

1 . The nurse is caring for the client following a knee arthroscopy. What information should the nurse teach? Select all that apply.

- A. Elevate the involved extremity on pillows for 24 to 48 hours.
- B. Apply an ice pack continually to the involved joint for 24 hours.
- C. Report severe joint pain immediately to the health care provider.
- D. Resume usual activities to minimize joint stiffness and swelling.
- E. Treat pain with a mild analgesic such as acetaminophen.

ANSWER: A, C, E

- A. Elevation will help to decrease edema.
- B. Ice should be applied intermittently (usually 20—30 minutes with 10- to 15-minute warming periods between applications). Hypothermia causes vasoconstriction and decreased circulation to the area.
- C. Severe joint pain may indicate a possible complication and should be reported immediately.
- D. Activity is initially limited and slowly progressed.
- E. Usually a mild analgesic such as acetaminophen (Tylenol) is sufficient for pain control following a diagnostic arthroscopy.

2. The client is being seen in the clinic for a second- degree ankle sprain. Which treatments should the nurse plan?

- A. Rest, elevate the extremity, apply ice intermittently, and apply a compression bandage.
- B. Do range of motion to determine the extent of injury, apply heat, and check circulation.
- C. Use moist heat and then apply ice; check circulation, motion, and sensation; and elevate.
- D. Refer to an orthopedic surgeon, apply ice, give an analgesic, elevate, and encourage rest.

ANSWER: A

- A. Rest prevents further injury and promotes healing. Ice and elevation control swelling. Compression with an elastic bandage controls bleeding, reduces edema, and provides support for injured tissues.
- B. Performing ROM would be contraindicated initially because it causes pain and possible further injury. heat causes vasodilation, increasing edema, and should not be used if swelling is present.
- C. Heat causes vasodilation, increasing edema, and should not be used if swelling is present.
- D. Immediate orthopedic referral is reserved for emergent, frequently open, injuries.

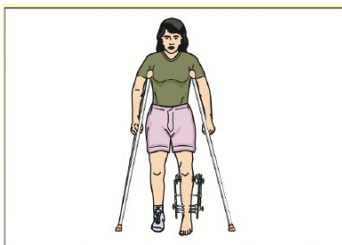
3. The nurse is assessing the client who is to have a closed reduction for a right elbow dislocation. Which should be the nurse's priority?

- A. Presence of bruising to the right elbow
- B. Pain level rating on a 0—10 scale
- C. Sensation and pulse of the right forearm
- D. Left-handed or right-handed

ANSWER: C

- A. Bruising is a common finding with dislocation. It can indicate bleeding in the tissue due to trauma, but that would not affect neurovascular status of the extremity.
- B. Pain is expected with a dislocation; the client should be medicated before the procedure regardless of current pain level. After the procedure, pain management is a nursing priority but not as urgent as other assessments.
- C. Impairment of the neurovascular system is a priority. The closed reduction could cause further damage, which would be noted distal to the injury. Sensation and pulses are part of a neurovascular assessment to an extremity.
- D. Dominant hand is important to address in discharge instructions; this is not a priority before the reduction.

4. The client has an external fixator for reduction of a tibia fracture. The nurse is evaluating the client's effectiveness in ambulating with crutches. Place an X on each of the three areas where the client should be bearing weight When crutch walking.



ANSWER:



The client should be bearing weight on the hand grips when bringing legs forward. When moving crutches, the weight should be borne on the unaffected leg.

5. An hour ago the HCP split the client's fore- arm cast due to severe arm pain, throbbing, and tingling. Which most important action should be taken by the nurse when the client's symptoms return?

- A. Administer an intravenous pain medication.
- B. Notify the health care provider immediately.
- C. Cut the cast padding and spread the cast Men
- D. Elevate the arm on pillows above the heart level.

ANSWER: B

- A. Although an analgesic should be administered, it is more important to notify the HCP because these symptoms suggest compartment syndrome.
- B. The nurse should notify the HCP immediately because these symptoms suggest compartment syndrome, which is a medical emergency.
- C. Bivalving the cast further may not relieve the pressure area, and further intervention such as cast removal may now be required.
- D. The nurse should elevate the arm to prevent edema and compartment syndrome; once compartment syndrome occurs, elevation is contraindicated because it further reduces perfusion to the extremity.

6. The nurse is discharging the client home with a plaster of Paris cast to the lower leg. Which self- care recommendation should the nurse include?

- A. Sprinkle powder in the cast to decrease moisture from sweating.
- B. Direct cool air from a hair dryer into the cast to relieve itching.
- C. Cover the cast with a plastic wrap before you bathe in a tub.
- D. Use hot, soapy water to wash the cast if it becomes very soiled.

ANSWER: B

- A. Nothing should be placed inside a cast; powder may become pasty inside the cast when exposed to moisture and increase skin breakdown-
- B. Cool air from a hair dryer helps to control itching on the skin within a cast. Hot air is not recommended because it could burn the skin.
- C. A plaster of Paris cast should not be submerged in water. A fiberglass cast may get wet.
- D. A plaster of Paris cast should be kept dry and should not be washed with soap and water.

7. A college student visits a campus health service reporting knee pain, clicking when walking, "locking," and "giving way" of the affected knee. The injury occurred when twisting the knee wrong during a tennis match. The nurse should further assess for which problem?

- A. Injury of the meniscus cartilage
- B. Fracture of the lateral tibial condyle
- C. Injury and possible fractured patella
- D. Lateral collateral ligament injury

ANSWER: A

- A. The nurse should assess for injury to the meniscus (knee) cartilage. Abrupt twisting can tear the cartilage, and the loose cartilage can cause locking of the joint, clicking, and the knee to “give way.”
- B. Locking and clicking are not associated with a tibial fracture.
- C. Locking and clicking are not associated with a patella fracture.
- D. In a collateral ligament injury, the client experiences acute pain, joint instability, and inability to walk without assistance.

8. The client with a pelvic fracture developed a fat embolism. The nurse should assess the client for which specific sign?

- A. Dyspnea
- B. Chest pain
- C. Delirium
- D. Petechiae

ANSWER: D

- A. Dyspnea can occur when pulmonary or cardiac vessels are occluded.
- B. Chest pain can occur when pulmonary or cardiac vessels are occluded.
- C. Cerebral disturbances, due to hypoxia and the lodging of emboli in the brain, vary from headache and mild agitation to delirium.
- D. The nurse should assess for petechiae. Petechiae (small purplish hemorrhagic spots on the skin) are thought to be due to transient thrombocytopenia. They can occur over the chest, anterior axillary folds, hard palate, buccal membranes, and conjunctival sacs.

9. The nurse is caring for the client involved in an MVA who sustained an unstable pelvic fracture. Which HCP order should be the nurse's priority?

- A. Urinalysis and culture and sensitivity
- B. Blood alcohol level and toxicology screen
- C. Computed tomography (CT) scan of the pelvis
- D. Give two units of cross-matched whole blood

ANSWER: D

- A. The client is at risk for fat emboli. Free fat may show in the urine, but this is not priority.
- B. The administration of analgesics and anesthetics is affected by blood alcohol and toxicology results, but this is not the priority.
- C. CT of the pelvis will determine the extent of the fracture but is not the priority.
- D. Significant blood loss occurs because the pelvis is a highly vascular area. A type and cross-match must be completed prior to administering blood, which takes time.

1 0. The LPN is reporting observations and cares to the RN. Based on the LPN's report, which client should the RN assess immediately?

- A. The client, 2 hours post-total knee replacement, has 100 mL bloody drainage in the autotransfusion drainage system container.
- B. The client with a crush injury to the arm was given another analgesic and a skeletal muscle relaxant for throbbing, unrelenting pain.
- C. The client in a new body cast was turned every 2 hours and is being supported with waterproof pillows.
- D. The client with a left leg external fixator has serous drainage from the pin sites, and pulses are present by Doppler.

ANSWER: B

- A. Postoperative drainage from a TKR ranges from 200 to 400 mL during the first 24 hours. This amount is neither alarming nor sufficient enough to autotransfuse.
- B. The RN should assess this client immediately. Throbbing, unrelenting pain could be the first sign of compartment syndrome. The neurovascular status of the extremity should be assessed. Unrelieved pressure can lead to compromised circulation and avascular necrosis.
- C. The client in a body cast should be turned every 2 hours to promote drying of the cast. To avoid cracking or dealing of the cast, the client is supported with waterproofpillows next to each other without open spaces.
- D. Some serous drainage, which is due to tissue trauma and edema, is expected from pin sites of an external fixator. The pulses obtainable by Doppler are concerning, but the client with unrelenting pain is priority.

1 1 . The nurse assesses that the client has some finger swelling of a newly casted right arm fracture with no other abnormal findings. Which is the nurse's priority action?

- A. Notify the HCP immediately.
- B. Split the cast to prevent constriction.
- C. Elevate the casted arm on pillows.
- D. Document the degree of finger swelling.

ANSWER: C

- A. There is no indication of a complication, so it is unnecessary to notify the HCP.
- B. There is no indication of a complication, so it is unnecessary to cut the cast open.
- C. Swelling is an expected finding; elevating the extremity decreases edema.
- D. Findings should be documented, but this is not the priority action.

1 2. The nurse is reviewing the serum laboratory results of the client with DM prior to surgical removal of pins used to stabilize a compound ankle fracture. Based on the results, which action should the nurse take?

Client's Serum Lab	Client's Value
Creatinine (SCr)	1.1 mg/dL
Potassium	4.1 mEq/L
Glucose	106 mg/dL
WBC	17,900/mm ³
Hgb	14.1 g/dL
Hct	40%

- A. Notify the surgeon because the white blood cell count is elevated.
- B. Notify the anesthesiologist because multiple lab values are abnormal.
- C. Give potassium chloride 10 mEq in 100 ML NaCl per agency protocol.
- D. Continue to prepare the client for the scheduled pin removal surgery.

ANSWER: A

- A. The elevated WBC indicates that the client may have an infection, which increases the risk of developing osteomyelitis. DM and a compound fracture also increase the client's risk for osteomyelitis.
- B. Only the WBC is elevated, not multiple lab values.
- C. Potassium chloride would not be administered when the potassium is WNL of 3.5—5.5 mEq/L.
- D. The nurse should notify the surgeon because surgery may need to be postponed.

1 3. The clinic nurse completed teaching the client with a rotator cuff tear who is being treated conservatively. Which client statement indicates that further teaching is needed?

- A. "I received a corticosteroid injection in my shoulder to reduce the inflammation and pain."

- B. "Now that the pain is controlled, I can do progressive stretching and strengthening exercises."
- C. "I will continue to take ibuprofen for pain control, but I should take it with food."
- D. "I will need an open acromioplasty to repair the torn cuff after the swelling is reduced."

ANSWER: A

- A. The elevated WBC indicates that the client may have an infection, which increases the risk of developing osteomyelitis. DM and a compound fracture also increase the client's risk for osteomyelitis.
- B. Only the WBC is elevated, not multiple lab values.
- C. Potassium chloride would not be administered when the potassium is WNL of 3.5—5.5 mEq/L.
- D. The nurse should notify the surgeon because surgery may need to be postponed.

1 4. The client is admitted to the ED after a sports injury. The client verbalizes extreme shoulder pain, and the nurse sees that the client's right arm is shorter than the left. What should the nurse do initially? Select all that apply.

- A. Lift the right arm to support it with a pillow.
- B. Apply a covered ice pack to the left shoulder.
- C. Prepare the client for immediate surgical repair.
- D. Check the pulses and sensation of the right arm.
- E. Prepare to administer an analgesic as prescribed
- F. Inspect the left shoulder for swelling and bruising.

ANSWER: D, E

- A. Movement should be restricted with a possible shoulder dislocation.
- B. Ice will constrict blood vessels and reduce inflammation. However, the right shoulder and not the left is affected-
- C. Usually the I-ICP can manipulate the shoulder to realign the bones (shoulder reduction) without surgical repair.
- D. Assessment of pulses and sensation is important because compression of nerves and blood vessels can occur with shoulder dislocation. A shortened arm on the right indicates that the right shoulder is affected.
- E. The client is in severe pain and requires pain control.
- F. The affected side is the right shoulder, not the left.

1 5. The nurse is assessing the client diagnosed with a left femoral neck fracture. Which findings should the nurse expect? Select all that apply.

- A. Left leg is in an abducted position.
- B. Left leg is externally rotated.
- C. Left leg is shorter than the right.
- D. Pain is in the lateral left knee.
- E. Pain is in the groin area.

ANSWER: B. C. E

- A. With a left femoral neck fracture, the leg is adducted (not abducted).
- B. With a left femoral neck fracture, the leg is externally rotated.
- C. With a left femoral neck fracture, the leg is shortened.
- D. With a left femoral neck fracture, pain is in the medial (not lateral) side of the knee and hip.
- E. With a left femoral neck fracture, pain is experienced in the groin area.

1 6. The client and spouse were involved in a motorcycle accident in which the spouse was killed. The client, being treated for multiple rib fractures and a broken leg, asks the nurse in which room his wife is located. Which response is most appropriate?

- A. "Unfortunately, your wife is not in the hospital at this time."
- B. "I'm sorry, but your wife did not survive the motorcycle accident."
- C. "Let me get your family so that you can talk to them about your wife."
- D. "The doctor will be talking to you to let you know where she is located."

ANSWER: B

- A. Although telling the client his wife is not in the hospital is correct, it is deceitful, and the client will likely want more information.
- B. Because the nurse-client relationship is built on trust, the nurse should not withhold information from the client. The nurse should disclose that the spouse did not survive and be available for support.
- C. Leaving the client to obtain family does not offer support, is withholding information, and could increase the client's anxiety.
- D. Deferring the explanation to the HCP without providing an answer could increase the client's anxiety.

1 7. The client with Alzheimer's dementia is being admitted to the nursing unit following a hip hemiarthroplasty to treat a hip fracture. Which initial intervention should the nurse plan for the client's pain control?

- A. Apply a fentanyl transdermal patch and replace after 24 hours.
- B. Start morphine sulfate per patient-controlled analgesia (PCA) with a basal rate.
- C. Administer intravenous morphine sulfate based on the client's report of pain.

- D. Administer scheduled doses of morphine sulfate intravenously around the clock.

ANSWER: D

- A. A transdermal analgesic patch such as fentanyl (Duragesic) is used to treat chronic, not acute, pain.
- B. Although a PCA affords the client better control over the pain, the client with dementia would be unable to adequately use a PCA.
- C. The client with dementia typically cannot report the level of pain accurately.
- D. In addition to scheduling pain medication around the clock, supplemental NSAIDs can be given to reduce inflammation and enhance the effects of the analgesic.

1 8. The client with DM is admitted with possible osteomyelitis secondary to an ankle wetmd. The client's ankle is painful, red, swollen, and warm, and the wound is persistently draining. The client's temperature is 102.2°F (39°C). Based on the client's status, which HCP order should the nurse plan to defer until later?

- A. Obtain a culture of the ankle wound.
- B. Administer ceftriaxone 1 g IV q12h.
- C. Apply splint to immobilize the ankle.
- D. Teach on IV antibiotic self-administration.

ANSWER: D

- A. The wound culture should be obtained before antibiotics are started. Ceftriaxone is a third- generation cephalosporin used in treating bone infections.
- B. The order is correct. The usual dose of ceftriaxone (Rocephin) ranges from 1 to 2 g every 12 or 24 hours.
- C. Immobilizing with a splint helps to decrease pain and muscle spasms.
- D. The nurse should defer teaching. Pain and an elevated temperature are barriers to learning.

1 9. The nurse is to administer nafcillin 500 mg intravenously to the client with osteomyelitis. A vial of 1 g of powdered nafcillin is to be reconstituted with 3.4 mL of 0.9% NaCl. How many milliliters should the nurse plan to administer?

_____ mL (Record your answer rounded to the nearest tenth.)

ANSWER: 1.7

Rationale:

$$\frac{500 \text{ mg}}{1,000 \text{ mg}} \times \frac{3.4 \text{ mL}}{1,000 \text{ mg}} = \frac{1,700}{1,000} = 1.7 \text{ mL}$$

The nurse should prepare 1.7 mL nafcillin (Nallpen).

20. The client has Buck's traction to temporarily immobilize a fracture of the proximal femur prior to surgery. Which assessment finding requires the nurse to intervene immediately?

- A. Reddened area at the client's coccygeal area
- B. Voiding concentrated urine at 50 mL per hour
- C. Capillary refill 3 seconds, pedal pulses palpable
- D. Ropes, pulleys intact; 5—1b weight hangs freely

ANSWER: A

- A. A reddened sacrum is the first sign of a pressure ulcer that is caused by pressure or friction and shear. Shear results from the weight of the skin traction pulling the client to the foot of the bed and then sliding back up in bed. Immediate interventions are required before it develops into a stage 1 ulcer.
- B. The 50-mL/hr output is adequate, although the nurse should evaluate the client's amount of intake-
- C. These findings are normal.
- D. Buck's traction is skeletal traction. Traction (usually 5 to 8 lb) is applied either to a boot in which the client's lower extremity is secured or to traction tapes applied to the client's extremity.

21 . The nurse completes teaching the client who has a plaster cast following a right wrist fracture. Which statement, if made by the client, indicates the need for additional teaching?

- A. "I should keep my cast uncovered while drying so that moisture can evaporate."
- B. "My cast initially may smell musty. When dry, it should be odorless and shiny white."
- C. "My cast may feel sticky and very warm initially, but it will dry in about 30 minutes."
- D. "I should avoid sharp or hard surfaces while drying because it causes dents in the cast."

ANSWER: C

- A. The freshly applied plaster cast should be exposed to circulating air and not covered by clothing or bed linens.
- B. A wet plaster cast is musty smelling and dull gray until it dries.

- C. Although the cast will feel very warm for about 15 to 20 minutes, a plaster cast requires 24 to 72 hours (not 30 minutes) to dry completely.
- D. Sharp objects, firm surfaces, and pressure from fingers can dent the cast during drying.

22. The client has been in a body cast for the past 2 days to treat numerous broken vertebrae from a fall. The client is reporting dyspnea, vomiting, epigastric pain, and abdominal distention. Which action demonstrates the nurse's best clinical judgment?

- A. Immediately notify the health care provider.
- B. Initiate oxygen at 2 liters per nasal cannula.
- C. Place ice packs around the outside of the cast.
- D. Administer ondansetron prescribed q6h prn.

ANSWER: A

- A. The nurse should immediately notify the HCP. A window in the abdominal portion of the cast or bivalving is needed to relieve the pressure.
- B. The action of initiating oxygen at 2 liters per nasal cannula to relieve the dyspnea should also be implemented, but option 1 demonstrates the nurse's best clinical judgment of suspecting cast syndrome.
- C. The action of placing ice packs around the cast to reduce the abdominal distention should also be implemented, but option 1 demonstrates the nurse's best clinical judgment of suspecting cast syndrome.
- D. Ondansetron (Zofran) should be given, but option 1 demonstrates the nurse's best clinical judgment of suspecting cast syndrome.

23. The experienced nurse observes the new nurse caring for the client who is in skeletal traction to stabilize a proximal femur fracture prior to surgery. Which observation by the experienced nurse indicates the new nurse needs additional orientation?

- A. Positions the client so the client's feet stay clear of the bottom of the bed
- B. Checks ropes so that they are positioned in the wheel grooves of the pulleys
- C. Removes weights from ropes until the weights hang free of the bed frame
- D. Performs pin site care with chlorhexidine solution once during the 8-hour shift

ANSWER: C

- A. The client's feet need to stay clear of the bottom of the bed for the traction to be effective.
- B. Ropes should be correctly positioned in the pulleys for the traction to be effective.
- C. Weights should be hanging freely, but weights should never be removed (unless a life-threatening situation occurs) because removal could result in

injury and defeats the purpose of the traction. The lengths of the ropes need to be adjusted so the weights do not rest on the bed frame.

- D. Chlorhexidine is recommended by some as the most effective cleansing solution. Water and saline are alternate choices.

24. The client, who is diagnosed with CA, tells the clinic nurse about the inability to ambulate and about staying on bedrest due to hip stiffness. In addition to teaching the client measures to reduce joint stiffness, which referral for the client should the nurse plan to discuss with the IICP?

- A. Psychiatrist
- B. Social worker
- C. Physical therapist
- D. Arthritis Foundation

ANSWER: C

- A. A psychiatrist would assist the client in dealing with the mental health aspects related to the disease, such as ineffective coping, loss, or anger. There is no evidence that the client has mental health issues.
- B. The social worker would address issues such as finances, home assistance, placement, or acquiring assistive devices.
- C. The nurse should plan to discuss a referral to a physical therapist (PT). The PT can assist the client in adopting self-management strategies and teach isometric, postural, and aerobic exercises that prevent joint overuse.
- D. The Arthritis Foundation provides a wealth of information to the client, but a referral is not necessary. The client can initiate the contact.

25. The nurse documents the admission assessment for the client who is to have a left total hip arthroplasty to treat chronic degenerative joint disease. Which statements indicate that the client uses alternative therapies for DA treatment? Select all that apply.

- A. "I take ibuprofen every 4 to 6 hours."
- B. "I wear a copper bracelet all the time."
- C. "I take glucosamine sulfate 1000 mg daily."
- D. "I apply special magnets to the hip joint."
- E. "I sleep on the unaffected hip, turning often."

ANSWER: B, C, D

- A. Taking NSAIDs such as ibuprofen (Advil) is a proven intervention that reduces or minimizes pain; it is not an alternative therapy.
- B. Wearing a copper bracelet is an alternative therapy used by some with GA for pain control and reduction of joint stiffness.
- C. Taking glucosamine sulfate is an alternative therapy used by some with CA. Glucosamine is taken to modify cartilage structure, but studies supporting this have been inconclusive.

- D. Using magnets designed for body application is an alternative therapy used by some with CA for pain control and reduction of joint stiffness.
- E. Sleeping on the unaffected side is a proven intervention that reduces or minimizes pain.

26. The client just underwent a left THR. After a family member assists the client with repositioning in bed, the client states hearing a “pop” and has increased pain at the surgical site. Which is the most appropriate initial action by the nurse?

- A. Check the position of the left lower extremity.
- B. Elevate the head of the client’s bed.
- C. Adjust the pillow used for abduction.
- D. Administer the prescribed pain medication.

ANSWER: A

- A. The nurse’s initial action should be to check the extremity’s position. Improper movement and repositioning can cause prosthesis dislocation; an audible pop and increased pain are signs of possible dislocation.
- B. The nurse should not raise the head of the bed until the cause of the pain is determined.
- C. Adjusting the abduction pillow may increase comfort, but the cause of the pain should be determined first.
- D. The nurse should not medicate for pain before determining the cause of the pain.

27. The nurse is caring for the client 2 days post-right THR in which the traditional posterior approach was used. Which interventions should the nurse implement?

- A. Checks that an elevated toilet seat is in place and assists the client to the bathroom using a walker
- B. Removes the wedge pillow at the client’s request and places pillows to maintain right leg adduction
- C. Reinfuses the 400-mL wound autotransfusion drainage system returns that collected in the past 24 hours
- D. Assists the client to get out of bed on the left side so the client can stand to place and use the urinal

ANSWER: A

- A. The client should be able to ambulate with the use of a walker. An elevated toilet seat is used to prevent hip flexion of greater than 90 degrees when the client sits.
- B. The wedge pillow maintains the client’s legs in abduction; using pillows for adduction could cause dislocation.

- C. Drainage from a wound drain reinfusion system would not be used after 6 hours postoperatively because the drainage would primarily be fluid and debris and not blood. Not every client may have a wound drainage system following a THR.
- D. The best side for the client to get out of bed is the affected side. This allows the client to shift position to the edge of the bed by using the good leg and the trapeze. As the client lowers the affected leg over the edge of the bed, the nurse can assist the client to turn to a sitting position without exceeding the 90-degree hip flexion.

28. The nurse is caring for the client 24 hours following total hip arthroplasty using the traditional posterior approach. Which interventions should the nurse plan to implement? Select all that apply.

- A. Place pillows or a wedge pillow between the client's legs to keep them abducted.
- B. Have the client flex the unaffected hip and use the trapeze to help move up in bed.
- C. Raise the head of the bed to no more than 90 degrees when the bed is placed contour.
- D. Place a pillow between the client's knees when initially assisting the client out of bed.
- E. Applies antiembolism stockings that should not be removed for 24 hours postoperatively.

ANSWER: A, B, D

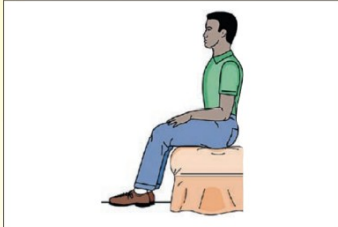
- A. A pillow should be used to maintain abduction to prevent dislocation.
- B. Using the trapeze and flexing the unaffected legs while keeping the affected leg straight help prevent flexion with position changes. The client's hip should not be flexed more than 90 degrees.
- C. Elevating the head of the bed to no more than 90 degrees when the bed is in a contour position will result in a greater than 90-degree hip flexion.
- D. In initial transfers, a pillow is used to remind the client to maintain abduction and prevent internal and external hip rotation.
- E. Antiembolic stockings should be removed twice daily to prevent skin breakdown.

29. The home health nurse is caring for clients who had a THR through the posterior surgical approach 2 weeks ago. It is most important for the nurse to intervene immediately for which client?

1.



2.



3.



4.



ANSWER: A

- A. After a THR, the client should not flex the hip greater than 90 degrees or have adduction of the hip because it can cause hip dislocation. Wearing socks that do not have grippers on the bottom increases the client's risk for a fall.
- B. After a THR the client may sit at 90 degrees.
- C. After a THR the client may lie supine.
- D. After a THR the client may be up. However, this client should be wearing shoes or gripper socks or slippers to prevent a fall. Although the nurse should intervene, it is more important for the nurse to intervene with client 1.

30. The nurse, caring for the client who had bilateral THRs 2 days ago, determines that the client will need a referral to manage exercises and stairs when at home. The nurse should plan to initiate a referral with which interdisciplinary team member?

- A. Occupational therapist
- B. Social worker
- C. Physical therapist
- D. Health care provider

ANSWER: C

- A. The occupational therapist can assist the client with activities of daily living such as bathing, dressing, and meal preparation.
- B. The social worker assists the client with acquiring resources needed for continuation of care.
- C. The physical therapist is the team member with expertise to assist in exercises and ambulating with assistive devices.
- D. The HCP is responsible for the medical management and overall treatment plan for the client.

31 . One month after discharge, the client who had a left THR calls a clinic reporting acute, constant pain in the left groin and hip area and feeling like the left leg is shorter than the right. The nurse advises the client to come to the clinic immediately, suspecting which problem?

- A. An infection of the wound
- B. Deep vein thrombosis (DVT)
- C. Dislocation of the prosthesis
- D. Aseptic loosening of the prosthesis

ANSWER: C

- A. Signs of a wound infection include swelling, purulent drainage, pain, and fever.
- B. Signs of DVT include calf pain and swelling.
- C. Indicators of a prosthesis dislocation include increased surgical site pain, acute groin pain, shortening of the leg, abnormal external or internal rotation, restricted ability or inability to move the leg, and reports of a popping sensation in the hip.
- D. Aseptic loosening of the prosthesis causes pain that diminishes with rest.

32. The nurse is caring for the client after a right TKR. To prevent circulatory complications, the nurse should ensure that the client is performing which action?

- A. Flexing both feet and exercising uninvolved joints every hour while awake
- B. Using the continuous passive motion device (CPM) every 2 hours for 30 minutes
- C. Being assisted up to a chair as soon as the effects of anesthesia have worn off
- D. Using the trapeze to lift off the bed and then rotating each leg intermittently

ANSWER: A

- A. Dorsiflexion of the foot promotes muscle contraction, which compresses veins. This reduces venous stasis and risk of thrombus formation. It should be performed every hour while awake.
- B. The CPM device may or may not be prescribed. If prescribed, it should be on and used most of the time.
- C. The client may be up the evening of surgery or the following day; the client may not be stable immediately after the anesthesia has worn off.
- D. Rotating the right knee could result in dislocation of the knee prosthesis. The knee should be kept in a neutral position.

33. The nurse assesses the client 4 hours following a left TKR. The client has a knee immobilizer in place with medial and lateral packs that are warm- An autotransfusion wound drainage system has 350 mL collected. The client has not voided since before surgery but does not express a need. Which interventions should the nurse plan to implement at this time? Select all that apply.

- A. Reinfuse the salvaged blood from the wound drainage system.
- B. Remove the immobilizer to place the knee in 90-degree flexion.
- C. Stand the client at the bedside to facilitate bladder emptying.
- D. Place the left leg in a continuous passive motion device (CPM).
- E. Replace the warm packs in the knee immobilizer with ice packs.

ANSWER: A, E

- A. An autotransfusion drainage system is used in the immediate postoperative period if extensive bleeding is anticipated. Collected drainage can be reinfused up to 6 hours postoperative.
- B. Flexing the knee to 90° staunches excessive bleeding, but this is not necessary since 350 mL is an acceptable amount.
- C. The client's bladder should first be assessed using a bedside bladder ultrasound device to determine the amount of urine in the bladder.
- D. The client's leg would not begin cycling in the CPM machine until the amount of drainage decreases.
- E. Ice packs, used to reduce swelling and control bleeding, are replaced every 2 hours. If they have warmed, they need to be replaced.

34. The nursing student is caring for the client who had a right TKR 1 day ago. Which action by the student requires the nurse to intervene?

- A. Hands the client the control for the continuous passive motion (CPM) machine
- B. Offers the client an analgesic when pain is rated at 3 on a 0 to 10 scale
- C. Repositions the leg to insert an abductor pillow between the client's legs
- D. Places an ice pack wrapped within a towel on the client's operative knee

ANSWER: C

- A. The client should have the control to the CPM machine to stop the machine when indicated.
- B. Most clients who have had a TKR will have pain. A level of 3 may indicate the need for an analgesic before the pain intensifies.
- C. Attempting to insert an abductor pillow may cause knee misalignment. An abductor pillow may be used for the client following a TIR.
- D. An ice pack is applied to the operative site to decrease swelling.

35. The nurse is assessing the client immediately following a C5—C6 anterior cervical discectomy. Which potential problem should be the nurse's priority?

- A. Altered breathing pattern
- B. Impaired tissue perfusion
- C. Altered mobility
- D. Impaired skin integrity

ANSWER: A

- A. Retractors used during surgery can injure the recurrent laryngeal nerve, resulting in the inability to cough effectively to clear secretions. Edema and bleeding can also compromise the airway and compress the spinal cord.
- B. Bleeding from the surgical incision can place the client at risk for impaired tissue perfusion, but the airway is priority.
- C. After a cervical discectomy, the client should prevent neck flexion, but this is not the priority.
- D. The surgical incision alters skin integrity, but this is not the priority.

36. The HCP prescribes cyclobenzaprine 30 mg orally tid for the client hospitalized with acute cervical neck pain. The pharmacy supplied 10-mg tablets. Which action by the nurse is best?

- A. Administer three 10-mg tablets with food
- B. Call the HCP to question the dose prescribed
- C. Observe for drowsiness after administration
- D. Also give prn prescribed morphine sulfate IV

ANSWER: B

- A. Cyclobenzaprine can be given with food to decrease gastric distress, but 30 mg is too high a dose.
- B. The nurse should call the HCP to question the dose. If carried out as prescribed, the client would receive a total daily dose of 90 mg of cyclobenzaprine (Flexeril). The total daily dose should not exceed 60 mg.
- C. Although drowsiness is a side effect and should be assessed by the nurse, the dose is excessive.

- D. The nurse should consider immediate pain control measures because the onset of action is 1 hour, but the dose of cyclobenzaprine is excessive and should not be given.

37. The college student consults the clinic nurse for advice on managing lower back pain. Which instructions should the nurse include? Select all that apply.

- A. Continue routine activity within your pain tolerance while paying attention to correct posture.
- B. Temporarily avoid lifting and other activities that increase mechanical stress on your spine.
- C. When sleeping on your side, flex your hips and knees and place a pillow between your knees.
- D. Stay at home for 1 week on bedrest to minimize physical activity and straining your back.
- E. Stand intermittently during classes, and sit with a soft support at the small of your back-

ANSWER: A, B, C, E

- A. Remaining active is best. Using good posture will minimize back strain.
- B. Mechanical stress can increase pain. Prolonged unsupported sitting, heavy lifting, and bending or twisting the back, especially while lifting, should be avoided.
- C. Using pillows and hip and knee flexion promotes lumbar flexion and back alignment.
- D. Prolonged bedrest is not recommended because it contributes to deconditioning.
- E. Prolonged sitting should be avoided because fatigue contributes to spasm of the back muscles. Lordosis can be decreased by using a soft support at the small of the back.

38. The nurse assesses the client 6 hours following a lumbar spinal fusion. The client has a throbbing headache, but VS and CMS of the lower extremities are WNL. The lungs have fine basilar crackles. The back dressing has a dime-sized bloody spot surrounded by clear yellow drainage. Which nursing action demonstrates the nurse's best clinical judgment?

- A. Give prescribed morphine sulfate IV
- B. Have the client cough and deep breathe
- C. Reinforce the incisional dressing
- D. Notify the health care provider

ANSWER: D

- A. The nurse should administer morphine sulfate because the client has pain, but this does not demonstrate the nurse's best clinical judgment.

- B. Encouraging coughing and deep breathing is correct because the client has crackles, but this does not demonstrate the nurse's best clinical judgment.
- C. Reinforcing the incisional dressing is correct because there is drainage, but this does not demonstrate the nurse's best clinical judgment.
- D. A bloody area surrounded by clear yellowish fluid on the dressing and the client's headache suggest a CSF leak. The nurse should notify the HCP.

39. The nurse is caring for the client who had a surgical repair of a right Dupuytren's contracture. Which intervention should the nurse plan?

- A. Elevate the right lower extremity above the level of the heart
- B. Assist the client with bathing, dressing, grooming, and toileting
- C. Instruct about wearing low-heeled and properly fitting shoes
- D. Frequently rewrap the elastic bandage on the right extremity

ANSWER: B

- A. Dupuytren's contracture involves the palm and fingers, not the lower extremity.
- B. Independent self-care is impaired for a few days after surgery because the hand is bandaged. The nurse should plan that the client receive assistance with personal care and ADLS.
- C. Dupuytren's contracture involves the palm and fingers, not the foot.
- D. The elastic bandage should be kept clean and dry and removed only by the surgeon.

40. The nurse is teaching the client with carpal tunnel syndrome how best to utilize a wrist splint. Which statement is most appropriate for the nurse to include in the teaching?

- A. Leave the splint in place even when bathing-
- B. Wear the splint as tight as can be tolerated.
- C. Remove the splint intermittently throughout the day.
- D. Only wear the splint when doing work that stresses the fingers.

ANSWER: C

- A. The splint should be removed for bathing and intermittently during the day to exercise the wrist.
- B. The splint should not be overly tight, as it can impair circulation to the hand.
- C. Although the splint decreases swelling and promotes healing and is necessary in the management of the pain with carpal tunnel syndrome, it should be removed intermittently during the day to exercise the wrist and bathe.
- D. The splint is used to protect the wrist and not the fingers.

41 . The client is to be discharged after receiving treatment for right shoulder tendonitis. Which actions indicate to the nurse that the client is ready for discharge? Select all that apply.

- A. Verbalizes about resuming normal activities within a day or two
- B. Demonstrates proper use of an arm sling and the need to wear it during sleep
- C. Verbalizes to keep the arm extended and flat on the mattress when lying in bed
- D. Demonstrates how to properly apply the ice packs on the shoulder joint
- E. States will take ibuprofen every four to six hours as needed for pain

ANSWER: B, D, E

- A. With tendonitis, the joint should be rested until inflammation and pain have decreased.
- B. An arm sling helps to rest the joint and keep it stabilized, especially during sleep.
- C. The affected joint in tendonitis should be elevated as often as possible to promote a decrease in inflammation; lying with the head and arm elevated (not flat) would decrease inflammation.
- D. Ice application reduces joint inflammation and pain associated with tendonitis.
- E. NSAIDs such as ibuprofen (Motrin) are effective for controlling pain and reducing inflammation with tendonitis.

42. The nurse is assessing the client 3 months following a left shoulder arthroplasty. Which assessment findings should prompt the nurse to consider that the client may have developed osteomyelitis? Select all that apply.

- A. Sudden onset of chills
- B. Temperature 103°F (39.4°C)
- C. Sudden onset of bradycardia
- D. Pulsating shoulder pain that is worsening
- E. Painful, swollen area on the left shoulder

ANSWER: A, B, D, E

- A. A sudden onset of chills suggests the infection of osteomyelitis is blood-borne.
- B. A high fever suggests the infection of osteomyelitis is blood-borne.
- C. Tachycardia, not bradycardia, would be present from the pain associated with osteomyelitis.
- D. The pulsating shoulder pain is caused from the pressure of the collecting pus.
- E. The infected area becomes swollen, painful, and extremely tender.

43- The Muslim client practicing Islam is hospitalized following surgical repair of a hip fracture. The client informs the nurse about wishing to observe Ramadan, which is occurring now. Which statement by the nurse is respectful of the client's faith beliefs?

- A. "I'm going to uncover your hip and leg now to check the incision and your pulses."
- B. "A dietitian helps to plan your meals so that meat and dairy products are not together."
- C. "I've asked that physical therapy be postponed until around 3 p.m., when Ramadan ends."
- D. "I should let the care team know not to bring food or beverages from sunrise to sunset."

ANSWER: D

- A. Muslim men and women are reluctant to expose their bodies. The nurse should first request permission before uncovering any part of the body.
- B. Members of the Jewish faith (not Islam) may follow a kosher diet of not having meat and dairy products at the same meal.
- C. Fasting occurs from sunrise to sunset during the month of Ramadan, and the client's fall risk increases if fasting, so delaying physical therapy is appropriate. However, Ramadan ends at sundown, not a specific time.
- D. During the month of Ramadan, those of the Islamic faith do not eat or drink from sunrise to sunset.

44. The nurse notes during an annual health screening for the 78-year-old client that the client is 1.5 inches shorter than at last year's visit. Which initial screening might the nurse best anticipate for this client?

- A. Bone mineral density (BMD) test
- B. An x-ray of both hips and spine
- C. A bone scan of the hips and spine
- D. A physical check for scoliosis

ANSWER: A

- A. BMD testing will best determine if the loss of height is due to osteoporosis, a common finding with aging.
- B. A hip x-ray is a diagnostic test and can help determine if there is a possible hip or spinal fracture as the cause of the loss of the client's stature. It is not a screening test.
- C. A bone scan is not indicated for identifying osteoporosis.
- D. Scoliosis is not the deformity noted in osteoporosis; it is kyphosis.

45. The nurse is analyzing the serum laboratory report for the client diagnosed with lung cancer that has metastasized to the pelvic bone. Which specific finding should the nurse anticipate?

- A. Elevated calcium
- B. Decreased hemoglobin
- C. Elevated creatinine (SCr)
- D. Elevated creatine kinase (CK)

ANSWER: A

- A. Malignant tumors cause hypercalcemia through a variety of mechanisms, one being an increased release of calcium from the bones.
- B. Although a low Hgb may exist in the client with lung cancer, this is less specific than an elevated serum calcium level from bone metastasis.
- C. An elevated SCr is seen with renal disease.
- D. An elevated CK would be seen with muscle damage.

46. When reviewing the chart of a 25 -year-old male, the nurse reads that the client was diagnosed with an osteosarcoma of the distal femur. Which statement indicates the nurse's correct interpretation of the client's diagnosis?

- A. The tumor originated elsewhere in the client's body and metastasized to the bone.
- B. Osteosarcoma is the most common and most often fatal primary malignant bone tumor.
- C. The only treatment for osteosarcoma is a leg amputation well above the tumor growth.
- D. The tumor is nonmalignant; it can be excised and the bone replaced with a bone graft.

ANSWER: B

- A. Osteosarcoma is a primary malignant tumor; it does not originate elsewhere in the client's body.
- B. Osteosarcoma is a malignant primary tumor of the bone, appearing most frequently in males between 10 and 25 years (when bones grow rapidly). Prognosis depends on whether the tumor has metastasized to the lungs, but it is often fatal.
- C. Treatment includes combined chemotherapy that is started before and continued after surgery.
- D. Osteosarcoma is a primary malignant tumor.

47. The 75-year-old client continues to experience phantom limb pain following an AKA, despite being given the prescribed morphine sulfate and using distraction. Which interventions, if prescribed by the HCP, should the nurse plan to implement? Select all that apply.

- A. Apply lidocaine patch 5% to the residual limb
- B. Start transcutaneous electrical nerve stimulation (TENS)
- C. Give atenolol 12-5 mg orally twice daily with food
- D. Give oxcarbazepine 300 mg orally twice daily
- E. Limit the client's activity until the sensations resolve

ANSWER: A, B, C, D

- A. A local anesthetic provides pain relief for some with phantom limb pain.
- B. A TENS unit sends stimulating pulses across the skin surface and along the nerve to help prevent pain signals from reaching the brain.
- C. Beta blockers such as atenolol (Tenormin) may relieve (lull, burning discomfort).
- D. Antiseizure medication such as oxcarbazepine (Trileptal) has been shown to control stabbing and cramping pain.
- E. Increasing, not decreasing, the client's activity helps to reduce the occurrence of phantom limb pain.

48. The client with a lower leg amputation has edema, so the NA elevates the client's residual left limb on pillows. What is the most appropriate action by the nurse when observing that the client's leg has been elevated?

- A. Thank the nursing assistant (NA) for being so observant and intervening appropriately to treat the client's edema of the residual limb.
- B. Remove the pillows, raise the foot of the bed, and inform the NA that the limb should not be elevated on pillows because it could cause a flexion contracture.
- C. Inform the NA that this was the correct action at this time in the client's recovery, but once the client's incision heals, the leg should not be elevated-
- D. Report the incident to the surgeon and tell the NA to complete a variance report because the client's leg should not have been elevated.

ANSWER: B

- A. Thanking the NA for being so observant and intervening appropriately is inappropriate since the action was incorrect.
- B. The nurse should perform this action. Flexion, abduction, and external rotation of the residual lower limb are avoided to prevent hip contracture.
- C. The NA should not have elevated the client's residual limb at this time in the client's recovery.

- D. It is unnecessary for the nurse to report the incident to the surgeon and to complete a variance report unless the client was in the position for an extended period of time.

49. The nurse starting the shift is determining priorities for the day. Prioritize the order that the nurse should plan to assess the four clients-

- A. Client who had a left BKA and has left foot pain of 6 on a 0 to 10 scale
- B. Client who has a right lower leg cast whose right foot is cold to the touch
- C. Client who had a THR and 200-mL wound drain output during the past 8 hours
- D. Client who had a spinal fusion and has not voided since the urinary catheter removal 4 hours ago

ANSWER: B, A, D, C

B. The client who has a right lower leg cast whose right foot is cold to the touch should be assessed first. The data could indicate compartment syndrome, which is an emergent condition.

A. The client who had a left BKA and has left foot pain of 6 on a 0 to 10 scale should be assessed second because pain is a priority in a postoperative client and should be addressed in a timely manner, but this is not an emergent situation.

D. The client who had a spinal fusion and has not voided since the urinary catheter removal 4 hours ago should be assessed third for the presence of urinary retention. Usually the client should void within 6 hours after a urinary catheter has been removed.

C. The client who had a THR and 200-mL wound drain output during the past 8 hours should be assessed last. This amount of output is a common finding following a THR due to the vascular nature of the operative site.

50. While caring for multiple clients, the nurse delegates client skin care to the UAP on a musculoskeletal unit. Which client is most appropriate for the nurse to delegate skin care to the UAP?

- A. The client with osteomyelitis of the tibia who needs a wound dressing change
- B. The client with an inoperable hip fracture who is in Buck's traction
- C. The client with a pelvic fracture who is in skeletal traction
- D. The client with a femur fracture who has an external fixator in place

ANSWER: B

- A. Osteomyelitis is a bone infection that requires specific wound care and careful assessment. This skin care would not be appropriate to delegate.

- B. Buck's traction is skin traction. Because there is no open site that needs care with this type of traction, it would be appropriate to delegate skin care.
- C. Skeletal traction has pins that enter the skin. The nurse should perform the pin site care and carefully assess the pin sites for infection.
- D. An external fixator has pin sites that need to be cleaned and carefully assessed. This type of skin care would not be appropriate to delegate.