

NCLEX

Exam Questions NCLEX-RN

National Council Licensure Examination(NCLEX-RN)



NEW QUESTION 1

- (Topic 1)

A laboratory technique specific for diagnosing Lyme disease is:

- A. Polymerase chain reaction
- B. Heterophil antibody test
- C. Decreased serum calcium level
- D. Increased serum potassium level

Answer: A

Explanation:

(A) Polymerase chain reaction is the laboratory technique specific for Lyme disease. (B) Heterophil antibody test is used to diagnose mononucleosis. (C) Lyme disease does not decrease the serum calcium level. (D) Lyme disease does not increase the serum potassium level.

NEW QUESTION 2

- (Topic 1)

A client with bipolar disorder taking lithium tells the nurse that he has ringing in his ears, blurred vision, and diarrhea. The nurse notices a slight tremor in his left hand and a slurring pattern to his speech. Which of the following actions by the nurse is appropriate?

- A. Administer a stat dose of lithium as necessary.
- B. Recognize this as an expected response to lithium.
- C. Request an order for a stat blood lithium level.
- D. Give an oral dose of lithium antidote.

Answer: C

Explanation:

(A) These symptoms are indicative of lithium toxicity. A stat dose of lithium could be fatal.

(B) These are toxic effects of lithium therapy. (C) The client is exhibiting symptoms of lithium toxicity, which may be validated by lab studies. (D) There is no known lithium antidote.

NEW QUESTION 3

- (Topic 1)

Provide the 1-minute Apgar score for an infant born with the following findings: Heart rate: Above 100 Respiratory effort: Slow, irregular Muscle tone: Some flexion of extremities Reflex irritability: Vigorous cry Color: Body pink, blue extremities

- A. 7
- B. 10
- C. 8
- D. 9

Answer: A

Explanation:

(A) Seven out of a possible perfect score of 10 is correct. Two points are given for heart rate above 100; 1 point is given for slow, irregular respiratory effort; 1 point is given for some flexion of extremities in assessing muscle tone; 2 points are given for vigorous cry in assessing reflex irritability; 1 point is assessed for color when the body is pink with blue extremities (acrocyanosis). (B) For a perfect Apgar score of 10, the infant would have a heart rate over 100 but would also have a good cry, active motion, and be completely pink.

(C) For an Apgar score of 8 the respiratory rate, muscle tone, or color would need to fall into the 2-point rather than the 1-point category. (D) For this infant to receive an Apgar score of 9, four of the areas evaluated would need ratings of 2 points and one area, a rating of 1 point.

NEW QUESTION 4

- (Topic 1)

The initial treatment for a client with a liquid chemical burn injury is to:

- A. Irrigate the area with neutralizing solutions
- B. Flush the exposed area with large amounts of water
- C. Inject calcium chloride into the burned area
- D. Apply lanolin ointment to the area

Answer: B

Explanation:

(A) In the past, neutralizing solutions were recommended, but presently there is concern that these solutions extend the depth of burn area. (B) The use of large amounts of water to flush the area is recommended for chemical burns. (C) Calcium chloride is not recommended therapy and would likely worsen the problem. (D) Lanolin is of no benefit in the initial treatment of a chemical injury and may actually extend a thermal injury.

NEW QUESTION 5

- (Topic 1)

A child is admitted to the emergency room with her mother. Her mother states that she has been exposed to chickenpox. During the assessment, the nurse would note a characteristic rash:

- A. That is covered with vesicular scabs all in the macular stage
- B. That appears profusely on the trunk and sparsely on the extremities
- C. That first appears on the neck and spreads downward
- D. That appears especially on the cheeks, which gives a "slapped-cheek" appearance

Answer: B

Explanation:

- (A) A rash with vesicular scabs in all stages (macule, papule, vesicle, and crusts). (B) A rash that appears profusely on the trunk and sparsely on the extremities. (C) A rash that first appears on the neck and spreads downward is characteristic of rubeola and rubella. (D) A rash, especially on the cheeks, that gives a "slapped-cheek" appearance is characteristic of roseola.

NEW QUESTION 6

- (Topic 1)

The following medications were noted on review of the client's home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

- A. KCl
- B. Thyroid agents
- C. Quinidine
- D. Theophylline

Answer: C

Explanation:

- (A) Hypokalemia can cause digoxin toxicity. Administration of KCl would prevent this. (B) Thyroid agents decrease digoxin levels. (C) Quinidine increases digoxin levels dramatically. (D) Theophylline is not noted to have an effect on digoxin levels.

NEW QUESTION 7

- (Topic 1)

A pregnant woman at 36 weeks' gestation is followed for PIH and develops proteinuria. To increase protein in her diet, which of the following foods will provide the greatest amount of protein when added to her intake of 100 mL of milk?

- A. Fifty milliliters light cream and 2 tbsp corn syrup
- B. Thirty grams powdered skim milk and 1 egg
- C. One small scoop (90 g) vanilla ice cream and 1 tbsp chocolate syrup
- D. One package vitamin-fortified gelatin drink

Answer: B

Explanation:

- (A) This choice would provide more unwanted fat and sugar than protein. (B) Skim milk would add protein. Eggs are good sources of protein while low in fat and calories. (C) The benefit of protein from ice cream would be outweighed by the fat content. Chocolate syrup has caffeine, which is contraindicated or limited in pregnancy. (D) Although most animal proteins are higher in protein than plant proteins, gelatin is not. It loses protein during the processing for food consumption.

NEW QUESTION 8

- (Topic 1)

Hypoxia is the primary problem related to near-drowning victims. The first organ that sustains irreversible damage after submersion in water is the:

- A. Kidney (urinary system)
- B. Brain (nervous system)
- C. Heart (circulatory system)
- D. Lungs (respiratory system)

Answer: B

Explanation:

- (A) The kidney can survive after 30 minutes of water submersion. (B) The cerebral neurons sustain irreversible damage after 4–6 minutes of water submersion. (C) The heart can survive up to 30 minutes of water submersion. (D) The lungs can survive up to 30 minutes of water submersion.

NEW QUESTION 9

- (Topic 1)

The physician orders fluoxetine (Prozac) for a depressed client. Which of the following should the nurse remember about fluoxetine?

- A. Because fluoxetine is a tricyclic antidepressant, it may precipitate a hypertensive crisis.
- B. The therapeutic effect of the drug occurs 2–4 weeks after treatment is begun.
- C. Foods such as aged cheese, yogurt, soy sauce, and bananas should not be eaten with this drug.
- D. Fluoxetine may be administered safely in combination with monoamine oxidase (MAO) inhibitors.

Answer: B

Explanation:

- (A) Fluoxetine is not a tricyclic antidepressant. It is an atypical antidepressant. (B) This statement is true. (C) These foods are high in tyramine and should be avoided when the client is taking MAO inhibitors. Fluoxetine is not an MAO inhibitor. (D) Fatal reactions have been reported in clients receiving fluoxetine in combination with MAO inhibitors.

NEW QUESTION 10

- (Topic 1)

A six-month-old infant has been admitted to the emergency room with febrile seizures. In the teaching of the parents, the nurse states that:

- A. Sustained temperature elevation over 103F is generally related to febrile seizures
- B. Febrile seizures do not usually recur

- C. There is little risk of neurological deficit and mental retardation as sequelae to febrile seizures
- D. Febrile seizures are associated with diseases of the central nervous system

Answer: C

Explanation:

(A) The temperature elevation related to febrile seizures generally exceeds 101F, and seizures occur during the temperature rise rather than after a prolonged elevation. (B) Febrile seizures may recur and are more likely to do so when the first seizure occurs in the 1st year of life. (C) There is little risk of neurological deficit, mental retardation, or altered behavior secondary to febrile seizures. (D) Febrile seizures are associated with disease of the central nervous system.

NEW QUESTION 10

- (Topic 1)

A 30-year-old male client is admitted to the psychiatric unit with a diagnosis of bipolar disorder. For the last 2 months, his family describes him as being ??on the move,?? sleeping 3–4 hours nightly, spending lots of money, and losing approximately 10 lb. During the initial assessment with the client, the nurse would expect him to exhibit which of the following?

- A. Short, polite responses to interview questions
- B. Introspection related to his present situation
- C. Exaggerated self-importance
- D. Feelings of helplessness and hopelessness

Answer: C

Explanation:

(A) During the manic phase of bipolar disorder, clients have short attention spans and may be abusive toward authority figures. (B) Introspection requires focusing and concentration; clients with mania experience flight of ideas, which prevents concentration.

(C) Grandiosity and an inflated sense of self-worth are characteristic of this disorder. (D) Feelings of helplessness and hopelessness are symptoms of the depressive stage of bipolar disorder.

NEW QUESTION 15

- (Topic 1)

Hematotympanum and otorrhea are associated with which of the following head injuries?

- A. Basilar skull fracture
- B. Subdural hematoma
- C. Epidural hematoma
- D. Frontal lobe fracture

Answer: A

Explanation:

(A) Basilar skull fractures are fractures of the base of the skull. Blood behind the eardrum or blood or cerebrospinal fluid (CSF) leaking from the ear are indicative of a dural laceration. Basilar skull fractures are the only type with these symptoms. (B, C, D) These do not typically cause dural lacerations and CSF leakage.

NEW QUESTION 19

- (Topic 1)

Which of the following nursing orders should be included in the plan of care for a client with hepatitis C?

- A. The nurse should use universal precautions when obtaining blood samples.
- B. Total bed rest should be maintained until the client is asymptomatic.
- C. The client should be instructed to maintain a low semi-Fowler position when eating meals.
- D. The nurse should administer an alcohol backrub at bedtime.

Answer: A

Explanation:

(A) The source of infection with hepatitis C is contaminated blood products. (B) Modified bed rest should be maintained while the client is symptomatic. Routine activities can be slowly resumed once the client is asymptomatic. (C) Nausea and vomiting occur frequently with hepatitis C. A high Fowler position may decrease the tendency to vomit. (D) The buildup of bilirubin in the client??s skin may cause pruritus. Alcohol is a drying agent.

NEW QUESTION 21

- (Topic 1)

A child sustains a supracondylar fracture of the femur. When assessing for vascular injury, the nurse should be alert for the signs of ischemia, which include:

- A. Bleeding, bruising, and hemorrhage
- B. Increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase
- C. Pain, pallor, pulselessness, paresthesia, and paralysis
- D. Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus

Answer: C

Explanation:

(A) Bleeding, bruising, and hemorrhage may occur due to injury but are not classic signs of ischemia. (B) An increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase is related to the disruption of muscle integrity. (C) Classic signs of ischemia related to vascular injury secondary to long bone fractures include the five ??P??s??: pain, pallor, pulselessness, paresthesia, and paralysis. (D) Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus are common clinical manifestations of a fracture but not ischemia.

NEW QUESTION 26

- (Topic 1)

When administering phenytoin (Dilantin) to a child, the nurse should be aware that a toxic effect of phenytoin therapy is:

- A. Stevens-Johnson syndrome
- B. Folate deficiency
- C. Leukopenic aplastic anemia
- D. Granulocytosis and nephrosis

Answer: A

Explanation:

(A) Stevens-Johnson syndrome is a toxic effect of phenytoin. (B) Folate deficiency is a side effect of phenytoin, but not a toxic effect. (C) Leukopenic aplastic anemia is a toxic effect of carbamazepine (Tegretol). (D) Granulocytosis and nephrosis are toxic effects of trimethadione (Tridione).

NEW QUESTION 30

- (Topic 1)

As the nurse assesses a male adolescent with chlamydia, the nurse determines that a sign of chlamydia is:

- A. Enlarged penis
- B. Secondary lymphadenitis
- C. Epididymitis
- D. Hepatomegaly

Answer: C

Explanation:

(A) An enlarged penis is not a sign of chlamydia. (B) Secondary lymphadenitis is a complication of lymphogranuloma venereum. (C) Untreated chlamydial infection can spread from the urethra, causing epididymitis, which presents as a tender, scrotal swelling. (D) Hepatomegaly is not a complication.

NEW QUESTION 34

- (Topic 1)

Which of the following ECG changes would be seen as a positive myocardial stress test response?

- A. Hyperacute T wave
- B. Prolongation of the PR interval
- C. ST-segment depression
- D. Pathological Q wave

Answer: C

Explanation:

(A) Hyperacute T waves occur with hyperkalemia. (B) Prolongation of the P R interval occurs with first-degree AV block. (C) Horizontal ST-segment depression of >1 mm during exercise is definitely a positive criterion on the exercise ECG test. (D) Pathological Q waves occur with MI.

NEW QUESTION 38

- (Topic 1)

Dietary planning is an essential part of the diabetic client's regimen. The American Diabetes Association recommends which of the following caloric guidelines for daily meal planning?

- A. 50% complex carbohydrate, 20%–25% protein, 20%–25% fat
- B. 45% complex carbohydrate, 25%–30% protein, 30%–35% fat
- C. 70% complex carbohydrate, 20%–30% protein, 10%–20% fat
- D. 60% complex carbohydrate, 12%–15% protein, 20%–25% fat

Answer: D

Explanation:

(A) The percentage of carbohydrates is too low to maintain blood sugar levels. The percent range of protein is too high and may cause extra workload on the kidney as it is metabolized. (B) The percentage of carbohydrates is too low to maintain blood sugar levels. The percent range of protein is too high and may cause extra workload on the kidney. (C) The percentage of carbohydrates is too high; the percent range of protein is too high, and of fat, too low. (D) This combination provides enough carbohydrates to maintain blood glucose levels, enough protein to maintain body repair, and enough fat to ensure palatability.

NEW QUESTION 39

- (Topic 1)

A client confides to the nurse that he tasted poison in his evening meal. This would be an example of what type of hallucination?

- A. Auditory
- B. Gustatory
- C. Olfactory
- D. Visceral

Answer: B

Explanation:

(A) Auditory hallucinations involve sensory perceptions of hearing. (B) Gustatory hallucinations involve sensory perceptions of taste. (C) Olfactory hallucinations involve sensory perceptions of smell. (D) Visceral hallucinations involve sensory perceptions of sensation.

NEW QUESTION 44

- (Topic 1)

A psychotic client who believes that he is God and rules all the universe is experiencing which type of delusion?

- A. Somatic
- B. Grandiose
- C. Persecutory
- D. Nihilistic

Answer: B

Explanation:

(A) These delusions are related to the belief that an individual has an incurable illness. (B) These delusions are related to feelings of self-importance and uniqueness. (C) These delusions are related to feelings of being conspired against. (D) These delusions are related to denial of self-existence.

NEW QUESTION 46

- (Topic 1)

When teaching a mother of a 4-month-old with diarrhea about the importance of preventing dehydration, the nurse would inform the mother about the importance of feeding her child:

- A. Fruit juices
- B. Diluted carbonated drinks
- C. Soy-based, lactose-free formula
- D. Regular formulas mixed with electrolyte solutions

Answer: C

Explanation:

(A) Diluted fruit juices are not recommended for rehydration because they tend to aggravate the diarrhea. (B) Diluted soft drinks have a high-carbohydrate content, which aggravates the diarrhea. (C) Soy-based, lactose-free formula reduces stool output and duration of diarrhea in most infants. (D) Regular formulas contain lactose, which can increase diarrhea.

NEW QUESTION 49

- (Topic 1)

Pregnant women with diabetes often have problems related to the effectiveness of insulin in controlling their glucose levels during their second half of pregnancy. The nurse teaches the client that this is due to:

- A. Decreased glomerular filtration and increased tubular absorption
- B. Decreased estrogen levels
- C. Decreased progesterone levels
- D. Increased human placental lactogen levels

Answer: D

Explanation:

(A) There is a rise in glomerular filtration rate in the kidneys in conjunction with decreased tubular glucose reabsorption, resulting in glycosuria. (B) Insulin is inhibited by increased levels of estrogen. (C) Insulin is inhibited by increased levels of progesterone. (D) Human placental lactogen levels increase later in pregnancy. This hormonal antagonist reduces insulin's effectiveness, stimulates lipolysis, and increases the circulation of free fatty acids.

NEW QUESTION 52

- (Topic 1)

After 3 weeks of treatment, a severely depressed client suddenly begins to feel better and starts interacting appropriately with other clients and staff. The nurse knows that this client has an increased risk for:

- A. Suicide
- B. Exacerbation of depressive symptoms
- C. Violence toward others
- D. Psychotic behavior

Answer: A

Explanation:

(A) When the severely depressed client suddenly begins to feel better, it often indicates that the client has made the decision to kill himself or herself and has developed a plan to do so. (B) Improvement in behavior is not indicative of an exacerbation of depressive symptoms. (C) The depressed client has a tendency for self-violence, not violence toward others. (D) Depressive behavior is not always accompanied by psychotic behavior.

NEW QUESTION 54

- (Topic 1)

When a client is receiving vasoactive therapy IV, such as dopamine (Intropin), and extravasation occurs, the nurse should be prepared to administer which of the following medications directly into the site?

- A. Phentolamine (Regitine)
- B. Epinephrine
- C. Phenylephrine (Neo-Synephrine)
- D. Sodium bicarbonate

Answer: A

Explanation:

(A) Phentolamine is given to counteract the-adrenergic effects that cause ischemia and necrosis of local tissue. (B) Epinephrine is an endogenous catecholamine that produces vasoconstriction and increases heart rate and contractility. (C) Phenylephrine causes constriction of arterioles of skin, mucous membranes, and viscera, which in turn can cause ischemia and necrosis. (D) Sodium bicarbonate is an alkalinizing agent that is incompatible with dopamine.

NEW QUESTION 57

- (Topic 1)

The usual treatment for diabetes insipidus is with IM or SC injection of vasopressin tannate in oil. Nursing care related to the client receiving IM vasopressin tannate would include:

- A. Weigh once a week and report to the physician any weight gain of 10 lb.
- B. Limit fluid intake to 500 mL/day.
- C. Store the medication in a refrigerator and allow to stand at room temperature for 30 minutes prior to administration.
- D. Hold the vial under warm water for 10–15 minutes and shake vigorously before drawing medication into the syringe.

Answer: D

Explanation:

(A) Weight should be obtained daily. (B) Fluid is not restricted but is given according to urine output. (C) The medication does not have to be stored in a refrigerator. (D) Holding the vial under warm water for 10–15 minutes or rolling between your hands and shaking vigorously before drawing medication into the syringe activates the medication in the oil solution.

NEW QUESTION 60

- (Topic 1)

A 55-year-old man is admitted to the hospital with complaints of fatigue, jaundice, anorexia, and clay-colored stools. His admitting diagnosis is ??rule out hepatitis.?? Laboratory studies reveal elevated liver enzymes and bilirubin. In obtaining his health history, the nurse should assess his potential for exposure to hepatitis.

Which of the following represents a high-risk group for contracting this disease?

- A. Heterosexual males
- B. Oncology nurses
- C. American Indians
- D. Jehovah??s Witnesses

Answer: B

Explanation:

(A) Homosexual males, not heterosexual males, are at high risk for contracting hepatitis.

(B) Oncology nurses are employed in high-risk areas and perform invasive procedures that expose them to potential sources of infection. (C) The literature does not support the idea that any ethnic groups are at higher risk. (D) There is no evidence that any religious groups are at higher risk.

NEW QUESTION 62

- (Topic 1)

The primary reason for sending a burn client home with a pressure garment, such as a Jobst garment, is that the garment:

- A. Decreases hypertrophic scar formation
- B. Assists with ambulation
- C. Covers burn scars and decreases the psychological impact during recovery
- D. Increases venous return and cardiac output by normalizing fluid status

Answer: A

Explanation:

(A) Tubular support, such as that received with a Jobst garment, applies tension of 10–20 mm Hg. This amount of uniform pressure is necessary to prevent or reduce hypertrophic scarring. Clients typically wear a pressure garment for 6–12 months during the recovery phase of their care. (B) Pressure garments have no ambulatory assistive properties. (C) Pressure garments can worsen the psychological impact of burn injury, especially if worn on the face. (D) Pressure garments do not normalize fluid status.

NEW QUESTION 65

- (Topic 1)

Clinical manifestations seen in left-sided rather than in right-sided heart failure are:

- A. Elevated central venous pressure and peripheral edema
- B. Dyspnea and jaundice
- C. Hypotension and hepatomegaly
- D. Decreased peripheral perfusion and rales

Answer: D

Explanation:

(A, B, C) Clinical manifestations of right-sided heart failure are weakness, peripheral edema, jugular venous distention, hepatomegaly, jaundice, and elevated central venous pressure. (D) Clinical manifestations of left-sided heart failure are left ventricular dysfunction, decreased cardiac output, hypotension, and the backward failure as a result of increased left atrium and pulmonary artery pressures, pulmonary edema, and rales.

NEW QUESTION 70

- (Topic 1)

Assessment of the client with pericarditis may reveal which of the following?

- A. Ventricular gallop and substernal chest pain
- B. Narrowed pulse pressure and shortness of breath
- C. Pericardial friction rub and pain on deep inspiration
- D. Pericardial tamponade and widened pulse pressure

Answer: C

Explanation:

(A) No S3 or S4 are noted with pericarditis. (B) No change in pulse pressure occurs. (C) The symptoms of pericarditis vary with the cause, but they usually include chest pain, dyspnea, tachycardia, rise in temperature, and friction rub caused by fibrin or other deposits. The pain seen with pericarditis typically worsens with deep inspiration. (D) Tamponade is not typically seen early on, and no change in pulse pressure occurs.

NEW QUESTION 73

- (Topic 1)

A male client receives 10 U of regular human insulin SC at 9:00 AM. The nurse would expect peak action from this injection to occur at:

- A. 9:30 AM
- B. 10:30 AM
- C. 12 noon
- D. 4:00 PM

Answer: C

Explanation:

(A) This is too early for peak action to occur. (B) This is too early for peak action to occur. (C) Regular insulin peak action occurs 2–4 hours after administration. (D) This is too late for peak action to occur.

NEW QUESTION 76

- (Topic 1)

The nurse is aware that nutrition is an important aspect of care for a client with hepatitis. Which of the following diets would be most therapeutic?

- A. High protein and low carbohydrate
- B. Low calorie and low protein
- C. High carbohydrate and high calorie
- D. Low carbohydrate and high calorie

Answer: C

Explanation:

(A) Protein increases the workload of the liver. Increased carbohydrates provide needed calories and promote palatability. (B) Dietary intake should be adequate to ensure wound healing. (C) Increased carbohydrates provide needed calories. (D) A high-calorie diet is best obtained from carbohydrates because of their palatability. Fats increase the workload of the liver.

NEW QUESTION 80

- (Topic 1)

The primary reason that an increase in heart rate (100 bpm) detrimental to the client with a myocardial infarction (MI) is that:

- A. Stroke volume and blood pressure will drop proportionately
- B. Systolic ejection time will decrease, thereby decreasing cardiac output
- C. Decreased contractile strength will occur due to decreased filling time
- D. Decreased coronary artery perfusion due to decreased diastolic filling time will occur, which will increase ischemic damage to the myocardium

Answer: D

Explanation:

(A) Decreased stroke volume and blood pressure will occur secondary to decreased diastolic filling. (B) Tachycardia primarily decreases diastole; systolic time changes very little. (C) Contractility decreases owing to the decreased filling time and decreased time for fiber lengthening. (D) Decreased O₂ supply due to decreased time for filling of the coronary arteries increases ischemia and infarct size. Tachycardia primarily robs the heart of diastolic time, which is the primary time for coronary artery filling.

NEW QUESTION 85

- (Topic 1)

When the nurse is evaluating lab data for a client 18–24 hours after a major thermal burn, the expected physiological changes would include which of the following?

- A. Elevated serum sodium
- B. Elevated serum calcium
- C. Elevated serum protein
- D. Elevated hematocrit

Answer: D

Explanation:

(A) Sodium enters the edema fluid in the burned area, lowering the sodium content of the vascular fluid. Hyponatremia may continue for days to several weeks because of sodium loss to edema, sodium shifting into the cells, and later, diuresis. (B) Hypocalcemia occurs because of calcium loss to edema fluid at the burned site (third space fluid). (C) Protein loss occurs at the burn site owing to increased capillary permeability. Serum protein levels remain low until healing occurs. (D) Hematocrit level is elevated owing to hemoconcentration from hypovolemia. Anemia is present in the postburn stage owing to blood loss and hemolysis, but it cannot be assessed until the client is adequately hydrated.

NEW QUESTION 87

- (Topic 1)

The physician has ordered that a daily exercise program be instituted by a client with type I diabetes following his discharge from the hospital. Discharge instructions about exercise should include which of the following?

- A. Exercise should be performed 30 minutes before meals.
- B. A snack may be needed before and/or during exercise.
- C. Hyperglycemia may occur 2–4 hours after exercise.
- D. The blood glucose level should be 100 mg or below before exercise is begun.

Answer: B

Explanation:

(A) Exercise should not be performed before meals because the blood sugar is usually lower just prior to eating; therefore, there is an increased risk for hypoglycemia. (B) Exercise lowers blood sugar levels; therefore, a snack may be needed to maintain the appropriate glucose level. (C) Exercise lowers blood sugar levels. (D) Exercise lowers blood sugar levels. If the blood glucose level is 100 mg or below at the start of exercise, the potential for hypoglycemia is greater.

NEW QUESTION 91

- (Topic 1)

The nurse would need to monitor the serum glucose levels of a client receiving which of the following medications, owing to its effects on glycogenolysis and insulin release?

- A. Norepinephrine (Levophed)
- B. Dobutamine (Dobutrex)
- C. Propranolol (Inderal)
- D. Epinephrine (Adrenalin)

Answer: D

Explanation:

(A) Norepinephrine's side effects are primarily related to safe, effective care environment and include decreased peripheral perfusion and bradycardia. (B) Dobutamine's side effects include increased heart rate and blood pressure, ventricular ectopy, nausea, and headache. (C) Propranolol's side effects include elevated blood urea nitrogen, serum transaminase, alkaline phosphatase, and lactic dehydrogenase. (D) Epinephrine increases serum glucose levels by increasing glycogenolysis and inhibiting insulin release. Prolonged use can elevate serum lactate levels, leading to metabolic acidosis, increased urinary catecholamines, false elevation of blood urea nitrogen, and decreased coagulation time.

NEW QUESTION 94

- (Topic 1)

When a client questions the nurse as to the purpose of exercise electrocardiography (ECG) in the diagnosis of cardiovascular disorders, the nurse's response should be based on the fact that:

- A. The test provides a baseline for further tests
- B. The procedure simulates usual daily activity and myocardial performance
- C. The client can be monitored while cardiac conditioning and heart toning are done
- D. Ischemia can be diagnosed because exercise increases O₂ consumption and demand

Answer: D

Explanation:

(A) The purpose of the study is not to provide a baseline for further tests. (B) The test causes an increase in O₂ demand beyond that required to perform usual daily activities. (C) Monitoring does occur, but the test is not for the purpose of cardiac toning and conditioning. (D) Exercise ECG, or stress testing, is designed to elevate the peripheral and myocardial needs for O₂ to evaluate the ability of the myocardium and coronary arteries to meet the additional demands.

NEW QUESTION 97

- (Topic 1)

The physician recommends immediate hospital admission for a client with PIH. She says to the nurse, "It's not so easy for me to just go right to the hospital like that." After acknowledging her feelings, which of these approaches by the nurse would probably be best?

- A. Stress to the client that her husband would want her to do what is best for her health.
- B. Explore with the client her perceptions of why she is unable to go to the hospital.
- C. Repeat the physician's reasons for advising immediate hospitalization.
- D. Explain to the client that she is ultimately responsible for her own welfare and that of her baby.

Answer: B

Explanation:

(A) This answer does not hold the client accountable for her own health. (B) The nurse should explore potential reasons for the client's anxiety: are there small children at home, is the husband out of town? The nurse should aid the client in seeking support or interventions to decrease the anxiety of hospitalization. (C) Repeating the physician's reason for recommending hospitalization may not aid the client in dealing with her reasons for anxiety. (D) The concern for self and welfare of baby may be secondary to a woman who is in a crisis situation. The nurse should explore the client's potential reasons for anxiety. For example, is there another child in the home who is ill, or is there a husband who is overseas and not able to return on short notice?

NEW QUESTION 99

- (Topic 2)

Prenatal clients are routinely monitored for early signs of pregnancy-induced hypertension (PIH). For the prenatal client, which of the following blood pressure changes from baseline would be most significant for the nurse to report as indicative of PIH?

- A. 136/88 to 144/93
- B. 132/78 to 124/76
- C. 114/70 to 140/88
- D. 140/90 to 148/98

Answer: C

Explanation:

(A) These blood pressure changes reflect only an 8 mm Hg systolic and a 5 mm Hg diastolic increase, which is insufficient for blood pressure changes indicating PIH. (B) These blood pressure changes reflect a decrease in systolic pressure of 8 mm Hg and diastolic pressure of 2 mm Hg; these values are not indicative of blood pressure increases reflecting PIH. (C) The definition of PIH is an increase in systolic blood pressure of 30 mm Hg and/or diastolic blood pressure of 15 mm Hg. These blood pressures reflect a change of 26 mm Hg systolically and 18mm Hg diastolically. (D) These blood pressures reflect a change of only 8 mm Hg systolically and 8 mm Hg diastolically, which is insufficient for blood pressure changes indicating PIH.

NEW QUESTION 102

- (Topic 2)

A client is pregnant with her second child. Her last menstrual period began on January 15. Her expected date of delivery would be:

- A. October 8
- B. October 15
- C. October 22
- D. October 29

Answer: C

Explanation:

(A) Incorrect application of Nägele's rule: correctly subtracted 3 months but subtracted 7 days rather than added. (B) Incorrect application of Nägele's rule: correctly subtracted 3 months but did not add 7 days. (C) Correct application of Nägele's rule: correctly subtracted 3 months and added 7 days. (D) Incorrect application of Nägele's rule: correctly subtracted 3 months but added 14 days instead of 7 days.

NEW QUESTION 107

- (Topic 2)

A 30-year-old client has just been treated in the ER for bruises and abrasions to her face and a broken arm from domestic violence, which has been increasing in frequency and intensity over the last few months. The nurse assesses her as being very anxious, fearful, bewildered, and feeling helpless as she states, "I don't know what to do, I'm afraid to go home." The best response by the nurse to the client would be:

- A. "I wouldn't want to go home either; call a friend who could help you."
- B. "Did you do something that could have made him so angry?"
- C. "Let's talk about people and resources available to you so that you don't have to go home."
- D. "I'll call the police and they will take care of him, and you can go home and get some rest."

Answer: C

Explanation:

(A) A person in crisis needs support, assistance, and direction from a caregiver rather than just an instruction. (B) A battered person may feel guilt and think that they cause the abuser's behavior; however, the abuser has the problem and goes through phases of violence. (C) The nurse should provide support and guidance to the client in crisis by offering alternatives and assist in referrals. (D) Focusing on help from law enforcement may be a very temporary solution, because the victim may be fearful of pressing charges. This answer does not address the crisis of going home.

NEW QUESTION 111

- (Topic 2)

A client is experiencing muscle weakness and lethargy. His serum K⁺ is 3.2. What other symptoms might he exhibit?

- A. Tetany
- B. Dysrhythmias
- C. Numbness of extremities
- D. Headache

Answer: B

Explanation:

(A) Tetany is seen with low calcium. (B) Low potassium causes dysrhythmias because potassium is responsible for cardiac muscle activity. (C) Numbness of extremities is seen with high potassium. (D) Headache is not associated with potassium excess or deficiency.

NEW QUESTION 115

- (Topic 2)

A 4-year-old child is being discharged from the hospital after being treated for severe croup. Which one of the following instructions should the nurse give to the child's mother for the home treatment of croup?

- A. Take him in the bathroom, turn on the hot water, and close the door.
- B. Give him a dose of antihistamine.
- C. Give large amounts of clear liquids if drooling occurs.
- D. Place him near a cool mist vaporizer and encourage crying.

Answer: A

Explanation:

(A) Initial home treatment of croup includes placing the child in an environment of high humidity to liquefy and mobilize secretions. (B) Antihistamines should be avoided because they can cause thickening of secretions. (C) Drooling is a characteristic sign of airway obstruction and the child should be taken directly to the emergency room. (D) Crying increases respiratory distress and hypoxia in the child with croup. The nurse should promote methods that will calm the child.

NEW QUESTION 116

- (Topic 2)

In assisting preconceptual clients, the nurse should teach that the corpus luteum secretes progesterone, which thickens the endometrial lining in which of the phases of the menstrual cycle?

- A. Menstrual phase
- B. Proliferative phase
- C. Secretory phase
- D. Ischemic phase

Answer: C

Explanation:

(A) Menses occurs during the menstrual phase, during which levels of both estrogen and progesterone are decreased. (B) The ovarian hormone responsible for the proliferative phase, during which the uterine endometrium enlarges, is estrogen. (C) The ovarian hormone responsible for the secretory phase is progesterone, which is secreted by the corpus luteum and causes marked swelling in the uterine endometrium. (D) The corpus luteum begins to degenerate in the ischemic phase, causing a fall in both estrogen and progesterone.

NEW QUESTION 117

- (Topic 2)

Iron dextran (Imferon) is a parenteral iron preparation. The nurse should know that it:

- A. Is also called intrinsic factor
- B. Must be given in the abdomen
- C. Requires use of the Z-track method
- D. Should be given SC

Answer: C

Explanation:

(A) Intrinsic factor is needed to absorb vitamin B12. (B) Iron dextran is given parenterally, but Z-track in a large muscle. (C) A Z-track method of injection is required to prevent staining and irritation of the tissue. (D) An SC injection is not deep enough and may cause subcutaneous fat abscess formation.

NEW QUESTION 119

- (Topic 2)

A pregnant client comes to the office for her first prenatal examination at 10 weeks. She has been pregnant twice before; the first delivery produced a viable baby girl at 39 weeks 3 years ago; the second pregnancy produced a viable baby boy at 36 weeks 2 years ago. Both children are living and well. Using the GTPAL system to record her obstetrical history, the nurse should record:

- A. 3-2-0-0-2
- B. 2-2-0-2-2
- C. 3-1-1-0-2
- D. 2-1-1-0-2

Answer: C

Explanation:

(A) This answer is an incorrect application of the GTPAL method.

One prior pregnancy was a preterm birth at 36 weeks (T = 1, P = 1; not T = 2). (B) This answer is an incorrect application of the GTPAL method. The client is currently pregnant for the third time (G = 3, not 2), one prior pregnancy was preterm (T = 1, P = 1; not T = 2), and she has had no prior abortions (A = 0). (C) This answer is the correct application of GTPAL method. The client is currently pregnant for the third time (G = 3), her first pregnancy ended at term (>37 weeks) (T = 1), her second pregnancy ended preterm 20–33 weeks (P = 1), she has no history of abortion (A = 0), and she has two living children (L = 2). (D) This answer is an incorrect application of the GTPAL method. The client is currently pregnant for the third time (G = 3, not 2).

NEW QUESTION 122

- (Topic 2)

A 16-year-old student has a long history of bronchial asthma and has experienced several severe asthmatic attacks during the school year. The school nurse is required to administer 0.2 mL of 1/1000 solution of epinephrine SC during an asthma attack. How does the school nurse evaluate the effectiveness of this intervention?

- A. Increased pulse rate
- B. Increased expectorate of secretions
- C. Decreased inspiratory difficulty
- D. Increased respiratory rate

Answer: C

Explanation:

(A) A side effect of epinephrine is fatal ventricular fibrillation owing to its effects on cardiac stimulation. (B) Medications used to treat asthma are designed to decrease bronchospasm, not to increase expectorate of secretions. (C) Epinephrine decreased inspiratory difficulty by stimulating α_1 and α_2 -receptors causing sympathomimetic stimulation (e.g., bronchodilation). (D) The person with asthma fights to inspire sufficient air thus increasing respiratory rate.

NEW QUESTION 126

- (Topic 2)

A 68-year-old woman is admitted to the hospital with chronic obstructive pulmonary disease (COPD). She is started on an aminophylline infusion. Three days later she is breathing easier. A serum theophylline level is drawn. Which of the following values represents a therapeutic level?

- A. 14 µg/mL
- B. 25 µg/mL
- C. 4 µg/mL
- D. 30 µg/mL

Answer: A

Explanation:

(A) The therapeutic blood level range of theophylline is 10–20 mg/mL. Therapeutic drug monitoring determines effective drug dosages and prevents toxicity. (B, D) This value is a toxic level of the drug. (C) This value is a nontherapeutic level of the drug.

NEW QUESTION 131

- (Topic 2)

A 54-year-old client is admitted to the hospital with a possible gastric ulcer. He is a heavy smoker. When discussing his smoking habits with him, the nurse should advise him to:

- A. Smoke low-tar, filtered cigarettes
- B. Smoke cigars instead
- C. Smoke only right after meals
- D. Chew gum instead

Answer: C

Explanation:

(A, B, D) Cigarettes, cigars, and chewing gum would stimulate gastric acid secretion. (C) Smoking on a full stomach minimizes effect of nicotine on gastric acid.

NEW QUESTION 136

- (Topic 2)

A client with severe PIH receiving MgSO₄ is placed in a quiet, darkened room. The nurse bases this action on the following understanding:

- A. The client is restless.
- B. The elevated blood pressure causes photophobia.
- C. Noise or bright lights may precipitate a convulsion.
- D. External stimuli are annoying to the client with PIH.

Answer: C

Explanation:

(A) The client may be anxious and hyperresponsive to stimuli but not necessarily restless. (B) This is not a physiological response to an elevated blood pressure in PIH. (C) The nurse must know the nursing measures that decrease the potential for convulsions. A quiet, darkened room decreases stimuli and promotes rest. (D) External stimuli might induce a convulsion but are not annoying to the client with PIH.

NEW QUESTION 140

- (Topic 2)

A client is admitted to the labor unit. On vaginal examination, the presenting part in a cephalic presentation was at station plus two. Station 12 means that the:

- A. Presenting part is 2 cm above the level of the ischial spines
- B. Biparietal diameter is at the level of the ischial spines
- C. Presenting part is 2 cm below the level of the ischial spines
- D. Biparietal diameter is 5 cm above the ischial spines

Answer: C

Explanation:

(A) Station is the relationship of the presenting part to an imaginary line drawn between the ischial spines. If the presenting part is above the ischial spines, the station is negative. (B) When the biparietal diameter is at the level of the ischial spines, the presenting part is generally at a +4 or +5 station. (C) Station is the relationship of the presenting part to an imaginary line drawn between the ischial spines. If the presenting part is below the ischial spines, the station is positive. Thus, 2 cm below the ischial spines is the station +2. (D) When the biparietal diameter is above the ischial spines by 5 cm, the presenting part is usually engaged or at station 0.

NEW QUESTION 141

- (Topic 2)

When a client with pancreatitis is discharged, the nurse needs to teach him how to prevent another occurrence of acute pancreatitis. Which of the following statements would indicate he has an understanding of his disease?

- A. ??I will not eat any raw or uncooked vegetables.??
- B. ??I will limit my alcohol to one cocktail per day.??
- C. ??I will look into attending Alcoholics Anonymous meetings.??
- D. ??I will report any changes in bowel movements to my doctor.??

Answer: C

Explanation:

- (A) Raw or uncooked vegetables are all right to eat postdischarge. (B) This client must avoid any alcohol intake. (C) The client displays awareness of the need to avoid alcohol.
 (D) This action would be pertinent only if fatty stools associated with chronic hepatitis were the problem.

NEW QUESTION 145

- (Topic 2)

A 35-weeks-pregnant client is undergoing a nonstress test (NST). During the 20-minute examination, the nurse notes three fetal movements accompanied by accelerations of the fetal heart rate, each 15 bpm, lasting 15 seconds. The nurse interprets this test to be:

- A. Nonreactive
- B. Reactive
- C. Positive
- D. Negative

Answer: B

Explanation:

(A) In a nonreactive NST, the criteria for reactivity are not met. (B) A reactive NST shows at least two accelerations of FHR with fetal movements, each 15 bpm, lasting 15 seconds or more, over 20 minutes. (C, D) This term is used to interpret a contraction stress test (CST), or oxytocin challenge test, not an NST.

NEW QUESTION 147

- (Topic 2)

The nurse would be sure to instruct a client on the signs and symptoms of an eye infection and hemorrhage. These signs and symptoms would include:

- A. Blurred vision and dizziness
- B. Eye pain and itching
- C. Feeling of eye pressure and headache
- D. Eye discharge and hemoptysis

Answer: B

Explanation:

(A) Although blurred vision may occur, dizziness would not be associated with an infection or hemorrhage. (B) Eye pain is a symptom of hemorrhage within the eye, and itching is associated with infection. (C) Nausea and headache would not be usual symptoms of eye hemorrhage or infection. (D) Some eye discharge might be anticipated if an infection is present; hemoptysis would not.

NEW QUESTION 149

- (Topic 2)

A gravida 2 para 1 client is hospitalized with severe preeclampsia. While she receives magnesium sulfate (MgSO₄) therapy, the nurse knows it is safe to repeat the dosage if:

- A. Deep tendon reflexes are absent
- B. Urine output is 20 mL/hr
- C. MgSO₄ serum levels are >15 mg/dL
- D. Respirations are >16 breaths/min

Answer: D

Explanation:

(A) MgSO₄ is a central nervous system depressant. Loss of reflexes is often the first sign of developing toxicity. (B) Urinary output at <25 mL/hr or 100 mL in 4 hours may result in the accumulation of toxic levels of magnesium. (C) The therapeutic serum range for MgSO₄ is 6–8 mg/dL. Higher levels indicate toxicity. (D) Respirations of >16 breaths/min indicate that toxic levels of magnesium have not been reached. Medication administration would be safe.

NEW QUESTION 150

- (Topic 2)

Which of the following menu choices would indicate that a client with pressure ulcers understands the role diet plays in restoring her albumin levels?

- A. Broiled fish with rice
- B. Bran flakes with fresh peaches
- C. Lasagna with garlic bread
- D. Cauliflower and lettuce salad

Answer: A

Explanation:

(A) Broiled fish and rice are both excellent sources of protein. (B) Fresh fruits are not a good source of protein. (C) Foods in the bread group are not high in protein. (D) Most vegetables are not high in protein; peas and beans are the major vegetables higher in protein.

NEW QUESTION 152

- (Topic 2)

An 8-week-old infant has been diagnosed with gastroesophageal reflux. The nurse is teaching the infant's mother to care for the infant at home. Which one of the following statements by the nurse is appropriate regarding the infant's home care?

- A. Lay the infant flat on her left side after feeding.
- B. Feed the infant every 4 hours with half-strength formula.
- C. Antacids need to be given an hour before feeding.
- D. Play activities should be carried out before instead of after feedings.

Answer: D

Explanation:

(A) Elevating the child's head to a 30-degree angle is the recommended position for gastroesophageal reflux. The supine position predisposes the child to aspiration. (B) Small, frequent feedings with thickened formula are recommended to minimize vomiting. (C) Antacids should be given at the same time as the feeding to improve their buffering action. (D) The infant should be kept still after feedings to reduce the risk of vomiting and aspiration. Vigorous activities should be carried out before feedings.

NEW QUESTION 154

- (Topic 2)

Azulfidine (Sulfasalazine) may be ordered for a client who has ulcerative colitis. Which of the following is a nursing implication for this drug?

- A. Limit fluids to 500 mL/day.
- B. Administer 2 hours before meals.
- C. Observe for skin rash and diarrhea.
- D. Monitor blood pressure, pulse.

Answer: C

Explanation:

(A) Fluids up to 2500–3000 mL/day are needed to prevent kidney stones. (B) The client should be instructed to take oral preparations with meals or snacks to lessen gastric irritation. (C) Sulfasalazine causes skin rash and diarrhea. (D) Blood pressure and pulse are not altered by sulfasalazine.

NEW QUESTION 156

- (Topic 2)

Respiratory function is altered in a 16-year-old asthmatic. Which of the following is the cause of this alteration?

- A. Altered surfactant production
- B. Paradoxical movements of the chest wall
- C. Increased airway resistance
- D. Continuous changes in respiratory rate and depth

Answer: C

Explanation:

(A) Altered surfactant production is found in sudden infant death syndrome. (B) Paradoxical breathing occurs when a negative intrathoracic pressure is transmitted to the abdomen by a weakened, poorly functioning diaphragm. (C) Asthma is characterized by spasm and constriction of the airways resulting in increased resistance to airflow. (D) If the pulmonary tree is obstructed for any reason, inspired air has difficulty overcoming the resistance and getting out. The rate of respiration increases in order to compensate, thus increasing air exchange.

NEW QUESTION 159

- (Topic 2)

A gravida 2 para 1 client delivered a full-term newborn 12 hours ago. The nurse finds her uterus to be boggy, high, and deviated to the right. The most appropriate nursing action is to:

- A. Notify the physician
- B. Place the client on a pad count
- C. Massage the uterus and re-evaluate in 30 minutes
- D. Have the client void and then re-evaluate the fundus

Answer: D

Explanation:

(A) The nurse should initiate actions to remove the most frequent cause of uterine displacement, which involves emptying the bladder. Notifying the physician is an inappropriate nursing action. (B) The pad count gives an estimate of blood loss, which is likely to increase with a boggy uterus; but this action does not remove the most frequent cause of uterine displacement, which is a full bladder. (C) Massage may firm the uterus temporarily, but if a full bladder is not emptied, the uterus will remain displaced and is likely to relax again. (D) The most common cause of uterine displacement is a full bladder.

NEW QUESTION 161

- (Topic 2)

A 26-year-old client is in a treatment center for aprazolam (Xanax) abuse and continues to manifest moderate levels of anxiety 3 weeks into the rehabilitation program, often requesting medication for his nerves. Included in the client's plan of care is to identify alternate methods of coping with stress and anxiety other than use of medication. After intervening with assistance in stress reduction techniques, identifying feelings and past coping, the nurse evaluates the outcome as being met if:

- A. Client promises that he will not abuse aprazolam after discharge
- B. Client demonstrates use of exercise or physical activity to handle nervous energy following conflicts of everyday life
- C. Client is able to verbalize effects of substance abuse on the body
- D. Client has remained substance free during hospitalization and is discharged

Answer: B

Explanation:

(A) This client response does not address stress reduction techniques. Verbal response focuses only on the problem. (B) Exercise or physical activity is a common strategy or coping technique used to reduce stress and anxiety. (C) Verbalizing effects of substance abuse on the body may help with insight and break through denial, but it is not a strategy to reduce anxiety. (D) Remaining substance-free does indicate motivation to change lifestyle of substance abuse or dependence, and it is not a stress reduction strategy in itself.

NEW QUESTION 163

- (Topic 2)

A client is being discharged with albuterol (Proventil) and beclomethasone dipropionate (Vanceril) to be administered via inhalation three times a day and at bedtime. Client teaching regarding the sequential order in which the drugs should be administered includes:

- A. Glucocorticoid followed by the bronchodilator
- B. Bronchodilator followed by the glucocorticoid
- C. Alternate successive administrations
- D. According to the client's preference

Answer: B

Explanation:

(A) The client would not receive therapeutic effects of the glucocorticoid when it is inhaled through constricted airways. (B) Bronchodilating the airways first allows for the glucocorticoid to be inhaled through open airways and increases the penetration of the steroid for maximum effectiveness of the drug. (C) Inaccurate use of the inhalers will lead to decreased effectiveness of the treatment. (D) Client teaching regarding the use and effects of inhalers will promote client understanding and compliance.

NEW QUESTION 164

- (Topic 2)

A postpartum client complains of rectal pressure and severe pain in her perineum; this may be indicative of:

- A. Afterbirth pains
- B. Constipation
- C. Cystitis
- D. A hematoma of the vagina or vulva

Answer: D

Explanation:

(A) Afterbirth pains are a common complaint in the postpartum client, but they are located in the uterus. (B) Constipation may cause rectal pressure but is not usually associated with severe pain. (C) Cystitis may cause pain, but the location is different. (D) Hematomas are frequently associated with severe pain and pressure. Further assessments are indicated for this client.

NEW QUESTION 165

- (Topic 2)

To prevent fungal infections of the mouth and throat, the nurse should teach clients on inhaled steroids to:

- A. Rinse the plastic holder that aerosolizes the drug with hydrogen peroxide every other day
- B. Rinse the mouth and gargle with warm water after each use of the inhaler
- C. Take antacids immediately before inhalation to neutralize mucous membranes and prevent infection
- D. Rinse the mouth before each use to eliminate colonization of bacteria

Answer: B

Explanation:

(A) It is sufficient to rinse the plastic holders with warm water at least once per day. (B) It is important to rinse the mouth after each use to minimize the risk of fungal infections by reducing the droplets of the glucocorticoid left in the oral cavity. (C) Antacids act by neutralizing or reducing gastric acid, thus decreasing the pH of the stomach. Neutralizing the oral mucosa prior to inhalation of a steroid inhaler does not minimize the risk of fungal infections. (D) Rinsing prior to the use of the glucocorticoid will not eliminate the droplets left on the oral mucous membranes following the use of the inhaler.

NEW QUESTION 170

- (Topic 2)

Following a gastric resection, which of the following actions would the nurse reinforce with the client in order to alleviate the distress from dumping syndrome?

- A. Eating three large meals a day
- B. Drinking small amounts of liquids with meals
- C. Taking a long walk after meals
- D. Eating a low-carbohydrate diet

Answer: D

Explanation:

(A) Six small meals are recommended. (B) Liquids after meals increase the time food empties from the stomach. (C) Lying down after meals is recommended to prevent gravity from producing dumping. (D) A low-carbohydrate diet will prevent a hypertonic bolus, which causes dumping.

NEW QUESTION 175

- (Topic 2)

An 83-year-old client has been hospitalized following a fall in his home. He has developed a possible fecal impaction. Which of the following assessment findings would be most indicative of a fecal impaction?

- A. Boardlike, rigid abdomen
- B. Loss of the urge to defecate
- C. Liquid stool
- D. Abdominal pain

Answer: C

Explanation:

(A) A boardlike, rigid abdomen would point to a perforated bowel, not a fecal impaction. (B) When a client is fecally impacted, a common symptom is the urge to defecate but the inability to do so. (C) When an impaction is present, only liquid stool will be able to pass around the impacted site. (D) Abdominal pain without distention is not a sign of a fecal impaction.

NEW QUESTION 179

- (Topic 2)

A nurse should carefully monitor a client for the following side effect of MgSO₄:

- A. Visual blurring
- B. Tachypnea
- C. Epigastric pain
- D. Respiratory depression

Answer: D

Explanation:

(A, C) The nurse should provide good distractors because these symptoms indicate that PIH has become more severe and may precede the convulsive or eclamptic phase. (B) This is the oppositeside effect of this medication. (D) This is a common side effect of this medication and needs to be monitored and recorded frequently.

NEW QUESTION 181

- (Topic 2)

The nurse provides a male client with diet teaching so that he can help prevent constipation in the future. Which food choices indicate that this teaching has been understood?

- A. Omelette and hash browns
- B. Pancakes and syrup
- C. Bagel with cream cheese
- D. Cooked oatmeal and grapefruit half

Answer: D

Explanation:

(A) Eggs and hash browns do not provide much fiber and bulk, so they do not effectively prevent constipation. (B) Pancakes and syrup also have little fiber and bulk, so they do not effectively prevent constipation. (C) Bagel and cream cheese do not provide intestinal bulk. (D) A combination of oatmeal and fresh fruit will provide fiber and intestinal bulk.

NEW QUESTION 182

- (Topic 2)

A 42-year-old client with bipolar disorder has been hospitalized on the inpatient psychiatric unit. She is dancing around, talking incessantly, and singing. Much of the time the client is anorexic and eats very little from her tray before she is up and about again. The nurse's intervention would be to:

- A. Confront the client with the fact that she will have to eat more from her tray to sustain her
- B. Try to get the client to focus on her eating by offering a detailed discussion on the importance of nutrition
- C. Let her have snacks and drinks anytime that she wants them because she will not eat at regular meal times
- D. Not expect the client to sit down for complete meals; monitor intake, offering snacks and juice frequently

Answer: D

Explanation:

(A) The manic client's mood may easily change from euphoric to irritable. The nurse should avoid confrontation and let the client know what she can do, rather than what she cannot. (B) Although helpful to refocus or redirect the manic client to discuss only one topic at a time, distractibility is very high and it's best to avoid long discussions. (C) Manic clients have a tendency to manipulate persons in their environment. Staff should monitor intake, including at mealtime and snacks, and be consistent in their approach to meeting nutritional needs. (D) Manic clients may not sit and eat complete meals, but they can carry foods and liquids from regular meals with them. Staff can monitor and give high-caloric and high-energy snacks and liquids.

NEW QUESTION 184

- (Topic 2)

In performing the initial nursing assessment on a client at the prenatal clinic, the nurse will know that which of the following alterations is abnormal during pregnancy?

- A. Striae gravidarum
- B. Chloasma
- C. Dysuria
- D. Colostrum

Answer: C

Explanation:

(A) Striae gravidarum are the normal stretch marks that frequently occur on the breasts, abdomen, and thighs as pregnancy progresses. (B) Chloasma is the "mask of pregnancy" that normally occurs in many pregnant women. (C) Dysuria is an abnormal danger sign during pregnancy and may indicate a urinary tract infection. (D) Colostrum is a yellow breast secretion that is normally present during the last trimester of pregnancy.

NEW QUESTION 188

- (Topic 2)

The nurse would assess the client's correct understanding of the fertility awareness methods that enhance conception, if the client stated that:

- A. My sexual partner and I should have intercourse when my cervical mucosa is thick and cloudy.
- B. At ovulation, my basal body temperature should rise about 0.5F.
- C. I should douche immediately after intercourse.
- D. My sexual partner and I should have sexual intercourse on day 14 of my cycle regardless of the length of the cycle.

Answer: B

Explanation:

(A) At ovulation, the cervical mucus is increased, stretchable, and watery clear. (B) Under the influence of progesterone, the basal body temperature increases slightly after ovulation. (C) To enhance fertility, measures should be taken that promote retention of sperm rather than removal. (D) Ovulation, the optimal time for conception, occurs 14+2 days before the next menses; therefore, the date of ovulation is directly related to the length of the menstrual cycle.

NEW QUESTION 190

- (Topic 2)

A client is admitted to the hospital for an induction of labor owing to a gestation of 42 weeks confirmed by dates and ultrasound. When she is dilated 3 cm, she has a contraction of 70 seconds. She is receiving oxytocin. The nurse's first intervention should be to:

- A. Check FHT
- B. Notify the attending physician
- C. Turn off the IV oxytocin
- D. Prepare for the delivery because the client is probably in transition

Answer: C

Explanation:

(A) FHT should be monitored continuously with an induction of labor; this is an accepted standard of care. (B) The physician should be notified, but this is not the first intervention the nurse should do. (C) The standard of care for an induction according to the Association of Women's Health, Obstetric, and Neonatal Nurses and American College of Obstetrics and Gynecology is that contractions should not exceed 60 seconds in an induction. Inductions should simulate normal labor; 70-second contractions during the latent phase (3 cm) are not the norm. The next contractions can be longer and increase risks to the mother and fetus. (D) Contractions lasting 60–90 seconds during transition are typical; this provides a good distractor. The nurse needs to be knowledgeable of the phases and stages of labor.

NEW QUESTION 191

- (Topic 2)

A mother continues to breast-feed her 3-month-old infant. She tells the nurse that over the past 3 days she has not been producing enough milk to satisfy the infant. The nurse advises the mother to do which of the following?

- A. Start the child on solid food.
- B. Nurse the child more frequently during this growth spurt.
- C. Provide supplements for the child between breastfeeding so you will have enough milk.
- D. Wait 4 hours between feedings so that your breasts will fill up.

Answer: B

Explanation:

(A) Solid foods introduced before 4–6 months of age are not compatible with the abilities of the GI tract and the nutritional needs of the infant. (B) Production of milk is supply and demand. A common growth spurt occurs at 3 months of age, and more frequent nursing will increase the milk supply to satisfy the infant. (C) Supplementation will decrease the infant's appetite and in turn decrease the milk supply. When the infant nurses less often or with less vigor, the amount of milk produced decreases. (D) Rigid feeding schedules lead to a decreased milk supply, whereas frequent nursing signals the mother's body to produce a correspondingly increased amount of milk.

NEW QUESTION 195

- (Topic 3)

After performing a sterile vaginal exam on a client who has just been admitted to the unit in active labor and placed on an electronic fetal monitor, the RN assesses that the fetal head is at 21 station. She documents this on the monitor strip. Fetal head at 21 station means that the fetal head is located where in the pelvis?

- A. One centimeter below the ischial spines
- B. One centimeter above the ischial spines
- C. Has not entered the pelvic inlet yet
- D. Located in the pelvic outlet

Answer: B

Explanation:

(A) The ischial spines are located on both sides of the midpelvis. These spines mark the diameter of the narrowest part of the pelvis that the fetus will encounter. They are not sharp protrusions that will harm the fetus. Station refers to the relationship between the ischial spines in the pelvis and the fetus. The ischial spines are designated at 0 station. If the presenting part of the fetus is located above the ischial spines, a negative number is assigned, noting the number of centimeters above the ischial spines. Therefore, 1 centimeter below the ischial spines is designated as +1 station. (B) See explanation in A. One centimeter above the ischial spines is designated as +1 station. (C) The pelvic inlet is the first part of the pelvis that the fetus enters in routine delivery. The midpelvis is the second part of the pelvis to be entered by the fetus. The ischial spines are located on both sides of the midpelvis. (D) The pelvic outlet is the last part of the pelvis that the fetus will enter. When the fetus reaches this part of the pelvis, birth is near.

NEW QUESTION 197

- (Topic 3)

A 55-year-old man has recently been diagnosed with hypertension. His physician orders a low-sodium diet for him. When he asks, "What does salt have to do

with high blood pressure????? the nurse??s initial response would be:

- A. ??The reason is not known why hypertension is associated with a high-salt diet.??
- B. ??Large amounts of salt in your diet can cause you to retain fluid, which increases your blood pressure.??
- C. ??Salt affects your blood vessels and causes your blood pressure to be high.??
- D. ??Salt is needed to maintain blood pressure, but too much causes hypertension.??

Answer: B

Explanation:

(A) This response is untrue. (B) Decreasing salt intake reduces fluid retention and decreases blood pressure. (C) Salt does not have an effect on the blood vessels themselves, but on fluid retention, which accompanies salt intake. (D) This response is untrue.

NEW QUESTION 201

- (Topic 3)

A 1000-mL dose of D5W 12 normal saline is to be infused in 8 hours. The drop factor for the tubing is 60 gtt/min. How many drops per minute should the nurse administer?

- A. 75 gtt/min
- B. 100 gtt/min
- C. 125 gtt/min
- D. 150 gtt/min

Answer: C

Explanation:

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) 125 gtt/min. (D) This answer is a miscalculation.

NEW QUESTION 206

- (Topic 3)

On a mother??s 2nd postpartum day after having a vaginal delivery, the RN is preparing to assess her perineum and anus as part of her daily assessment. The best position for the client to be placed in for this assessment is:

- A. Sims??
- B. Fowler??s
- C. Prone
- D. Any position that the RN chooses

Answer: A

Explanation:

(A) The Sims?? position is the best position for assessment of the perineum and anus. The top leg is placed over the bottom leg, and the RN raises the upper buttocks to fully expose the perineum and anus. (B) Fowler??s position is a sitting position, and the perineum and anus would not be exposed. (C) The prone position would have the mother on her back, and her perineum and anus would not be exposed. (D) The position of choice should always be the Sims??.

NEW QUESTION 207

- (Topic 3)

A 60-year-old male client was hospitalized 3 days ago with the diagnosis of acute anterior wall myocardial infarction. Today he has been complaining of increasing weakness and shortness of breath. Crackles in both lung bases are audible on auscultation. He is developing:

- A. An extension of his myocardial infarction
- B. Pneumonia
- C. Pulmonary edema
- D. Pulmonary emboli

Answer: C

Explanation:

(A) Extensions of his myocardial infarction would be chest pain unrelieved with nitroglycerin, cardiac enzyme elevations, and electrocardiographic changes. (B) Persons with pneumonia may complain of weakness and shortness of breath and have crackles in their lung bases. However, they would also have sputum production and leukocytosis. (C) Persons who have had myocardial infarctions (especially anterior wall) are at risk of developing left ventricular heart failure, which is a major cause of pulmonary edema. Pulmonary edema is manifest by shortness of breath, weakness, and crackles on auscultation of the lung fields. (D) Pulmonary emboli may be accompanied by shortness of breath, weakness, and crackles. However, the pulmonary hypertension that accompanies pulmonary emboli results in signs of increased systemic venous pressure as well.

NEW QUESTION 209

- (Topic 3)

A client was prescribed a major tranquilizer 2 months ago. One month ago she was placed on benztropine (Cogentin). What would indicate that benztropine therapy is effective?

- A. Smooth, coordinated voluntary movement
- B. Tremors
- C. Rigidity
- D. Muscle weakness

Answer: A

Explanation:

(A) Benzotropine is prescribed to decrease or alleviate extrapyramidal side effects of major tranquilizers. Smooth, coordinated voluntary movement indicates minimal extrapyramidal side effects. (B) Tremors are an extrapyramidal side effect. (C) Rigidity is an extrapyramidal side effect. (D) Muscle weakness is an extrapyramidal side effect.

NEW QUESTION 211

- (Topic 3)

A newborn has been delivered with a meningomyelocele. The nursery nurse should position the newborn:

- A. Prone
- B. Supine
- C. Side lying
- D. Semi-Fowler

Answer: A

Explanation:

(A) The prone position reduces pressure and tension on the sac. Primary nursing goals are to prevent trauma and infection of the sac. (B) The supine position exerts pressure on the sac. (C) Newborns usually cannot maintain side-lying position. (D) The semi-Fowler position exerts pressure on the sac.

NEW QUESTION 214

- (Topic 3)

A 3-year-old child is admitted with a diagnosis of possible noncommunicating hydrocephalus. What is the first symptom that indicates increased intracranial pressure?

- A. Bulging fontanelles
- B. Seizure
- C. Headache
- D. Ataxia

Answer: C

Explanation:

(A) Bulging fontanelles are a symptom of increased intracranial pressure in infants. (B) Seizure is a late sign of increased intracranial pressure. (C) Headache is a very early symptom of increased intracranial pressure in the child. (D) Ataxia is a late sign of increased intracranial pressure.

NEW QUESTION 218

- (Topic 3)

At 38 weeks gestation, a client is in active labor. She is using her Lamaze breathing techniques. The RN is coaching her breathing and encouraging her to relax and work with her contractions. Which one of the following complaints by the client will alert the RN that she is beginning to hyperventilate with her breathing?

- A. I am cold.
- B. I have a backache.
- C. I feel dizzy.
- D. I am nauseous.

Answer: C

Explanation:

(A) Cold is not a symptom of hyperventilation. This could be due to the temperature of the room. (B) Backache is not a symptom of hyperventilation. This is probably due to the gravid uterus and its effect on the back muscles, or it may be due to the client's position in bed. (C) Dizziness is the first symptom of hyperventilation. It occurs because the body is eliminating too much CO₂. (D) Nausea is not a symptom of hyperventilation. It could be a symptom of pain.

NEW QUESTION 221

- (Topic 3)

A pregnant client during labor is irritable and feels the urge to vomit. The nurse should recognize this as the:

- A. Fourth stage of labor
- B. Third stage of labor
- C. Transition stage of labor
- D. Second stage of labor

Answer: C

Explanation:

(A) The fourth stage begins after expulsion of the placenta. Client symptoms are: fatigue; chills; scant, bloody vaginal discharge; and nausea. (B) The third stage is from birth to expulsion of placenta. Client symptoms are uterine contractions, gush of blood, and perineal pain. (C) The transition stage is characterized by strong uterine contractions and cervical dilation. Client symptoms are irritability, restlessness, belching, muscle tremors, nausea, and vomiting. (D) The second stage is characterized by full dilation of cervix. Client symptoms are perineal bulge, pushing with contractions, great irritability, and leg cramps.

NEW QUESTION 225

- (Topic 3)

A 35-year-old client is admitted to the hospital with diabetic ketoacidosis. Results of arterial blood gases are pH 7.2, PaO₂ 90, PaCO₂ 45, and HCO₃ 16. The nursing assessment of arterial blood gases indicate the presence of:

- A. Respiratory alkalosis
- B. Respiratory acidosis
- C. Metabolic alkalosis

D. Metabolic acidosis

Answer: D

Explanation:

(A) Respiratory alkalosis is determined by elevated pH and low PaCO₂. (B) Respiratory acidosis is determined by low pH and elevated PaCO₂. (C) Metabolic alkalosis is determined by elevated pH and HCO₃. (D) Metabolic acidosis is determined by low pH and HCO₃.

NEW QUESTION 227

- (Topic 3)

At 32 weeks gestation, a client is scheduled for a fetal activity test (nonstress test). She calls the clinic and asks the RN, "How do I prepare for the test I am scheduled for?" The RN will most likely inform her of the following instructions to help prepare her for the test:

- A. "You need to know that an IV is always started before the test."
- B. "You will need to drink 6 to 8 glasses of water to fill your bladder."
- C. "Do not eat any food or drink any liquids before the test is started."
- D. "You will have to remain as still as you possibly can."

Answer: D

Explanation:

(A) An IV line is not started in a nonstress test, because this test is used as an indicator of fetal well-being. This test measures fetal activity and heart rate acceleration. (B) The bladder does not have to be full prior to this test. It is not a sonogram test where a full bladder enables other structures to be scanned. (C) It has been proved that eating or drinking liquids prior to the test can assist in increasing fetal activity. (D) Any maternal activity will interfere with the results of the test.

NEW QUESTION 228

- (Topic 3)

A 45-year-old male client was admitted to a chemical dependency treatment center following legal problems related to alcohol abuse. He states, "I know that alcohol is a problem for some people, but I can stop whenever I want to. I'm never sick or miss work, and no one can complain about me." During the initial assessment, the best response by the nurse would be:

- A. "The fact is you are an alcoholic or you wouldn't be here."
- B. "I understand it took strength to admit yourself to the unit, and I will do my part to help you to stay alcohol-free."
- C. "If you can stop drinking when you want to, why don't you stop?"
- D. "It's good that you can stop drinking when you want to."

Answer: B

Explanation:

(A) Direct confrontation initially is nontherapeutic and may result in the client becoming frustrated and wanting to leave. (B) A positive, supportive attitude builds trust, and identifying positive strength raises self-esteem. Offering help allows the client to feel that he is not alone in dealing with problems. (C) Asking the client why or to give an explanation for his behavior puts him in a position of having to justify his behavior to the nurse. (D) Giving approval or placing a value on feelings or a behavior may limit the client's freedom to behave in a way that may displease another. This response may lead to seeking praise instead of progress.

NEW QUESTION 229

- (Topic 3)

A client had a myocardial infarction 5 days ago. His physician has ordered an echocardiogram to determine how his myocardial infarction has affected his ventricular wall motion. When the client asks if this test is painful, an appropriate response is:

- A. "No, but you must be able to ride on a stationary bicycle while the test is being performed."
- B. "No, but you will have to lie still and the gel that is used may be cool."
- C. "Yes, but your physician will be there and will order pain medicine for you."
- D. "Your physician has ordered medicine, which you will be given before you go for the test, which will make you sleepy."

Answer: B

Explanation:

(A) Riding a stationary bicycle or walking on a treadmill is done during a stress test. (B) During an echocardiogram, the client must lie supine while a technician performs the test. To perform the test, the technician uses a conductive gel and a transducer to obtain ultrasound tracings of the heart. (C) A physician need not be present during an echocardiogram, and it is neither invasive nor painful. (D) There is no premedication required for an echocardiogram.

NEW QUESTION 233

- (Topic 3)

A physician's order reads: Administer furosemide oral solution 0.5 mL stat. The furosemide bottle dosage is 10 mg/mL. What dosage of furosemide should the nurse give to this infant?

- A. 5 mg
- B. 0.5 mg
- C. 0.05 mg
- D. 20 mg

Answer: A

Explanation:

(A) 1 mg = 0.1 mL, then 0.5 mL X = 5 mg. (B) This answer is a miscalculation. (C) This answer is a miscalculation. (D) This answer is a miscalculation.

NEW QUESTION 237

- (Topic 3)

The nurse working with a client who is out of control should follow a model of intervention that includes which of the following?

- A. Approach the client on a continuum of least restrictive care.
- B. Challenge client's behavior immediately with steps to prevent injury to self or others.
- C. Leave the aggressive client to himself or herself, and take other clients away.
- D. To ensure safety of other clients, place client in seclusion immediately when he or she begins shouting.

Answer: A

Explanation:

(A) Approaching a client's aggressive behavior on a continuum of least restrictive care is in agreement with his or her rights (i.e., verbal methods to help maintain control, medication, seclusion, and restraints, as necessary). (B) Approaching a client in a challenging manner is threatening and inappropriate. A nonchallenging and calm approach reflects staff in control and may increase client's internal control. (C) It is inappropriate to leave an aggressive client who is acting out alone. The nurse should acquire qualified help to prevent client from harm or injury to self or others. (D) Moving a client to seclusion immediately for shouting is inappropriate. The nurse should offer the client an opportunity to control self with limit setting. The client should understand that the staff will assist with control if necessary (i.e., quietly accompany out of environment to decrease stimulation and allow for verbalization) employing the least restrictive care model of intervention.

NEW QUESTION 241

- (Topic 3)

A nurse is performing a vaginal exam on a client in active labor. An important landmark to assess during labor and delivery are the ischial spines because:

- A. Ischial spines are the narrowest diameter of the pelvis
- B. Ischial spines are the widest diameter of the pelvis
- C. They represent the inlet of birth canal
- D. They measure pelvic floor

Answer: A

Explanation:

(A) The fetal descent, or station, is determined by the relationship of the presenting part to the spine. (B) Ischial spines are the narrowest measurement. (C) Ischial spines measure the pelvic outlet. (D) Pelvic floor measurement is not related to fetal descent.

NEW QUESTION 246

- (Topic 3)

A 16-year-old client with anorexia nervosa is on an inpatient psychiatric unit. She has a fear of gaining weight and is refusing to eat sufficient amounts to maintain body weight for her age, height, and stature. To assist with the problem of powerlessness and plan for the client to no longer need to withhold food to feel in control, the nurse uses the following strategy:

- A. Establish a structured environment with routine tasks and activities
- B. Also, serve meals at the same time each day.
- C. Distract the client during meals to get her to eat because she must take in sufficient amounts to keep from starving.
- D. Do frequent room checks to be sure that the client is not hiding food or throwing it away.
- E. Listen attentively and participate in in-depth discussions about food, because these actions may encourage her to eat.

Answer: A

Explanation:

(A) Anorexia nervosa clients feel out of control. Providing a structured environment offers safety and comfort and can help them to develop internal control, thus reducing their need to control by self-starvation. (B) Distraction does not focus on the client's need for control. (C) Doing frequent room checks reinforces feelings of powerlessness and the need to continue with the dysfunctional behavior. (D) Participating in long discussions about food does not make the client want to eat, but rather this strategy allows her to indulge in her preoccupation and to continue with the dysfunctional behavior.

NEW QUESTION 249

- (Topic 3)

The physician is preparing to induce labor on a 40-week multigravida. The nurse should anticipate the administration of:

- A. Oxytocin (Pitocin)
- B. Progesterone
- C. Vasopressin (Pitressin)
- D. Ergonovine maleate

Answer: A

Explanation:

(A) Oxytocin is a hormone secreted by the neurohypophysis during suckling and parturition that produces strong uterine contractions. (B) Progesterone has a quiescence effect on the uterus. (C) Vasopressin is an antidiuretic hormone that promotes water reabsorption by the renal tubules. (D) Ergonovine produces dystocia as a result of sustained uterine contractions.

NEW QUESTION 253

- (Topic 3)

A laboring client presents with a prolapsed cord. The nurse should immediately place the client in what position?

- A. Reverse Trendelenburg
- B. Fowler's

- C. Trendelenburg
- D. Sims??

Answer: C

Explanation:

(A) Reverse Trendelenburg position increases pressure on the perineum. This position will not relieve cord pressure. (B) Fowler??s position increases perineal pressure. Cord pressure would not be relieved. (C) Trendelenburg position will decrease perineal pressure. Cord compression will be decreased and increase in fetal blood flow occurs. (D) Sims?? position does not relieve pressure on cord or perineum.

NEW QUESTION 255

- (Topic 3)

After the RN is finished the initial assessment of a newborn baby and after the initial bonding between the newborn and the mother has taken place in the delivery room, the RN will bring the newborn to the well-baby nursery. Before the newborn is taken from the delivery room and brought to the well-baby nursery, the RN makes sure that which of the following interventions was completed?

- A. The physician verifies the exact time of birth.
- B. The nurse counts the instruments and sponges with the scrub nurse.
- C. The nurse instills prophylactic ointment in the conjunctival sacs of the newborn??s eyes.
- D. The nurse makes sure the mother and her newborn have been tagged with identical bands.

Answer: D

Explanation:

(A) The delivery room personnel are responsible for verifying time of birth. (B) The scrub and circulating nurses count sponges and instruments. (C) This intervention is done in the nursery. (D) Tagging the mother and infant with identical bands is of utmost importance. The mother wears one band, and the newborn wears two. Identical numbers on the three bands provide identification for the newborn and the birth mother. Every time the newborn is brought to the mother after delivery, those bands are checked to be sure that the numbers are identical.

NEW QUESTION 260

- (Topic 3)

A physician??s order reads: Administer KCl 10% oral solution 1.5 mL. The KCl bottle reads 20 mEq/15 mL. What dosage should the nurse administer to the infant?

- A. 1 mEq
- B. 1.13 mEq
- C. 2 mEq
- D. Not enough information to calculate

Answer: C

Explanation:

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) $1.33 \text{ mEq} = 1 \text{ mL}$, then $1.5 \text{ mL} \times 1.99$, or 2 mEq. (D) Information is adequate for calculation.

NEW QUESTION 265

- (Topic 3)

A type I diabetic client delivers a male newborn. The newborn is 45 minutes old. What is the primary nursing goal in the nursery during the first hours for this newborn?

- A. Bonding
- B. Maintain normal blood sugar
- C. Maintain normal nutrition
- D. Monitor intake and output

Answer: B

Explanation:

(A) Bonding is necessary but would not be the priority with this newborn in the nursery. (B) The infant will be at risk for hypoglycemia because of excess insulin production. (C) Normal nutrition is a goal for all newborns. (D) Monitoring intake and output is necessary but is not the most critical nursing goal.

NEW QUESTION 268

- (Topic 3)

After an infant is delivered by cesarean delivery and placed on the warmer, the RN dries and assesses the infant. At 1 and 5 minutes after birth, the RN does the Apgar scoring of the infant. The RN knows that because this infant was delivered by cesarean section, he is at increased risk for having which one of the following:

- A. Cold stress
- B. Cyanosis
- C. Respiratory distress syndrome
- D. Seizures

Answer: C

Explanation:

(A) The infant is placed on the warmer and dried after birth. Cold stress occurs when the infant is not dried and kept warm. (B) The fact that this infant was born by cesarean delivery does not place him at a greater risk for cyanosis than an infant delivered vaginally. Cyanosis occurs when infants cannot oxygenate their blood after the umbilical cord is severed. (C) Infants born by cesarean delivery are at a higher risk for developing respiratory distress syndrome because these infants do not pass through the pelvis, where the chest is compressed and fluid is able to escape from the lungs. (D) Cesarean-delivered infants are not at greater risk for

seizures than infants delivered vaginally.

NEW QUESTION 273

- (Topic 3)

Nursing care of the infant prior to surgical closure of a meningomyelocele would include:

- A. Cover sac with dry sterile dressing
- B. Cover sac with saline-soaked sterile dressing
- C. Do not apply dressing; keep sac open to air
- D. Aspirate any fluid from sac

Answer: B

Explanation:

(A) A dry, sterile dressing would adhere to the sac, causing tissue damage. (B) A saline-soaked sterile dressing protects the sac from contamination by air and prevents drying. (C) A sac open to air causes drying and potential for contamination. (D) This intervention is not an independent nursing action.

NEW QUESTION 274

- (Topic 3)

The nurse instructs a client on the difference between true labor and false labor. The nurse explains, "In true labor:

- A. Uterine contractions will weaken with walking."
- B. Uterine contractions will strengthen with walking."
- C. The cervix does not dilate."
- D. The fetus does not descend."

Answer: B

Explanation:

(A) Uterine contractions increase with activity. (B) Walking will increase the strength and regularity of uterine contractions in true labor. (C) Uterine contractions that are strong and regular facilitate cervical dilation. (D) Regular, strong uterine contractions, as in true labor, result in fetal descent.

NEW QUESTION 275

- (Topic 3)

An 11-year-old boy has received a partial-thickness burn to both legs. He presents to the emergency room approximately 15 minutes after the accident in excruciating pain with charred clothing to both legs. What is the first nursing action?

- A. Apply ice packs to both legs.
- B. Begin debridement by removing all charred clothing from wound.
- C. Apply Silvadene cream (silver sulfadiazine).
- D. Immerse both legs in cool water.

Answer: D

Explanation:

(A) Ice creates a dramatic temperature change in the tissue, which can cause further thermal injury. (B) Charred clothing should not be removed from wound first. This creates further tissue damage. Debridement is not the first nursing action. (C) Applying silver sulfadiazine cream first insulates heat in injured tissue and increases potential for infection. (D) Emergency care of a thermal burn is immersing both legs in cool water. Cool water permits gradual temperature change and prevents further thermal damage.

NEW QUESTION 277

- (Topic 3)

Painless vaginal bleeding in the last trimester may be caused by:

- A. Menstruation
- B. Abruptio placentae
- C. Placenta previa
- D. Polyhydramnios

Answer: C

Explanation:

(A) Menstruation should not occur during pregnancy. (B) Abruptio placentae is marked by painful vaginal bleeding following a premature placental detachment after 20th week of gestation. (C) A low-lying placenta separates from the uterine wall as the uterus contracts and cervix dilates. This separation causes painless bleeding in the 7th-8th month. (D) Polyhydramnios is excessive amniotic fluid.

NEW QUESTION 282

- (Topic 3)

A client had a vaginal delivery 3 days ago and is discharged from the hospital on the 2nd day postpartum. She told the RN, "I need to start exercising so that I can get back into shape. Could you suggest an exercise I could begin with?" The RN could suggest which one of the following?

- A. Push-ups
- B. Jumping jacks
- C. Leg lifts
- D. Kegel exercises

Answer: D

Explanation:

(A, B, C) This exercise is too strenuous at this time. (D) This exercise is recommended for the first few days after delivery. It helps to stimulate muscle tonus in the area of the perineum and the area around the urinary meatus and vagina.

NEW QUESTION 286

- (Topic 3)

A 70-year-old client is almost finished receiving her second unit of packed red blood cells. The client, who weighs 80 lb, has started complaining of being short of breath and now has crackles in the bases of her lungs. After slowing or stopping the transfusion, the most appropriate initial nursing action would be to:

- A. Raise the client's head and place her feet in a dependent position
- B. Notify the physician
- C. Place the client on 2 liters of O₂ via nasal cannula
- D. Administer furosemide (Lasix) 20 mg IV push

Answer: A

Explanation:

(A) Raising the client's head and placing her feet in a dependent position is an independent nursing action that can be taken to decrease venous return and to reduce pulmonary congestion. (B) Notifying the physician is an appropriate action that should be taken after the client is positioned to maximize her respiratory status. (C) Placing the client on O₂ may be done with a physician's order or according to an institution's standing orders; however, other actions should be taken first. (D) Furosemide 20 mg IV push is an appropriate medication for the client, but it must be ordered by her physician.

NEW QUESTION 289

- (Topic 3)

A mother who is breast-feeding her newborn asks the RN, "How can I express milk from my breasts manually?" The RN tells her that the correct method for manual milk expression includes using the thumb and the index finger to:

- A. Alternately compress and release each nipple
- B. Roll the nipple and gently pull the nipple forward
- C. Slide the thumb and index finger forward from the outer border of the areola toward the end of the nipple
- D. Compress and release each breast at the outer border of the areola

Answer: D

Explanation:

(A) Manipulation of nipples will cause soreness and trauma. (B) Pulling the nipples will cause discomfort and soreness. (C) Sliding the thumb and index finger forward over the nipple will cause soreness. (D) The best method to express milk from the breast is to position the thumb and index finger at the outer border of the areola and compress. This is the location of the milk sinuses.

NEW QUESTION 293

- (Topic 3)

A client who is 7 months pregnant is diagnosed with pyelonephritis. The nurse anticipates the physician ordering:

- A. Oxytocin
- B. Magnesium sulfate (MgSO₄)
- C. Ampicillin
- D. Tetracycline

Answer: C

Explanation:

(A) Oxytocin is prescribed to stimulate uterine contractions. (B) MgSO₄ is a central nervous system depressant prescribed to prevent and control convulsions related to preeclampsia. (C) Ampicillin is a penicillin derivative with no known teratogenic effects. This is the safest antibiotic during pregnancy. (D) Tetracycline stains teeth yellow and is not as safe as ampicillin during pregnancy.

NEW QUESTION 295

- (Topic 3)

Which type of insulin can be administered by a continuous IV drip?

- A. Humulin N
- B. NPH insulin
- C. Regular insulin
- D. Lente insulin

Answer: C

Explanation:

(A) Humulin N cannot be administered IV. (B) NPH insulin cannot be administered IV. (C) Regular insulin is the only insulin that can be administered IV. (D) Lente insulin cannot be administered IV.

NEW QUESTION 300

- (Topic 3)

A client's physician has prescribed theophylline (Theo-Dur) to help control the bronchospasm associated with the client's COPD. Instructions that should be given to the client include:

- A. ??Call your physician if you develop palpitations, dizziness, or restlessness.????
- B. ??Cigarette smoking may significantly increase the risk for theophylline toxicity.????
- C. ??Take this medication on an empty stomach.????
- D. ??Do not take your medicine if your pulse is less than 60 beats per minute.????

Answer: A

Explanation:

(A) Indications of theophylline toxicity include palpitations, dizziness, restlessness, nausea, vomiting, shakiness, and anorexia. (B) Cigarette smoking significantly lowers theophylline plasma levels. (C) Theophylline should be taken with food to decrease stomach upset. (D) These instructions are appropriate for someone taking digoxin.

NEW QUESTION 305

- (Topic 3)

A 40-year-old client is admitted to the hospital for tests to diagnose cancer. Since his admission, he has become dependent and demanding to the nursing staff. The nurse identifies this behavior as which defense mechanism?

- A. Denial
- B. Displacement
- C. Regression
- D. Projection

Answer: C

Explanation:

(A) Denial is the disowning of consciously intolerable thoughts. (B) Displacement is the referring of a feeling or emotion from one person, object, or idea to another. (C) Regression is returning to an earlier stage of development. (D) Projection is attributing one's own thoughts, feelings, or impulses to another person.

NEW QUESTION 306

- (Topic 3)

A client suspects that she is pregnant. She reports two missed menstrual periods. The first day of her last menstrual period was August 3. Her estimated date of confinement would be:

- A. November 7
- B. November 10
- C. May 7
- D. May 10

Answer: D

Explanation:

(A) Wrong calculation (B) Wrong calculation (C) Wrong calculation
(D) Nägele's rule is: Expected Date of Confinement = Last Menstrual Period - 3 months + 7 days + 1 year

NEW QUESTION 308

- (Topic 3)

A schizophrenic is admitted to the psychiatric unit. What affect would the nurse expect to observe?

- A. Anger
- B. Apathy and flatness
- C. Smiling
- D. Hostility

Answer: B

Explanation:

(A) Anger is an emotion that is not necessarily present in schizophrenia. (B) Lack of response to or involvement with environment and distancing are characteristic of schizophrenia. (C) Euphoria is more characteristic of manic-depressive disorder (bipolar disorder). (D) Hostility is an emotion that is not necessarily present in schizophrenia.

NEW QUESTION 313

- (Topic 3)

A male client has been hospitalized with congestive heart failure. Medical management of heart failure focuses on improving myocardial contractility. This can be achieved by administering:

- A. Digoxin (Lanoxin) 0.25 mg po every day
- B. Furosemide (Lasix) 40 mg po every morning
- C. O₂ 2 L/min via nasal cannula
- D. Nitroglycerin (Nitrol) 1 inch topically every 4 hours

Answer: A

Explanation:

(A) Digoxin is a cardiac glycoside given to clients in heart failure to improve their myocardial contractility. (B) Furosemide is a loop diuretic given to clients in heart failure to promote diuresis. (C) O₂ is given to clients in heart failure to increase oxygenation and to prevent or treat hypoxemia. (D) Nitroglycerin is a nitrate given to clients in heart failure to increase their cardiac output by decreasing the peripheral resistance that the left ventricle must pump against.

NEW QUESTION 318

- (Topic 3)

A 19-year-old client fell off a ladder approximately 3 ft to the ground. He did not lose consciousness but was taken to the emergency department by a friend to have a scalp laceration sutured. The nurse instructs the client to:

- A. Clean the sutured laceration twice a day with povidone- iodine (Betadine)
- B. Remove his scalp sutures after 5 days
- C. Return to the hospital immediately if he develops confusion, nausea, or vomiting
- D. Take meperidine 50 mg po q4–6h prn for headache

Answer: C

Explanation:

(A) Povidone-iodine is very irritating to skin and should not be routinely used. (B) Sutures should not be removed by the client. (C) Confusion, nausea, vomiting, and behavioral changes may indicate increasing intracranial pressure as a result of intracerebral bleeding. (D) Use of a narcotic opiate such as meperidine is not recommended in clients with a possible head injury because it may produce sedation, pupil changes, euphoria, and respiratory depression, which may mask the signs of increasing intracranial pressure.

NEW QUESTION 323

- (Topic 3)

A 6-year-old child is attending a pediatric clinic for a routine examination. What should the nurse assess for while conducting a vision screening?

- A. Hearing test
- B. Gait
- C. Strabismus
- D. Papilledema

Answer: C

Explanation:

(A) Hearing should be assessed separately. (B) Gait should be assessed separately. Client usually remains in one place for vision screening. Gait is part of neurological assessment. (C) Strabismus is crossing of eyes or outward deviation, which may cause diplopia or amblyopia. It is easily assessed during vision screening. (D) Papilledema is assessed by an ophthalmoscopic examination, which follows vision screening. It is part of neurological assessment.

NEW QUESTION 325

- (Topic 3)

At 16 weeks?? gestation, a pregnant client is admitted to the maternity unit to have a McDonald procedure (cerclage) done. She tells the RN who is admitting her to the unit that her physician had explained what this procedure was, but that she did not understand. The RN explains to the client that the purpose for this procedure is to:

- A. Reinforce an incompetent cervix
- B. Repair the amniotic sac
- C. Evaluate cephalopelvic disproportion
- D. Dilate the cervix

Answer: A

Explanation:

(A) The treatment most commonly uses the Shirodkar-Barter procedure (McDonald procedure) or cerclage to enforce the weakened cervix by encircling it with a suture at the level of the internal os. (B) There is no known procedure that is used to repair the amniotic sac. (C) Cephalopelvic disproportion is evaluated later in pregnancy. It is not related to this procedure. (D) No procedure is done to dilate the cervix at 16 weeks?? gestation unless the pregnancy is to be terminated.

NEW QUESTION 327

- (Topic 3)

A client was not using his seat belt when involved in a car accident. He fractured ribs 5, 6, and 7 on the left and developed a left pneumothorax. Assessment findings include:

- A. Crackles and paradoxical chest wall movement
- B. Decreased breath sounds on the left and chest pain with movement
- C. Rhonchi and frothy sputum
- D. Wheezing and dry cough

Answer: B

Explanation:

(A) Crackles are caused by air moving through moisture in the small airways and occur with pulmonary edema. Paradoxical chest wall movement occurs with flail chest when a segment of the thorax moves outward on inspiration and inward on expiration. (B) Decreased breath sounds occur when a lung is collapsed or partially collapsed. Chest pain with movement occurs with rib fractures. (C) Rhonchi are caused by air moving through large fluid-filled airways. Frothy sputum may occur with pulmonary edema. (D) Wheezing is caused by fluid in large airways already narrowed by mucus or bronchospasm. Dry cough could indicate a cardiac problem.

NEW QUESTION 329

- (Topic 3)

A burn victim??s immunization history is assessed by the nurse. Which immunization is of priority concern?

- A. Oral poliovirus vaccine
- B. Inactivated poliovirus vaccine
- C. Tetanus toxoid

D. Hepatitis B vaccine

Answer: C

Explanation:

(A) Oral poliovirus vaccine is given to prevent polio. Polio is transmitted by direct contact with an infected person. (B) Inactivated poliovirus vaccine is given to adults and immunosuppressed individuals. Polio is transmitted by direct contact with an infected person. (C) Tetanus toxoid prevents tetanus. Tetanus is transmitted through contaminated wounds. (D) Hepatitis B vaccine prevents hepatitis B infection. Hepatitis B is transmitted through contact with infected blood or body fluids.

NEW QUESTION 334

- (Topic 3)

A 2-month-old infant is receiving IV fluids with a volume control set. The nurse uses this type of tubing because it:

- A. Prevents administration of other drugs
- B. Prevents entry of air into tubing
- C. Prevents inadvertent administration of a large amount of fluids
- D. Prevents phlebitis

Answer: C

Explanation:

(A) A volume control set has a chamber that permits the administration of compatible drugs. (B) Air may enter a volume control set when tubing is not adequately purged. (C) A volume control set allows the nurse to control the amount of fluid administered over a set period. (D) Contamination of volume control set may cause phlebitis.

NEW QUESTION 336

- (Topic 3)

A 17-year-old client has a T-4 spinal cord injury. At present, he is learning to catheterize himself. When he says, "This is too much trouble. I would rather just have a Foley." An appropriate response for the RN teaching him would be:

- A. "I know."
- B. "It is a lot to learn."
- C. "In the long run, though, you will be able to reduce infections if you do an intermittent catheterization program."
- D. "It is not too much trouble."
- E. "This is the best way to manage urination."
- F. "Oh."
- G. "I'll ask your physician if we can replace the Foley."
- H. "You need to learn this because your doctor ordered it."

Answer: A

Explanation:

(A) This response acknowledges the client's feelings, gives him factual information, and acknowledges that the final decision is his. (B) This response is judgmental and discourages the client from expressing his feelings about the procedure. (C) Catheterization is a procedure that takes time to learn, but which, for the spinal cord-injured client, can significantly reduce the incidence of urinary tract infections. A young client with a T-4 injury has the hand function to learn this procedure fairly easily. (D) The final decision about bladder elimination management ultimately rests with the client and not the physician.

NEW QUESTION 341

- (Topic 3)

At 30 weeks' gestation, a client is admitted to the unit in premature labor. Her physician orders that an IV be started with 500 mL D5W mixed with 150 mg of ritodrine stat. The RN prepares the IV solution with the medication. The RN knows that clients receiving the medication ritodrine IV should be observed closely for which one of the following side effects:

- A. Hypoglycemia
- B. Hyperkalemia
- C. Tachycardia
- D. Increase in hematocrit and hemoglobin

Answer: C

Explanation:

(A) Ritodrine is a sympathomimetic 2-adrenergic agonist that can cause an elevation of blood glucose and plasma insulin in pregnant women. Hyperglycemia can occur in women with abnormal carbohydrate metabolism because of their inability to release more insulin. (B) Hypokalemia can occur resulting from the action of the β_2 -mimetics. It results from a displacement of the extracellular potassium into the intracellular space. (C) Ritodrine causes vasodilation of vessel walls, which can lead to hypotension. The body compensates by increasing heart rate and pulse pressure. (D) There is a lowering of serum iron resulting from the action of β_2 -mimetics to activate hematopoiesis.

NEW QUESTION 342

- (Topic 3)

On admission, the client has signs and symptoms of pulmonary edema. The nurse places the client in the most appropriate position for a client in pulmonary edema, which is:

- A. High Fowler
- B. Lying on the left side
- C. Sitting in a chair
- D. Supine with feet elevated

Answer: A

Explanation:

(A) High Fowler position decreases venous return to the heart and permits greater lung expansion so that oxygenation is maximized. (B) Lying on the left side may improve perfusion to the left lung but does not promote lung expansion. (C) Sitting in a chair will decrease venous return and promote maximal lung expansion. However, clients with pulmonary edema can deteriorate quickly and require intubation and mechanical ventilation. If a client is sitting in a chair when this deterioration happens, it will be difficult to intervene quickly. (D) The supine with feet elevated position increases venous return and will worsen pulmonary edema.

NEW QUESTION 345

- (Topic 4)

An obstructing stone in the renal pelvis or upper ureter causes:

- A. Radiating pain into the urethra with labia pain experienced in females or testicular pain in males
- B. Urinary frequency and dysuria
- C. Severe flank and abdominal pain with nausea, vomiting, diaphoresis, and pallor
- D. Dull, aching, back pain

Answer: C

Explanation:

(A) Radiating pain in the urethra in both sexes, extending into the labia in females and into the testicle or penis in the male, indicates a stone in the middle or lower segment of the ureter. (B) Urinary frequency and dysuria are caused by a stone in the terminal segment of the ureter within the bladder wall. (C) An obstructing stone in the renal pelvis or upper ureter causes severe flank and abdominal pain with nausea, vomiting, diaphoresis, and pallor. (D) Dull and aching pain may indicate early stages of hydronephrosis. Also, a stone in the renal pelvis or upper ureter causes severe flank and abdominal pain.

NEW QUESTION 348

- (Topic 4)

Before completing a nursing diagnosis, the nurse must first:

- A. Write goals and objectives
- B. Perform an assessment
- C. Plan interventions
- D. Perform evaluation

Answer: B

Explanation:

(A) Goals and objectives are based on a nursing assessment and diagnosis. (B) Assessment is the first step of nursing process. (C) Interventions are nursing actions to meet goals and objectives. (D) Evaluation process follows nursing interventions.

NEW QUESTION 349

- (Topic 4)

When giving discharge instructions to a 24-year-old client who had a short-arm cast applied for a fractured right ulna, the nurse recognizes the importance of telling him that the drying time for a plaster of Paris cast is approximately:

- A. 30 minutes
- B. 1–4 hours
- C. 12–24 hours
- D. 24–72 hours

Answer: D

Explanation:

(A) Synthetic cast materials harden in 3–15 minutes. Weight bearing is permitted in 15–30 minutes. Drying time for plaster of Paris is about 24–72 hours. (B, C) Plaster of Paris cast materials are heavier than synthetic materials and require a drying time of 24–72 hours. Synthetic materials dry within 30 minutes. (D) Plaster of Paris cast materials are heavier than synthetic materials and require a longer period to set and dry. Even though setting time (hardening) is only 3–15 minutes, the drying time for plaster of Paris is 24–72 hours. This depends on the size and thickness of the cast, exposure to air, and humidity in the air.

NEW QUESTION 350

- (Topic 4)

A 72-year-old male client had the Foley catheter that was inserted during the transurethral resection of his prostate removed today. He is concerned about the urinary incontinence he is having since removal of the Foley catheter. The nurse explains that:

- A. He should not be concerned about it because it will resolve quickly
- B. This is usually temporary
- C. The nurse will keep him dry, and he should notify the nurse when this happens
- D. This is related to the bladder spasms and will soon stop

Answer: B

Explanation:

(A) This problem is temporary, but it may take some time to resolve, especially in an older man. (B) This problem is usually temporary, but it may take some time to resolve. (C) Keeping the client dry will not relieve his anxiety about his incontinence. (D) The bladder spasms are not the cause of the client's incontinence.

NEW QUESTION 351

- (Topic 4)

A depressed client is seen at the mental health center for follow-up after an attempted suicide 1 week ago. She has taken phenelzine sulfate (Nardil), a monoamine oxidase (MAO) inhibitor, for 7 straight days. She states that she is not feeling any better. The nurse explains that the drug must accumulate to an effective level before symptoms are totally relieved. Symptom relief is expected to occur within:

- A. 10 days
- B. 2–4 weeks
- C. 2 months
- D. 3 months

Answer: B

Explanation:

(A) This answer is incorrect. It can take up to 1 month for therapeutic effect of the medication. (B) This answer is correct. Because MAO inhibitors are slow to act, it takes 2–4 weeks before improvement of symptoms is noted. (C) This answer is incorrect. It can take up to 1 month for therapeutic effect of the medication. (D) This answer is incorrect. Therapeutic effects of the medication are noted within 1 month of drug therapy.

NEW QUESTION 352

- (Topic 4)

A 47-year-old client has been admitted to the general surgery unit for bowel obstruction. The doctor has ordered that an NG tube be inserted to aid in bowel decompression. When preparing to insert a NG tube, the nurse measures from the:

- A. Lower lip to the shoulder to the upper sternum
- B. Tip of the nose to the lower lip to the umbilicus
- C. End of the tube to the first measurement line on the tube
- D. Tip of the nose to the ear lobe to the xiphoid process or midepigastic area

Answer: D

Explanation:

(A) This measurement is 50 cm (48–49 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (B) This measurement is 50 cm (47–48 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (C) This measurement gives an approximate indication of the length necessary for the distal end of the tube to be in place in the stomach, but it is not as accurate as actually measuring the client (nose-ear-xiphoid). (D) This is the correct measurement of 50 cm from the tip of the client's nose to the tip of the earlobe to the xiphoid process (called the NEX [nose-ear-xiphoid] measurement). It is approximately equal to the distance necessary for the distal end of the tube to be located in the correct position in the stomach.

NEW QUESTION 355

- (Topic 4)

A 29-year-old client delivered her fifth child by the Lamaze method and developed a postpartal hemorrhage in the recovery room. What are the initial symptoms of shock that she may experience?

- A. Marked elevation in blood pressure, respirations, and pulse
- B. Decreased systolic pressure, cold skin, and anuria
- C. Rapid pulse; narrowed pulse pressure; cool, moist skin
- D. No urinary output, tachycardia, and restlessness

Answer: C

Explanation:

(A) Early shock does not exhibit the symptom of marked elevation in blood pressure. A narrowing of the pulse pressure is indicative of early shock. (B) Anuria is a clinical finding in late shock. (C) All of these clinical findings are congruent with early shock. (D) Absence of urinary output is a clinical finding in the late phase of shock.

NEW QUESTION 360

- (Topic 4)

A client is diagnosed with diabetic ketoacidosis. The nurse should be prepared to administer which of the following IV solutions?

- A. D5 in normal saline
- B. D5W
- C. 0.9 normal saline
- D. D5 in lactated Ringer's

Answer: C

Explanation:

(A) D5 in normal saline would increase serum glucose. (B) D5W would increase serum glucose. (C) A concentration of 0.9 NS is used to correct extracellular fluid depletion. (D) D5 in Ringer's lactate would increase serum glucose.

NEW QUESTION 363

- (Topic 4)

When caring for a postoperative cholecystectomy client, the nurse assesses patency and documents drainage of the T-tube. The nurse recognizes that the expected amount of drainage during the first 24 hours postoperatively is:

- A. 50–100 mL
- B. 200–300 mL
- C. 300–500 mL
- D. 1000–1200 mL

Answer: C

Explanation:

(A) During the first 24 hours after surgery, the drainage is normally 300–500 mL and then decreases to about 200 mL in 24 hours during the next 3–4 days. (B)

This range is the amount of drainage after the first 24 hours postoperatively. During the first 24 hours, it is 300-500 mL. (C) During the first 24 hours after surgery, this range is the expected amount of drainage. (D) The expected amount of drainage during the first 24 hours is 300–500 mL. An output of >500 mL should be reported to the physician, because an occlusion of some type, caused by a retained gallstone or an inflammatory process within the biliary drainage system, is evident.

NEW QUESTION 364

- (Topic 4)

A client returns to the cardiovascular intensive care unit following his coronary artery bypass graft. In planning his care, the most important electrolyte the nurse needs to monitor will be:

- A. Chloride
- B. HCO₃
- C. Potassium
- D. Sodium

Answer: C

Explanation:

(A) Chloride, HCO₃, and sodium will need to be monitored, but monitoring these electrolytes is not as important as potassium monitoring. (B) Chloride, HCO₃, and sodium will need to be monitored, but monitoring these electrolytes is not as important as potassium monitoring. (C) Potassium will need to be closely monitored because of its effects on the heart. Hypokalemia could result in supraventricular tachyarrhythmias. (D) Chloride, HCO₃, and sodium will need to be monitored, but monitoring these electrolytes is not as important as potassium monitoring.

NEW QUESTION 365

- (Topic 4)

A 48-year-old client is being seen in her physician's office for complaints of indigestion, heartburn, right upper quadrant pain, and nausea of 4 days' duration, especially after meals. The nurse realizes that these symptoms may be associated with cholecystitis and therefore would check for which specific sign during the abdominal assessment?

- A. Cullen's sign
- B. Rebound tenderness
- C. Murphy's sign
- D. Turner's sign

Answer: C

Explanation:

(A) This sign is a faint blue discoloration around the umbilicus found in clients who have hemorrhagic pancreatitis. (B) This sign indicates areas of inflammation within the peritoneum, such as with appendicitis. It is a deep palpation technique used on a nontender area of the abdomen, and when the palpating hand is removed suddenly, the client experiences a sharp, stabbing pain at an area of peritoneal inflammation. (C) This sign is considered positive with acute cholecystitis when the client is unable to take a deep breath while the right upper quadrant is being deeply palpated. The client will elicit a sudden, sharp gasp, which means the gallbladder is acutely inflamed. (D) This is a sign of acute hemorrhagic pancreatitis and manifests as a green or purple discoloration in the flanks.

NEW QUESTION 368

- (Topic 4)

A client is a depressed, 48-year-old salesman. A serious concern for the nurse working with depressed clients is the potential of suicide. The time that suicide is most likely to occur is:

- A. In the acutely depressed state
- B. When the depression starts to lift
- C. In the denial phase
- D. During a manic episode

Answer: B

Explanation:

(A) The client may be too disorganized in the acute phase to make a workable plan. (B) When the depression starts to lift, the client is able to make a workable plan. (C) There usually is not a significant denial phase related to depression. Suicide occurs in a state of despair and hopelessness. (D) Suicide is uncommon in the manic state. In this state, clients do not feel hopeless, but euphoric and overly confident.

NEW QUESTION 373

- (Topic 4)

A male client was involved in a motor vehicle accident earlier in the day. The nurse caring for him on evenings notices that on admission to the hospital, he lost a lot of blood and required multiple blood transfusions. The nurse would anticipate which blood product would be ordered when a large blood loss has occurred?

- A. Whole blood
- B. Platelets
- C. Fresh frozen plasma
- D. Packed red blood cells

Answer: A

Explanation:

(A) Whole blood is the transfusion component of choice when large volumes of blood need to be replaced. Whole blood contains all blood components that are lost during active bleeding. (B) Platelet therapy is indicated for thrombocytopenia if the client's platelet count is below 15,000/mm³. (C) Infusion of fresh frozen plasma is required when the prothrombin time and partial thromboplastin time are prolonged. (D) Packed red blood cells are transfused in instances of anemia with decreases in hematocrit and hemoglobin.

NEW QUESTION 375

- (Topic 4)

A mother called the physician's office to ask if it would help relieve her small daughter's abdominal pain if she gave an enema and placed a heating pad on the abdomen. Her daughter has a fever and has vomited twice.

The nurse's response is based on the knowledge that:

- A. The symptoms could easily have been caused by constipation, which an enema would relieve
- B. Heat would help to relax the abdominal muscles and relieve her pain
- C. Both heat and enemas stimulate intestinal motility and could increase the risk of perforation
- D. Complaints of stomach ache are common in young children and are generally best ignored

Answer: C

Explanation:

(A) Constipation does not cause fever or vomiting but may cause anorexia. Risk of perforation outweighs the possible benefits of an enema. (B) Heat will not relieve her symptoms but will increase intestinal motility and increase the risk of perforation. (C) Heat and enemas are contraindicated where severe abdominal pain is suspected because they increase intestinal motility and the risk of perforation. (D) Complaints accompanied by physical symptoms such as pain, anorexia, and fever should never be ignored.

NEW QUESTION 379

- (Topic 4)

A neonate was admitted to the hospital with projectile vomiting. According to the parents, the baby had experienced vomiting episodes after feeding for the last 2 days. A medical diagnosis of hypertrophic pyloric stenosis was made. On assessment, the infant had poor skin turgor, sunken eyeballs, dry skin, and weight loss. Identify the number-one priority nursing diagnosis.

- A. Fluid volume deficit
- B. Altered nutrition
- C. Altered bowel elimination
- D. Anxiety

Answer: A

Explanation:

(A) Fluid volume deficit is the major problem. Symptoms of dehydration are evident. The effects of fluid and electrolyte balance may be life threatening. Rehydration can be accomplished effectively through IV fluids and electrolytes. (B) Vomiting may also signal a nutritional problem. However, the nutritional problem would be secondary to fluid and electrolyte disturbances. The infant may also be placed on NPO status. (C) With vomiting, a decrease in the size and number of stools is expected. (D) The infant cannot verbalize feelings of anxiety. Anxiety would not be an appropriate diagnosis.

NEW QUESTION 383

- (Topic 4)

In the coronary care unit, a client has developed multifocal premature ventricular contractions. The nurse should anticipate the administration of:

- A. Furosemide
- B. Nitroglycerin
- C. Lidocaine
- D. Digoxin

Answer: C

Explanation:

(A) Furosemide is a loop diuretic. (B) Nitroglycerin is a vasodilator. (C) Lidocaine is the drug of choice to treat ectopic ventricular beats. (D) Digoxin slows down the electrical impulses and increases ventricular contractions, but it does not rapidly correct ventricular ectopy.

NEW QUESTION 386

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