1 . The client began wearing hearing aids 5 weeks earlier. Which statement to the nurse demonstrates that the client is successfully adapting to the hearing aids?

A. “I need to wear the hearing aids only when I go out in public.”
B. “I clean my ears with a cotton-tipped swab before I insert them.”
C. “I place the hearing aids in the protective box to store them at night.”
D. “I soak the plastic parts of the hearing aids in mild soap and water weekly.”

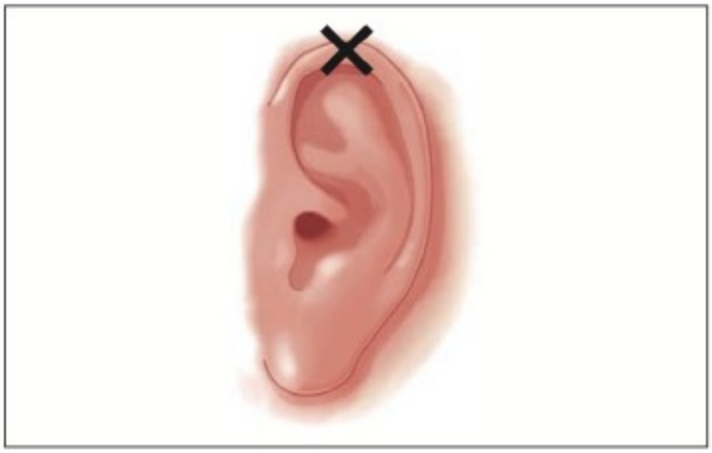
ANSWER: C

A. Hearing aids should be worn daily to adjust to their use. Noisy public situations are sometimes difficult for persons with hearing aids.
B. Cotton-tipped swabs should not be inserted into the ear canal due to possible injury and infection.
C. Hearing aids are expensive and delicate, and they should be stored in a protective container in a dry, safe place.
D. Hearing aids should be kept dry except when cleaning the ear mold with mild soap and water.

2. The nurse is inserting a hearing aid in the adult client’s ear. Place an “X” to indicate where the nurse’s fingers should be placed to facilitate insertion of the hearing aid.



ANSWER:



Placing the fingers on the helix to pull the car up and back straightens the ear canal.

3. The client has dentures, including both upper and lower plates. Which technique should the nurse use to correctly perform oral hygiene for this client?

A. Wear sterile gloves to remove the lower plate first and then the upper plate.
B. Use a foam swab to pry the upper and lower plates loose before removing these.
C. Grasp the upper plate at the front teeth with a piece of gauze and move it prior to removal.
D. Leave the dentures in the client's mouth and use a toothbrush to brush both denture plates.

ANSWER: C

A. Removing denture plates is a clean procedure, and sterile gloves are not necessary.
B. Removing the denture plates with a foam swab to pry the plate could injure the client.
C. Grasping the upper plate and moving it breaks the suction that holds the plate on the roof of the client's mouth.
D. Dentures must be removed to properly clean the client's mouth and the dentures.

4. The nurse is observing the UAP providing oral hygiene to the client Which action by the UAP requires follow-up?

A. Replacing the upper denture before the lower denture.
B. Placing the unconscious client in a supine position.
C. Brushing the tongue with a soft-bristled toothbrush.

D. Donning clean gloves prior to performing oral hygiene.

ANSWER: B

A. Remove and replace the upper denture first for ease of insertion.
B. The unconscious client should be placed in a side-lying position with the head turned to the side. Performing oral care in a supine position on the unconscious client can result in aspiration.
C. A soft-bristled toothbrush removes debris from the tongue, which can act as a reservoir for microorganisms.
D. Oral care is a clean procedure- Donning gloves prior to oral hygiene adheres to standard precautions.

5. The nurse is observing the nursing student caring for the client with an artificial eye. What action by the student nurse would require intervention?

A. Positioning the client lying down to remove the prosthetic eye
B. Drying the prosthetic eye with gauze before reinsertion
C. Cleansing the prosthetic eye with normal saline solution
D. Telling the client to remove the prosthetic eye weekly for cleaning

ANSWER: B

A. Positioning the client lying down aids with removal of the prosthetic eye; if the eye is accidentally dropped, it will fall onto the bed instead of the floor.
B. The prosthetic eye should be moist to facilitate insertion. Drying the prosthetic thoroughly with gauze could result in trauma to the eye socket
C. NS is an appropriate cleansing agent.
D. The prosthetic eye needs to be removed periodically for cleansing. It is recommended this be done every one to three weeks.

6. The nurse is caring for the newly admitted male client who is unconscious. The UAP asks if the client should be shaved. What is the nurse's best response?

A. "I need to find out the client's preferences first."
B. "Shave him only after you have bathed him."
C. "Use the electric razor when you shave him."
D. "Avoid shaving him. I need a doctor's order."

ANSWER: A

A. Removal of facial hair varies based on personal and cultural preferences. The nurse needs to assess the client's preferences before proceeding. If the client is unable to share his preferences, the family or significant other is consulted.
B. The nurse should not assert personal preferences with client grooming.
C. An electric shaver is a safe alternative to a razor, but the client's preferences are not known.
D. Shaving the client does not require a doctor's order.

7. The nurse is observing the UAP prepare a shower for the client who requires assistance with ambulation and hygiene. Which action(s) by the UAP indicate understanding of the procedure? Select all that apply.

A. Sets the water temperature at 100° to 105° F (37° to 40° C).
B. Locks the door to provide the client with privacy.
C. Uses a chair for the client to sit on in the shower.
D. Ensures a nonskid surface is in the shower.
E. Helps to wash areas the client cannot reach.

ANSWER: C, D , E

A. Water temperature should range from 110° to 115° F (43° to 46° C); the water temperature is too cool.
B. The client who requires assistance should not be left unattended behind a locked door. The UAP will not be able to reach the client.
C. This client requires assistance with ambulation and would be at risk for falling if attempting to shower without a shower chair.
D. A nonskid surface promotes safety in a wet environment where slips and falls may occur.
E. Assisting the client with hygiene in areas that the client cannot reach allows the client to be an active participant according to the client's ability.

8. The client who has bilateral hand burns reports wearing soft contact lenses that need to be removed. Which action(s) are important for the nurse to include in this procedure? Select all that apply.

A. Perform hand hygiene and don gloves.
B. Pinch the lens over the pupil and remove.
C. Place the lens in a sterile container with normal saline.
D. Irrigate the eye with normal saline to loosen the lens.
E. Instruct the client to look up when removing the lens.

ANSWER: A, C, E

A. Hand hygiene reduces introduction of microorganisms into the eye. Donning gloves prevents exposure to blood or body fluids.
B. The lens should slide down off the pupil before pinching and removing to prevent corneal abrasion.
C. The lens needs to be kept moist. If contact lens solution is unavailable, sterile normal saline is the best option.
D. Irrigating the eye could result in loss of the lens or injury to the cornea.
E. Instructing the client to look up allows the nurse to slide the lens down off the pupil before removing it.

9. The nurse is inserting a urinary catheter in the client with urinary retention. During balloon inflation, the client reports pain. What is the nurse's best action?

A. Withdraw the sterile water from the balloon and advance the catheter further.
B. Continue inflating the balloon as this finding is expected during catheter insertion.
C. Remove the catheter and reattempt insertion with a smaller urinary catheter.
D. Reposition the catheter by rotating it slightly and continue to inflate the balloon.

ANSWER: A

A. The catheter tip may be in the urethra rather than the bladder, which causes pain. With- drawing the sterile water and advancing the catheter will allow the catheter to enter the bladder.
B. Pain during balloon inflation is an abnormal finding. Continuing to inflate the balloon could damage the urethra.
C. The catheter should be removed if an attempt to advance the catheter fails. The size of the catheter does influence pain experienced during balloon inflation when improperly located.
D. Repositioning a catheter with a partially inflated balloon could damage the urethra and cause more pain for the client.

10. The client with an indwelling urinary catheter requires discharge teaching. Which interventions should the nurse include in the teaching plan? Select all that apply.

A. Plan to change the urinary catheter once a week.
B. Cleanse the perineal area daily with soap and water.
C. Secure the catheter tubing to the thigh with tape.
D. Avoid showering while the catheter is in place.
E. Perform hand hygiene before and after catheter care.

ANSWER: B, C, E

A. For clients with long-term indwelling urinary catheters, monthly catheter changes are recommended unless there is a greater risk for catheter blockage.
B. Soap and water is an appropriate perineal cleansing agent; routine use of antimicrobial cleansers is not recommended.
C. Securing the catheter to the thigh anchors the catheter and minimizes trauma to the urethra and bladder neck.
D. An indwelling catheter does not alter the client's method of meeting hygiene needs. The client may shower if the client's condition permits.
E. Performing hand hygiene prior to and after catheter reduces the risk of transmission of microorganisms that could cause UTI.

11 . The client voided 300 mL after having an indwelling urinary catheter removed six hours ago. A bladder scan immediately after the void showed that the client has a postvoid residual (PVR) volume of 250 mL. What should the nurse conclude from this finding?

A. This is an expected finding following catheter removal.
B. The client's bladder function is approximately 50% of normal.
C. The bladder scan was not done within 20 minutes of voiding.
D. The PVR volume is evidence of incomplete bladder emptying.

ANSWER: D

A. This is not an expected finding. If the bladder is functioning normally, PVR volume should be less than 50 mL.
B. It is not possible to estimate the percent of bladder functioning from this finding.
C. PVR volume should be measured within 20 minutes of voiding. A higher than expected PVR does not necessarily indicate this time frame was not met.
D. If the bladder scan is completed within 20 minutes of voiding, the PVR volume should be less than 50 mL. The 250 mL indicates that the client has incomplete bladder emptying.

12. The client is undergoing a 24-hour urine specimen collection. Twenty hours into the collection period, a single voided urine is accidentally discarded. What is the nurse's best action?

A. Resume the urine collection and collect one additional voided specimen.
B. Discard the urine collected and begin a new urine collection immediately.
C. Complete the urine collection and send all mine collected to the laboratory.
D. Dispose of the urine collected and reschedule the test to begin the next morning.

ANSWER: B

A. Resuming the collection and adding one additional voided specimen will result in test inaccuracies.
B. The urine collected must be discarded and restarted. When starting a 24-hour urine collection, the first void is discarded, and all urine is collected for the next 24 hours.
C. The specimen will be four hours short of 24 hours and could result in inaccurate test results.
D. There is no need to reschedule the test for the morning. The start time for a 24-hour urine does not affect test results. The first void is discarded. The accidentally discarded void is the first void.

13. The client reports pain in the right leg even though it was amputated. Which complementary therapy should the nurse use to control the phantom pain associated with the client's amputation?

A. A small dose of alprazolam at 8-hour intervals in addition to prescribed oxycodone and acetaminophen q6h pm
B. A high-fiber diet and 2000 mL fluid intake in 24 hours while taking hydromorphone at 4- to 6-hour intervals pm
C. Progressive relaxation exercises three times daily in addition to use of a transdermal patch of fentanyl
D. A local anesthetic as a nerve block in addition to prescribed long-acting oxycodone

ANSWER: C

A. Combining an antianxiety medication such as alprazolam (Xanax) with an analgesic such as oxycodone and acetaminophen (Percocet) is a conventional medicinal intervention.
B. Dietary interventions help control constipation associated with opioids such as hydrornorphone (Dilaudid) and are not a complementary therapy to control phantom limb pain.
C. Progressive relaxation therapy, used along with prescribed analgesic medication such as fentanyl (Duragesic) to control phantom pain, is an example of complementary therapy.
D. A nerve block with an analgesic such as oxycodone (OxyContin) is using conventional medicinal practice.

14. The client with a new colostomy asks how to deal with gas coming from the stoma. To respond to the client's concern, the nurse should ask the client to take which action? Select all that apply.

A. Describe the dietary intake, including types of foods.
B. Include cruciferous vegetables in the diet daily.
C. Decrease fluid intake to 1200 mL per 24 hours.
D. Prick the colostomy stoma pouch with a pin.
E. Limit intake of gas-producing carbonated sodas.
F. In the bathroom, open the pouch clamp to release gas.

ANSWER: A, E, F

A. The nurse can assess for foods and beverages known to produce gas if the usual dietary intake is described by the client.
B. Cruciferous vegetables, which include vegetables of the cabbage family, are known to cause gas formation.
C. The client needs at least 2000 mL of fluid daily to maintain proper function of the colostomy.
D. Pricking the colostomy pouch with a pin leads to constant gas release and an unpleasant odor.
E. Limiting carbonated beverages reduces gas formation in the intestinal tract.
F. Gas in the pouch should be released from the pouch in a restroom environment.

15. The postoperative male client has been unable to urinate into the urinal while lying in bed. Which interventions are appropriate to promote voiding for this client who is to be discharged home within a few hours? Select all that apply.

A. Have the client apply an external condom catheter while lying flat in bed
B. Assist the client to stand at the bedside to attempt to urinate in a urinal.
C. Administer a prescribed analgesic if the client is experiencing pain.
D. Turn on running water so it is heard while the client attempts to void.
E. Ask the client to imagine being at home and voiding in his own bathroom.

ANSWER: B, C, D, E

A. Use of an external catheter will not assist the client to void; it may be used for incontinence.
B. The nurse should try to assist the client to void by assisting him to the normal position of standing.
C. Pain may be interfering with the ability to urinate and should be treated.

D. Using the sound of running water stimulates the voiding reflex.
E. Guided imagery is a relaxation technique that may help the client to void.

16. The client was treated for constipation 1 month earlier. On a return clinic visit, which statement would best assist the nurse to evaluate that the client is no longer constipated?

A. "I drink 2000 milliliters of fluids daily, including drinking 4 ounces of prune juice."
B. "I have had a soft-formed stool without straining every other day for the past 2 weeks."
C. "I needed to give myself only one disposable enema since my appointment last month."
D. "I have a lot of discomfort from hemorrhoids during my daily bowel movements."

ANSWER: B

A. The fluid intake, which includes prune juice, shows the client is taking action to prevent constipation, but it does not indicate that the client is not constipated.
B. Constipation is having fewer than three bowel movements per week. The client is no longer constipated when having a soft-formed stool without straining every other day.
C. A disposable enema is used to stimulate bowel function. Using only one does not indicate that the client is no longer constipated.
D. Although the client is having a daily stool, there is insufficient information in this statement to evaluate what the client used to stimulate daily bowel movements or the consistency of the stool.

17. The client with diarrhea has had four bowel movements in the past eight hours, measuring 150 mL, 100 mL, 100 mL and 150 mL. The client is to receive one-to-one replacement with a bolus of IV 0.9% NaCl to be infused over the next two hours. How many mL of 0.9% NaCl will the nurse infuse each hour?

_____ mL (Record your answer as a whole number.)

ANSWER: 250

The total fluid loss from the client's diarrhea

is 500 mL (150 + 100 + 100 + 150). One-to-

one replacement equals 500 mL of NaCl to

be infused. The amount to be delivered over

2 hours is 500 mL; the amount for each hour

is 500 / 2 = 250 mL.

18. The client with intermittent abdominal pain recently had a barium enema. The client calls the nurse to report passage of a soft-formed, pale-colored stool. What is the nurse's best response?

A. "This is an expected finding after administration of barium."
B. "Describe any abdominal pain you had when passing the stool."
C. "What foods or fluids did you eat after you completed the test?"
D. "You need to increase the amount of water you are drinking."

ANSWER: A

1. Barium administered in the GI tract results in pale or white-colored stools due to residual barium being evacuated from the bowel.

2. Passage of stool may or may not result in additional abdominal pain; however, abdominal pain does not result in pale-colored stools.

3. Dietary intake after barium enema does not result in a pale stool color.

4. Water is important to drink after a barium enema, but there is no indication that the client requires additional water. If the stool had been fine or difficult to pass, additional water would have been beneficial.

19. The client uses a walker to ambulate with partial weight-bearing after foot surgery. What should the nurse observe when this client is using the walker correctly?

A. Has elbows bent at a 30-degree angle
B. Is bent over the front bar of the walker
C. While walking, lifts the walker 2 inches
D. Has a walker that has four wheels in place

ANSWER: A

A. When a walker is at the proper height, the client's elbows will be bent at a 30-degree angle.
B. The client should stand erect and not bent over while using the walker.

C. The client cannot be ambulating with partial weight-bearing if the client lifts the walker off the floor.
D. The client cannot be ambulating with partial weight-bearing if using a walker with four wheels.

20. The nurse learns at shift report that the immobile client has bilateral foot drop. Which finding during the nurse's assessment supports the presence of foot drop?

A. The client's great toe is dorsiflexed, and the other toes are fanned out.
B. The client's feet are unable to be maintained perpendicular to the legs.
C. The client is unable to move the feet into a position of plantar flexion.
D. The client is only able to dorsiflex both feet when asked to bend the feet.

ANSWER: B

A. A positive Babinski's sign occurs when the great To edorsiflexes and the toes fan out in response to stroking the lateral surface of the foot.
B. The client with foot drop is unable to hold the feet up in dorsiflexion or in a perpendicular position to the leg.
C. With foot drop, the feet stay in plantar flexion.
D. The client with bilateral foot drop is unable to dorsiflex the feet.

21 . The immobile client is in a hospital bed at home. Which information should the home health nurse include when teaching family caregivers how to safely move and reposition the client?

A. "Before moving the client, raise the bed to waist level. After completing the move, return the bed to the lowest level."
B. "The pillow should be removed from under the client's head when positioning in a dorsal recumbent position."
C. "Tighten your abdominal muscles and keep your feet together; use a lift sheet and pull the client up in bed."
D. "When the client is lying on the back, rest the client's heels on the bed and keep the feet perpendicular to the legs."

ANSWER: A

A. The nurse should instruct caregivers about safety measures. By raising the bed to waist level, caregivers put the client near their center of gravity. This improves their stability during the move and lessens the risk for injury. Returning the bed to the lowest position decreases the risk of injury if the client falls out of bed.
B. The client in dorsal recumbent position should have a pillow under the head to prevent hyperextension of the neck.

C. Family members should assume a broad stance to improve balance when moving the client.
D. The heels of the client should be kept off the bed to eliminate pressure on the heels while feet are maintained perpendicular to the legs to avoid foot drop.

22. The hospitalized client is at risk for thromboembolism. Which direction should the nurse include when teaching this client about wearing antiembolism hose stockings?

A. “Wearing the hose is unnecessary if ambulating 10 times daily for 5 minutes at a time.”
B. “When at home, apply the stockings in the morning before you stand to get out of bed.”
C. “The hose can cause pain to underlying skin; request pain medication to help alleviate this.”
D. “Cross your legs only while wearing these stockings; otherwise keep the legs uncrossed.”

ANSWER: B

A. Frequent ambulation prevents thromboembolism but should be in addition to wearing the antiembolism stockings.
B. The most appropriate time to apply antiembolism stockings is before getting out of bed. Compression is maximized, thus lessening venous distention and development of edema.
C. Pain could indicate impaired circulation. The nurse should assess the stockings for wrinkles and the skin underneath for impaired circulation.
D. Crossing the legs impedes circulation and should be avoided with or without the antiembolism stockings.

23. The nurse applies a warm, moist compress to the site where an IV solution has infiltrated. Which response is correct when the client asks the purpose of the compress?

A. “The application of moist heat will alter tissue sensitivity by producing numbness.”
B. “The application of moist heat will decrease the metabolic needs of the involved tissues.”
C. “The application of moist heat will stop the local release of histamine in the tissues.”
D. “The application of moist heat will increase blood flow and accelerate tissue healing.”

ANSWER: D

A. Application of cold, not, hot, alters the sensitivity of nerves in the area and causes numbness.
B. Heat causes an increase, not a decrease, in tissue metabolism.
C. Cold, not hot, decreases the inflammatory response by reducing the release of histamine from inflamed tissues.
D. Application of the warm, moist compress dilates the blood vessels, thus increasing local blood flow and capillary permeability. This accelerates the inflammatory response and promotes healing to the involved tissues.

24. The client who is Jewish is to receive a kosher meal. Which direction by the nurse to the NA is appropriate?

A. “Avoid eye contact when delivering the meal tray.”
B. “Do not remove the wrapping from the plastic utensils.”
C. “Have the client sit for the meal facing toward Mecca.”
D. “Check that the meal contains both milk and kosher meat.”

ANSWER: B

A. Avoiding eye contact is not a practice of those who are Jewish.
B. The NA should not unwrap the utensils. The client should do the unwrapping to be sure that the utensils have not been tainted by nonkosher items.
C. There is no need for the client who is Jewish to face toward Mecca when eating. Muslims turn their faces toward Mecca when they pray.
D. A kosher meal would not include both milk and kosher meat; milk or dairy products are kept separate from meat.

25. The nurse is assessing the female client who is 65 inches tall and has a small body frame. Based on the information in the chart illustrated, what is the client's approximate ideal body weight?

_____ lb (Record your answer as a whole number.)

Approximating Ideal Body Weight

Rule of 5 for Females	Rule of 6 for Males
105 lb for 5 ft of height	106 lb for 5 ft of height
+5 lb for each inch over 5 ft	+6 lb for each inch over 5 ft
±10% for body frame size	±10% for body frame size
Add 10% for large body frame size and subtract 10% for small body frame size.	

ANSWER: 117

First calculate the client's height in feet and inches.

Since 1 foot equals 12 inches, the client's height is 5 feet, 5 inches (65/12 = 5 remainder of 5).

Apply the formula from the chart: 105 lb for

5 ft height

5 lb X 5 = 25

105 + 25 = 130 lb

Since the client has a small body frame size, calculate 10% of 130 lb.

10% = 0.1

0.1 x130 =13 lb

Subtract the 10% due to small body frame size:

130 — 13 =117 lb.

26. The client residing in a nursing home has bilateral weak handgrips and visual and hearing deficits. Which interventions should the nurse implement when the client is eating a meal? Select all that apply.

A. Ask the client's permission to open containers and cut up meats on the food tray.
B. Obtain special easy-to-hold, built-up silverware for the client to use when eating.
C. Observe the client, but avoid providing assistance even if the client is frustrated.
D. Help feed the client if the client is eating too slowly so food does not get too cold.
E. Ensure that the client wears eyeglasses and hearing aids before starting to eat.

ANSWER: A, B, E

A. Asking permission allows the nurse to determine whether opening containers and cutting up meat are activities that the client is unable to perform. This promotes client autonomy and independence in decision making.
B. With easy-to-hold, built-up silverware the client can maintain independence with eating.
C. The nurse should observe the client and assist with specific obstacles to limit client frustration.
D. Feeding the client who is slow at eating will tend to extinguish independent behaviors.
E. The client will have greater independence with eating if eyeglasses and hearing aids are in place. The client should also have dentures in place if used.

27. The dietitian prescribes a 24-hour calorie count for the malnourished hospitalized client. Which action should be taken by the nurse?

A. Ask the client to recall at the end of the day the food and beverages consumed.
B. Inform the client how to count the calories in the food and beverages consumed.
C. Inform the client that a record will be maintained of food and beverages consumed.
D. Ask the client to identify the food groups and foods that are being consumed in each.

ANSWER: C

A. Having the client recall foods may or may not result in an accurate calorie count.
B. When hospitalized, the dietitian (not the client) will determine the number of calories the client consumed in 24 hours.
C. In a hospital, a calorie count involves the observation and documentation of the amount of foods eaten by the client from meal trays and snacks provided.
D. Identifying the food groups and foods obtained does not accurately describe a calorie count.

28. The hospitalized client is able to stand to use an electronic digital scale for obtaining the client's prescribed daily weight. Which nursing interventions best ensure that the client's daily weight is accurate? Select all that apply.

A. Ask the client to wear supportive shoes before stepping on the scale
B. Ensure that the scale is calibrated and "zeroed" before a weight is obtained
C. Weigh the client by moving the sliding indicator until the scale balances
D. Weigh the client at different times of the day and then average the weights
E. Take the weight as soon as the client wakens in the morning and after voiding

ANSWER: B, **E**

A. The client should not wear shoes because this will add to the weight.
B. Electronic digital scales should be calibrated and "zeroed" before weighing the client to ensure accuracy.
C. The nurse moves a slide indicator until the scale balances with a balancing arm scale, not an electronic digital scale.
D. For accuracy, it is best to weigh clients at the same time each day.
E. For accuracy, the client should be weighed at the same time each day with an empty bladder; a full bladder adds weight.

29. The nurse is developing guidelines to assist personnel in meeting the hygiene needs of clients with dementia. Which guidelines are appropriate for the nurse to include? Select all that apply.

A. To limit the client's ability to physically resist, two staff should quickly bathe the client.
B. Include music and dim lighting to create a calm environment when giving a bed bath.

C. Allow clients who are willing and able to participate in some of the hygienic activities.
D. Assess for and treat the client's pain before initiating hygienic cares with the client.
E. Wash the client's hair and body separately if either activity causes the client distress.

ANSWER: B, C, D, E

A. Quick and routine institutional bathing practices, which emphasize efficiency, can add to agitation and lack of cooperation in clients with dementia.
B. Research findings indicate that hygiene activities can be improved for clients with dementia and their caregivers by providing a calm bathing environment.
C. Clients are more likely to cooperate with hygiene activities when they are allowed to participate in the process.
D. Clients are more likely to cooperate with hygiene activities when pain is adequately controlled.
E. Separating hair washing from bathing limits the stress of activity on the client with dementia.

30. The nurse is giving report to the NA on the care of four clients. The nurse should inform the NA to avoid taking a rectal temperature for which client?

A. Adult who underwent ileoslomy surgery because of a perforated bowel
B. Adult who has a productive cough and is receiving oxygen by nasal cannula
C. Adult who develops thrombocytopenia after receiving chemotherapy treatments
D. Adult who has hypothermia after being outside in a below-zero temperature

ANSWER: C

A. An ilcostomy involves the small bowel and does not affect the rectal area.
B. A rectal temperature is not contraindicated for the client who has a productive cough and is receiving oxygen. The rectal route may be used if the client is unable to keep the thermometer under the tongue due to coughing.

C. Clients with thromboeytopenia have lower than normal levels of platelets and are at increased risk of bleeding. Measuring the temperature rectally exposes the client to the risk of rectal bleeding.
D. Monitoring rectal temperature is often used in clients with hypothermia; the temperature may be too low to be measured orally.

31 . The NA tells the nurse that the unit's small- adult BP cuff cannot be found and that the client's arm is too small to use a regular adult-sized cuff. Which direction should the nurse give to the NA?

A. Document the other vital signs and note that the proper-fitting BP cuff is not available.
B. Go to another nursing unit to obtain their small- adult BP cuff, and take the client's BP.
C. Use the regular-sized BP cuff and add 10 to the diastolic and systolic BP readings.
D. If the cuff closes around the arm, take the client's BP using the regular adult cuff.

ANSWER: B

A. The NA should not omit the BP but should obtain the correct-sized cuff.
B. For an accurate reading, the BP must be taken with the correct-sized BP cuff. When one is not available on the unit, one option is to direct the NA to obtain one from another unit.
C. Adding numbers to a BP when using an improperly sized cuff will not result in a correct BP measurement.
D. A BP cuff that is too large will result in a lower BP reading.

32. Before ambulating the client for the first time, the nurse obtains the client's BP with an automatic BP machine. Which actions should the nurse take first when obtaining a BP reading of 86/56 mm Hg and pulse rate of 64 bpm?

A. Assess the client for dizziness and feel the temperature of extremities
B. Obtain a manual BP cuff and machine and retake the client's BP
C. Elevate the head of the client's bed and assist the client out of bed
D. Review the medical record and determine the client's normal BP range

ANSWER: A

A. The nurse should first assess the condition of the client and ascertain if there are physical signs consistent with hypotension. Dizziness is a sign of decreased perfusion to the brain; cool, clammy extremities are a sign of decreased peripheral circulation.

B. After assessing the client's condition, the nurse should recheck the BP to verify the accuracy of the reading.
C. The nurse should not elevate the head of the client's bed; this action would further lower the BP. The nurse should first assess the client before getting the client out of bed.
D. Determining the normal range of BP is indicated after condition assessment and verifying the reading.

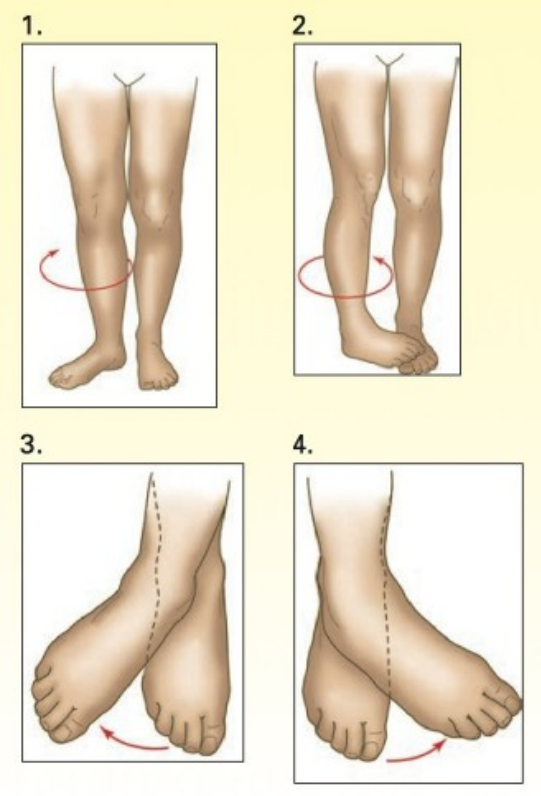
33. The nurse is taking the client's temperature. What should the nurse do to correctly obtain the temperature with a tympanic thermometer?

A. Ensure that the probe tip seals the ear canal prior to taking a temperature.
B. Irrigate the ear canal with sterile saline before obtaining the temperature.
C. When inserting the thermometer in the adult ear, pull downward on the pinna.
D. Check to be sure that the client does not have any tympanostomy tubes in place.

ANSWER: A

A. Failing to seal the ear canah will result in an inaccurate temperature reading.
B. Irrigating the ear canal is not indicated; earwax does not affect the temperature and results.
C. With an adult, the pinna of the ear should be pulled slightly upward to straighten the ear canal.
D. The presence of tympanostomy tubes does not affect the accuracy of the temperature reading; for comfort, a tympanic temperature should not be taken for a week after placement of the tubes.

34. The nurse is evaluating the client's ability to perform active ROM. Which illustration demonstrates the client's ability to correctly perform eversion?



ANSWER: C

A. This illustration shows external rotation.
B. This illustration shows internal rotation.
C. Eversion is turning outward.
D. This illustration shows inversion, turning inward.

35. The experienced nurse and the new nurse are preparing to provide phototherapy to the 4-day-old infant with hypcrbilirubincmia. Which information should the experienced nurse include when instructing the new nurse about providing phototherapy for the infant?

A. Keep the infant fully clothed to prevent chilling and hypothermia.
B. Cover the infant's eyes with eye shields to prevent retinal damage.
C. Limit the number of feedings to reduce the number of soiled diapers.
D. Discontinue the phototherapy if the infant develops a mild skin rash.

ANSWER: B

A. Phototherapy is designed to convert the bilirubin in the superficial capillaries in the skin. Keeping the baby fully clothed does not allow for maxi- mum skin exposure to achieve bilirubin conversion and excretion.

B. Covering the baby's eyes with eye shields will protect the baby's eyes from the phototherapy light, which could be damaging to the retinas.
C. Limiting the number of feedings is incorrect because bilirubin is excreted in the urine and stool, and excretion can be increased with increased feedings.
D. A rash can be caused by capillary dilation and is not harmful to the baby. Diseontinuing therapy is not warranted.

36. The nurse is using a hypothermia blanket for the febrile client. Which findings should prompt the nurse to consider that the client is hypotherrnic? Select all that apply.

A. Increased urine output
B. Increased drowsiness
C. Decreased heart rate (HR)
D. Decreased blood pressure (BP)
E. Increased core body temperature

ANSWER: B, C, D

A. Urine output is decreased in the hypothennic client as a result of decreased renal perfusion.
B. In hypothermia, a low cardiac output affects the CNS, producing drowsiness.
C. In hypothermia, the HR decreases due to the effects on the thermoregulation center in the brain.
D. In hypothermia, the BP decreases due to the effects on the thermoregulation center in the brain. A lowering of the BP decreases cardiac workload and cardiac output.
E. The core body temperature would be decreased, not increased, with hypothermia.

37. The client is in skeletal traction with 20 lb of traction applied to a right lower leg fracture. Which intervention should the nurse perform at regular intervals?

A. Perform pin site care
B. Remove the weights
C. Reposition the right leg
D. Perform passive ROM to the legs

ANSWER: A

A. Pin site care should be routinely performed per agency policy to reduce the risk of infection.

B. With skeletal traction the weights should never be removed except for emergencies.
C. The leg in traction needs to stay in proper alignment, so it would not be repositioned.
D. The leg in traction needs to stay in proper alignment, so ROM would not be performed on that leg.

38. The experienced nurse observes the student nurse caring for the client with the wet plaster cast illustrated. Which conclusion by the experienced nurse is correct?



A. The student should not be touching the plaster cast because it is wet.
B. The student should be using a pillow to lift the client's casted extremity.
C. The student is correctly handling a wet plaster cast with the palms.
D. The student should be using fingers and not the palms to handle the cast.

ANSWER: C

A. A plaster cast takes hours to dry and should be repositioned to allow drying of the underside of the cast and to prevent indentations.
B. Handling a wet plaster cast only with a pillow will not allow inspection of the underside of the cast.
C. The student nurse is observed safely handling the wet plaster cast with the palms of the hands to prevent indentations from the fingers. This technique prevents pressure areas from developing on the skin underneath the cast.
D. Using the fingers will cause indentations in the cast that will cause pressure areas.

39. The nurse is caring for the client with a stage III pressure ulcer to the right heel. Which actions should the nurse plan? Select all that apply.

A. Encourage foods high in vitamin C such as orange juice
B. Premedicate with analgesics prior to dressing changes
C. Monitor pedal pulses and capillary refill of affected extremity
D. Use hydrogen peroxide for cleaning of the ulcer wound
E. Turn and reposition the client every 1 to 2 hours
F. Elevate the extremity on pillows, keeping the heel off the pillow

ANSWER: A. B, C, E, F

A. Vitamin C promotes wound healing and should be encouraged.
B. Premedicating prior to dressing changes with analgesics for pain promotes client comfort.
C. Monitoring pedal pulses and capillary refill of the affected extremity alerts the nurse to further vascular compromise as a result of the wound.
D. The use of hydrogen peroxide can be excoriating to the wound and will not promote healing.
E. Repositioning the client promotes circulation and helps prevent further skin breakdown.
F. Elevation reduces edema; keeping the heel off the pillow avoids pressure on the ulcer.

40. The nurse is assessing the client who was just admitted to a surgical unit following abdominal surgery. Which assessment finding requires immediate intervention by the nurse?

A. Nasogastric tube to low intermittent suction has small amounts of dark bloody returns.
B. Oxygen saturation level is 92%, and oxygen by nasal cannula is set at 2 liters.
C. The incisional dressing has a 25-cent—piece-sized shadow of new drainage.
D. The Jackson-Pratt drain is round in shape with 30 mL serosanguineous drainage.

ANSWER: D

A. An NG tube to low intermittent suction with small amounts of dark bloody returns would be normal immediately after surgery if there

were any trauma associated with insertion of tube; thus no intervention would be required.

B. The oxygen saturation of 92% is normal. The 2 liters of oxygen by nasal cannula is maintaining this level. No intervention is required.
C. The nurse should monitor the incisional dressing for additional drainage, but an immediate intervention is not required.
D. A round JP drain requires immediate intervention; the drain needs to be emptied and compressed to create suction and collect fluid. Suction is lost when there is too much drainage or there is a leak in the system.

41 . The nurse is teaching the client, who is 24 hours post abdominal surgery, how to use an IS. Which instructions should the nurse include in the teaching? Select all that apply.

A. Inhale slowly and deeply through mouth
B. Seal lips tightly around mouthpiece
C. After inhaling, hold breath for 2 to 3 seconds
D. Sit with the HOB down and bed almost flat
E. Splint the incision with pillows
F. Exhale forcefully, fast, and hard

ANSWER: A, B, C, E

A. Inhaling slowly and deeply through the mouth prevents hyperventilation and provides maximal inflation of the alveoli.
B. Sealing the lips around the mouthpiece prevents leakage of air.
C. Holding the breath allows for maximal inflation of the alveoli.
D. Sitting with the I-IOB down or flat does not promote lung expansion. The desired position for maximum lung expansion is a high Fowler's position or a sitting position.
E. Splinting the incision promotes comfort and encourages the client to take larger-volume breaths.
F. Exhaling forcefully, fast, and hard may lead to hyperventilation; exhalation should be slow.

42. The client needs nasotracheal suctioning. The nurse explains the procedure to the client and performs hand hygiene. Prioritize the nurse's remaining actions to perform the nasotracheal suctioning by placing each step in the correct order.

A. Prepare suction supplies and equipment and pour sterile saline into a sterile container.
B. Place finger over suction control port of catheter and suction intermittently while withdrawing the catheter.

C. Put on sterile gloves.
D. Lubricate the catheter with sterile saline, insert into naris, and advance into pharynx.
E. When the client inhales, advance the catheter into the trachea.
F. Pick up suction catheter with the dominant hand and attach it to connection tubing; avoid contamination of the glove on the dominant hand.
G. Place tip into sterile saline container while applying suction to clear secretions from the tubing

ANSWER: A, C, F, D, E, B, G

A. Prepare suction supplies and equipment and pour sterile saline into a sterile container. Supplies should be prepared before donning sterile gloves.

C. Put on sterile gloves. Sterile gloves are worn when performing nasotracheal suctioning to avoid introducing microorganisms.

F. Pick up suction catheter with the dominant hand and attach it to connection tubing; avoid contamination of the glove on the dominant hand. The dominant hand is used to insert the catheter into the client's naris, and the glove should remain sterile.

D. Lubricate the catheter with the sterile saline, insert into naris, and advance into pharynx. The catheter is lubricated to avoid trauma to the nares and for ease of passage.

E. When the client inhales, advance the catheter into the trachea. Advancing while the client is swallowing will result in the catheter being misplaced.

B. Place linger over suction control port of catheter and suction intermittently while with- drawing the catheter. Intermittent suction is used to avoid trauma to tissues.

G. Place tip into sterile saline container while applying suction to clear secretions from the tubing. The tubing should be cleared of secretions before advancing the catheter again.

43. The nurse is caring for the 11-month-old infant with bronchopulmonary dysplasia. The infant has 30% supplemental oxygen provided via a tracheostomy. Which action should the nurse take when the infant has a decline in oxygen saturation from 96% to 87% and appears anxious and restless?

A. Obtain arterial blood gases (ABGs)
B. Increase oxygen rate from 30% to 50%
C. Suction the tracheostomy tube
D. Medicate for anxiety and pain

ANSWER: C

A. Obtaining ABGs may be helpful if oxygen saturations remain low after suctioning and the infant remains in distress, but clearing the airway should be priority.
B. Increasing the oxygen rate will not be effective if the airway is occluded by secretions.
C. Suctioning the tracheostomy is priority. A lowering of oxygen saturation and signs of respiratory distress can occur with secretions and a mucus plug.
D. Medicating for anxiety and pain would not improve oxygen saturations if the airway is not patent due to secretions. Medicating the infant may reduce respiratory drive and cause further distress.

44. The hospitalized client with limited mobility is at risk for skin breakdown. Which interventions should the nurse include in the plan of care to maintain the client's skin integrity? Select all that apply.

A. Massage vigorously over bony prominences daily
B. Wear sterile gloves when inspecting the client's skin
C. Apply a moisturizing lotion to bony prominences
D. Instruct the client to change position every 2 hours
E. Apply an overhead trapeze to the client's bed
F. Apply a barrier cream if the client is incontinent of stool

ANSWER: C, D, E, F

A. Bony prominences should not be vigorously massaged because this may lead to tissue trauma.
B. Wearing sterile gloves is not necessary when inspecting the client's skin; if skin breakdown is present, examination gloves should be worn.
C. Combating dry skin with moisturizing lotions helps prevent dryness and maintains the skin's natural integrity.
D. A change in position every 2 hours alters the area of the body bearing weight and improves overall circulation to tissues.
E. Use of an overhead trapeze allows the client to help lift some of the weight, decreasing friction and shear with lifts.
F. A barrier cream to the buttocks and rectal area will protect the skin from coming in contact with incontinent stool.

45. The client is receiving 2 liters of oxygen by nasal cannula. Which rationale should the nurse use to explain the reason for oxygen being bubbled through a humidifier?

A. Prevents the burning sensation of direct oxygen

B. Prevents the drying of the nasal passages
C. Prevents a chemical reaction between the tubing and oxygen
D. Prevents contamination with environmental gases

ANSWER: B

A. Oxygen does not cause a burning sensation, but it is combustible.
B. Humidification of the oxygen prevents drying of the client’s nasal passages.
C. Oxygen does not produce a chemical reaction with the tubing.
D. Oxygen is not contaminated by environmental gases.