marrow known as polycythemia rubra Vera, and abuse of the drug erythropoietin (Epogen) by athletes for "blood doping" purposes.

78. Answer: D. Nurse, help! My legs are cramping

The effects of low potassium include may cause the following symptoms: weakness, tiredness, or cramping in arm or leg muscles, sometimes severe enough to cause inability to move arms or legs due to weakness (much like a paralysis).

79. Answer: D. Alevaire

Alevaire is a Mucolytic Agent.

80. Answer: C. Coffee with Coffee mate

A clear liquid diet consists of clear liquids — such as water, broth and plain gelatin — that are easily digested and leave no undigested residue in your intestinal tract. A tea or coffee without milk or cream is considered a clear liquid diet.

81. Answer: A. Popsicles

A clear liquid diet is made up of only clear fluids and foods that turn to clear fluids when they are at room temperature. It includes things like clear broth, tea, cranberry juice, Jell-O, and Popsicles.

82. Answer: B. Creamed potato

The bland diet omits all foods that are bowel stimulants and are irritating to the gastrointestinal tract. Potatoes allowed include potato, mashed, creamed, baked, or broiled without skins, sweet potato or yams. Rice. Spaghetti, noodles or macaroni are also allowed. Avoid potato chips and potato skins.

83. Answer: B. Measure the amount of the tube to be inserted from the Tip of the nose, to the earlobe, to the xiphoid process

To measure the length of the tube to be inserted, stand to the patient's right, if you are right handed, and measure from the tip of the nose to the earlobe and to the xiphoid process. Experience has shown that in tall people, it may be necessary to add 2 inches to the length of the tube to ensure entrance into the stomach. If you are measure the tube for an infant, extend it from the tip of the nose to the earlobe and then from the nose to a point half-way between the xiphoid process and the umbilicus, because the body proportions are different in infants and adults. Mark the tube with a piece of tape.

84. Answer: A. X-Ray

The gold standard for nasoenteric feeding tube placement is radiographic confirmation with chest and abdominal x-rays.

85. Answer: B. Bring the client into a chair

This minimizes the possibility of aspiration (inhaling food into the lungs) and its inherent complication (pneumonia). If choking or difficulty of breathing occurs during a feeding, stop the feeding and call the doctor immediately.

86. Answer: D. 310 cc

250 cc of feeding ordered by the doctor plus the 60 cc of water to clear the lumen and the tube is 310 cc.

87. Answer: C. Ask the client to position in supine position immediately after feeding to prevent dumping syndrome

It is important to sit up or prop your patient's head up while receiving feeding and remain in that position for 30-60 minutes. This minimizes the possibility of aspiration (inhaling food into the lungs) and its inherent complication (pneumonia).

88. Answer: A. Diarrhea

The most common reported complication of tube feeding is diarrhea, defined as stool weight > 200 mL per 24 hours.

89. Answer: B. Pour 30 ml of water before and after feeding administration

The tube should be flushed with water before and after feeds.

90. Answer: B. Hypoglycemia

Hypoglycemia upon abrupt discontinuation of TPN is a complication that may result from endogenous insulin levels not adjusting to the sudden reduction in dextrose.

91. Answer: C. 3 day diet recall

A 3 day diet recall provides more representative intake information.

92. Answer: A. Medulla Oblongata

The medulla oblongata is the lower half of the brainstem, which is continuous with the spinal cord; the upper half being the pons. It is often referred to simply as the medulla. The medulla contains the cardiac, respiratory, vomiting and vasomotor centers and therefore deals with the autonomic (involuntary) functions of breathing, heart rate and blood pressure.

93. Answer: A. Aspiration

Impaired consciousness with drug or alcohol abuse, general anaesthesia, seizures, sedation, acute stroke, central nervous system lesions or head injury are considered risk factors for aspiration. Others include swallowing disorders such as esophageal stricture, dysphagia, stroke, bulbar palsy, pharyngeal disease (eg, malignancy), neuromuscular disorders (eg, multiple sclerosis).

94. Answer: C. Mongo

Bean sprouts have the richest source of amino acids (for protein), vitamins and minerals, and also contain a good amount of fiber. They contain all types of vitamins (A, B, C, D, E and K), folate and are an excellent source of iron, potassium, calcium, phosphorous, magnesium and zinc.

95. Answer: B. Liver

Liver is a particularly rich source of vitamin A, although this means you may be at risk of having too much vitamin A if you eat liver more than once a week.

96. Answer: B. Assess for patency of the tube

A gastrostomy tube allows the delivery of supplemental nutrition and medications directly into the stomach. Maintaining its patency is the most important nursing action to be considered before gastrostomy feeding in order for it to be successful.

97. Answer: C. Maintains Gastro esophageal sphincter integrity

One of the advantages of gastrostomy feeding is that it maintains the integrity of the gastroesophageal sphincter.

98. Answer: B. 19

$$BMI = \frac{mass\,(kg)}{height^2(m)} = \frac{mass\,(lb)}{height^2(in)} \times 703$$

$$BMI = \frac{54.56\,(kg)}{1.70^2(m)}$$

$$BMI = 18.88\,or\,19$$

99. Answer: C. Beefy red tongue

Pernicious anemia is a type of anemia caused by a lack of vitamin B12. Not having enough vitamin B12, or being unable to absorb it, can lead to symptoms such as nerve damage, confusion, dementia, memory loss, depression, nausea, heartburn, weight loss, and a smooth, beefy red tongue.

100. Answer: C. 200 U/L