NCLEX

Exam Questions NCLEX-PN

National Council Licensure Examination(NCLEX-PN)

NEW QUESTION 1
- (Topic 1)
A client who is immobilized secondary to traction is complaining of constipation. Which of the following medications should the nurse expect to be ordered?

A. Advil
B. Anasaid
C. Clinocil
D. Colace

Answer: D

Explanation:
Colace is a stool softener that acts by pulling more water into the bowel lumen, making the stool soft and easier to evacuate.Basic Care and Comfort

NEW QUESTION 2
- (Topic 1)
Teaching the client with gonorrhea how to prevent reinfection and further spread is an example of:

A. primary prevention.
B. secondary prevention.
C. tertiary prevention.
D. primary health care prevention.

Answer: B

Explanation:
Secondary prevention targets the reduction of disease prevalence and disease morbidity through early diagnosis and treatment.Physiological Adaptation

NEW QUESTION 3
- (Topic 1)
A middle-aged woman tells the nurse that she has been experiencing irregular menses for the past six months. The nurse should assess the woman for other symptoms of:

A. climacteric.
B. menopause.
C. perimenopause.
D. postmenopause.

Answer: C

Explanation:
Perimenopause refers to a period of time in which hormonal changes occur gradually, ovarian function diminishes, and menses become irregular. Perimenopause lasts approximately five years.
Climacteric is a term applied to the period of life in which physiologic changes occur and result in cessation of a woman??s reproductive ability and lessened sexual activity in males. The term applies to both genders. Climacteric and menopause are interchangeable terms when used for females. Menopause is the period when permanent cessation of menses has occurred. Postmenopause refers to the period after the changes accompanying menopause are complete.Health Promotion and Maintenance

NEW QUESTION 4
- (Topic 1)
Which of the following nursing diagnoses might be appropriate as Parkinson??s disease progresses and complications develop?

A. Impaired Physical Mobility
B. Dysreflexia
C. Hypothermia
D. Impaired Dentition

Answer: A

Explanation:
The client with Parkinson??s disease can develop a shuffling gait and rigidity, causing impaired physical mobility. The other diagnoses do not necessarily relate to a client with Parkinson??s disease.
Reduction of Risk Potential

NEW QUESTION 5
- (Topic 1)
The major electrolytes in the extracellular fluid are:

A. potassium and chloride.
B. potassium and phosphate.
C. sodium and chloride.
D. sodium and phosphate.

Answer: C

Explanation:
Sodium and chloride are the major electrolytes in the extracellular fluid.Physiological Adaptation

NEW QUESTION 6
- (Topic 1)
A client is complaining of difficulty walking secondary to a mass in the foot. The nurse should document this finding as:

A. plantar fasciitis.
B. hallux valgus.
C. hammertoe.
D. Morton??s neuroma.

Answer: D

Explanation:
Morton??s neuroma is a small mass or tumor in a digital nerve of the foot. Hallux valgus is referred to in lay
terms as abunion.Hammertoe is where one toe is cocked up over another toe. Plantar fasciitis is an inflammation of, or pain in, the arch of the foot.Basic Care and Comfort

NEW QUESTION 7
- (Topic 1)
A primary belief of psychiatric mental health nursing is:

A. most people have the potential to change and grow.
B. every person is worthy of dignity and respect.
C. human needs are individual to each person.
D. some behaviors have no meaning and cannot be understood.

Answer: B

Explanation:
Every person is worthy of dignity and respect. Every person has the potential to change and grow. All people have basic human needs in common with others. All behavior has meaning and can be understood from the client??s perspective.Psychosocial Integrity

NEW QUESTION 8
- (Topic 1)
The kind of man who beats a woman is:

A. from a minority culture in a low-income group.
B. from a majority culture in a middle-income group.
C. one who was never allowed to compete as a child.
D. from any walk of life, race, income group, or profession.

Answer: D

Explanation:
Batterers cannot be predicted by demographic features related to age, ethnicity, race, religious denomination, education, socioeconomic status, or class. Ninety-five percent of domestic abuse cases
involve male perpetrators and female victims.Psychosocial Integrity

NEW QUESTION 9
- (Topic 1)
The nurse is teaching parents of a newborn about feeding their infant. Which of the following instructions should the nurse include?

A. Use the defrost setting on microwave ovensto warm bottles.
B. When refrigerating formula, don??t feed the baby partially used bottles after 24 hours.
C. When using formula concentrate, mix two parts water and one part concentrate.
D. If a portion of one bottle is left for the next feeding, go ahead and add new formula to fill it.

Answer: A

Explanation:
Parents must be careful when warming bottles in a microwave oven because the milk can become superheated.
When a microwave oven is used, the defrost setting should be chosen, and the temperature of the formula should be checked before giving it to the baby. Refrigerated, partially used bottles should be discarded after 4 hours because the baby might have introduced some pathogens into the formula. Returning the bottle to the refrigerator does not destroy pathogens. Formula concentrate and water are usually mixed in a 1:1 ratio of one part concentrate and one part water. Infants should be offered fresh formula at each feeding. Partially used bottles should not have fresh formula added to them. Pathogens can grow in partially used bottles of formula and be transferred to the new formula.Health Promotion and Maintenance

NEW QUESTION 10
- (Topic 1)
Which of the following foods should be avoided by clients who are prone to develop heartburn as a result of gastroesophgeal reflux disease (GERD)?

A. lettuce
B. eggs
C. chocolate
D. butterscotch

Answer: C

Explanation:
Ingestion of chocolate can reduce lower esophageal sphincter (LES) pressure leading to reflux and clinical symptoms of GERD. The other foods do not affect LES pressure.Basic Care and Comfort

NEW QUESTION 10
- (Topic 1)
A client has been taking alprazolam (Xanax) for four years to manage anxiety. The client reports taking 0.5 mg four times a day. Which statement indicates that the client understands the nurse??s teaching about discontinuing the medication?

A. ??I can drink alcohol now that I am decreasing my Xanax.??
B. ??I should not take another Xanax pil
C. Here is what is left of my last prescription.??
D. ??I should take three pills per day next week, then two pills for one week, then one pill for one week.??
E. ??I can expect to be sleepy for several days after stopping the medicine.??

Answer: C

Explanation:
Xanax, like other benzodiazepines, can cause withdrawal symptoms that include agitation, insomnia, hypertension, seizures, and abdominal pain. The drug must be slowly decreased to prevent withdrawal symptoms.
Psychosocial Integrity

NEW QUESTION 15
- (Topic 1)
Ashley and her boyfriend Chris, both 19 years old, are transported to the Emergency Department after being involved in a motorcycle accident. Chris is badly hurt, but Ashley has no apparent injuries, though she appears confused and has trouble focusing on what is going on around her. She complains of dizziness and nausea. Her pulse is rapid, and she is hyperventilating. The nurse should assess Ashley??s level of anxiety as:

A. mild.
B. moderate.
C. severe.
D. panic.

Answer: C

Explanation:
The person whose anxiety is assessed as severe is unable to solve problems and has a poor grasp of what??s happening in his or her environment. Somatic symptoms such as those described by Ashley are usually present.
Vital sign changes are observed. The individual with mild anxiety might report being mildly uncomfortable and might even find performance enhanced. The individual with moderate anxiety grasps less information about the situation, has some difficulty problem-solving, and might have mild changes in vital signs.
The individual in panic demonstrates markedly disturbed behavior and might lose touch with reality.
Psychosocial Integrity

NEW QUESTION 19
- (Topic 1)
When making an occupied bed, it is important for the nurse to:

A. keep the bed in the low position.
B. use a bath blanket or top sheet for warmth and privacy.
C. constantly keep side rails raised on both sides.
D. move back and forth from one side to the other when adjusting the linens.

Answer: B

Explanation:
Using a bath blanket or top sheet keeps the client warm and provides privacy. Keeping the bed in the low position and working above raised side rails might strain the nurse??s back. Continually moving back and forth to tuck and arrange linen is time-consuming and disorganized.Basic Care and Comfort

NEW QUESTION 20
- (Topic 1)
A young boy is recently diagnosed with a seizure disorder. Which of the following statements by the boy??s mother indicates a need for further teaching by the nurse?

A. ??I should make sure he gets plenty of rest.??
B. ??I should get him a medic alert bracelet.??
C. ??I should lay him on his back during a seizure.??
D. ??I should loosen his clothing during a seizure.??

Answer: C

Explanation:
A client having a seizure should be turned to the side to prevent aspiration of secretions.
The other statements are correct and indicate adequate understanding of teaching.Reduction of Risk Potential

NEW QUESTION 21
- (Topic 1)
What is the primary nutritional deficiency of concern for a strict vegetarian?

A. vitamin C
B. vitamin B12
C. vitamin E
D. magnesium

Answer: B

Explanation:
Vitamin B12 is the primary nutritional deficiency of concern for a strict vegetarian.Health Promotion and Maintenance

NEW QUESTION 25
- (Topic 1)
A client comes to the clinic for assessment of his physical status and guidelines for starting a weight-reduction diet. The client??s weight is 216 pounds and his height is 66 inches. The nurse identifies the BMI (body mass index) as:

A. within normal limits, so a weight-reduction diet is unnecessary.
B. lower than normal, so education about nutrient-dense foods is needed.
C. indicating obesity because the BMI is 35.
D. indicating overweight status because the BMI is 27.

Answer: C

Explanation:
Obesity is defined by a BMI of 30 or more with no co-morbid conditions. It is calculated by utilizing a chart or nomogram that plots height and weight. This client??s BMI is 35, indicating obesity. Goals of diet therapy are aimed at decreasing weight and increasing activity to healthy levels based on a client??s BMI, activity status, and energy requirements.Physiological Adaptation

NEW QUESTION 30
- (Topic 1)
James returns home from school angry and upset because his teacher gave him a low grade on an assignment. After returning home from school, he kicks the dog. This coping mechanism is known as:

A. denial.
B. suppression.
C. displacement.
D. fantasy.

Answer: C

Explanation:
Displacement is the transference of anger to another. Anger is displaced on the dog as a convenient object.
Psychosocial Integrity

NEW QUESTION 33
- (Topic 1)
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

A. epilepsy
B. Parkinson??s
C. muscular sclerosis
D. Huntington??s chorea

Answer: D

Explanation:
Huntington??s chorea is characterized by writhing, twisting movements of the face and limbs.
The remaining options are neurological disorders that do not have such movements as part of their disease process.Reduction of Risk Potential

NEW QUESTION 38
- (Topic 1)
Which of the following is most likely to impact the body image of an infant newly diagnosed with Hemophilia?

A. immobility
B. altered growth and development
C. hemarthrosis
D. altered family processes

Answer: D

Explanation:
Altered Family Processes is a potential nursing diagnosis for the family and client with a new diagnosis of Hemophilia. Infants are aware of how their caregivers respond to their needs. Stresses can have an immediate impact on the infant??s development of trust and how others relate to them because of their diagnosis. The longterm effects of hemophilia can include problems related to immobility. Altered growth and

development could not have developed in a newly diagnosed client. Hemarthrosis is acute bleeding into a joint space that is characteristic of hemophilia. It does not have an immediate effect on the body image of a newly diagnosed hemophiliac.Health Promotion and Maintenance

NEW QUESTION 40
- (Topic 1)
To remove a client??s gown when she has an intravenous line, the nurse should:

A. temporarily disconnect the intravenous tubing at a point close to the client and thread it through the gown.
B. cut the gown with scissors.
C. thread the bag and tubing through the gown sleeve, keeping the line intact.
D. temporarily disconnect the tubing from the intravenous container and thread it through the gown.

Answer: C

Explanation:
Threading the bag and tubing through the gown sleeve keeps the system intact. Opening an intravenous line causes a break in a sterile system and introduces the potential for infection. Cutting a gown off is not an alternative except in an emergency. IV gowns, which open along sleeves, are widely available.Basic Care and Comfort

NEW QUESTION 43
- (Topic 1)
Which of the following values should the nurse monitor closely while a client is on total parenteral nutrition?

A. calcium
B. magnesium
C. glucose
D. cholesterol

Answer: C

Explanation:
Glucose is monitored closely when a client is on total parenteral nutrition, due to high glucose concentration in the solutions. The other values are not monitored as closely.Health Promotion and Maintenance

NEW QUESTION 45
- (Topic 1)
A client with dumping syndrome should _____ while a client with GERD should _____.

A. sit up 1 hour after meals; lie flat 30 minutes after meals
B. lie down 1 hour after eating; sit up at least 30 minutes after eating
C. sit up after meals; sit up after meals
D. lie down after meals; lie down after meals

Answer: B

Explanation:
Clients with dumping syndrome should lie down after eating to decrease dumping syndrome. GERD clients should sit up to prevent backflow of acid into the esophagus.Basic Care and Comfort

NEW QUESTION 47
- (Topic 1)
Major competencies for the nurse giving end-oflife care include:

A. demonstrating respect and compassion, and applying knowledge and skills in care of the family and the client.
B. assessing and intervening to support total management of the family and client.
C. setting goals, expectations, and dynamic changes to care for the client.
D. keeping all sad news away from the family and client.

Answer: A

Explanation:
There are many competencies that the nurse must have to care for families and clients at the end of life.
Demonstration of respect and compassion as well as using knowledge and skills in the care of the client and family are major competencies.Basic Care and Comfort

NEW QUESTION 49
- (Topic 1)
When helping a client gain insight into anxiety, the nurse should:

A. help relate anxiety to specific behaviors.
B. ask the client to describe events that precede increased anxiety.
C. instruct the client to practice relaxation techniques.
D. confront the client??s resistive behavior.

Answer: B

Explanation:

To gain insight, the client needs to recognize causal events. The other activities focus on recognition of anxiety.Psychosocial Integrity

NEW QUESTION 52
- (Topic 1)
Which fetal heart monitor pattern can indicate cord compression?

A. variable decelerations
B. early decelerations
C. bradycardia
D. tachycardia

Answer: A

Explanation:
Variable decelerations can be related to cord compression. The other patterns are not.
Reduction of Risk Potential

NEW QUESTION 56
- (Topic 1)
Following a classic cholecystectomy resection for multiple stones, the PACU nurse observes a serosanguious drainage on the dressing. The most appropriate intervention is to:

A. notify the physician of the drainage.
B. change the dressing.
C. reinforce the dressing.
D. apply an abdominal binder.

Answer: C

Explanation:
Serosanguious drainage is expected at this time. The dressing should be reinforced.
Changing a new postop dressing increases the risk of infection. An abdominal binder interferes with visualization of the dressing.Basic Care and Comfort

NEW QUESTION 57
- (Topic 1)
How often should the nurse change the intravenous tubing on total parenteral nutrition solutions?

A. every 24 hours
B. every 36 hours
C. every 48 hours
D. every 72 hours

Answer: A

Explanation:
The nurse should change the intravenous tubing on total parenteral nutrition solutions every 24 hours, due to the high risk of bacterial growth.Health Promotion and Maintenance

NEW QUESTION 60
- (Topic 1)
What do the following ABG values indicate: pH 7.38, PO2 78 mmHg, PCO2 36mmHg, and HCO3 24 mEq/L?

A. metabolic alkalosis
B. homeostasis
C. respiratory acidosis
D. respiratory alkalosis

Answer: B

Explanation:
These ABG values are within normal limits. Choices 1, 3, and 4 are incorrect because the ABG values indicate none of these acid-base disturbances.Physiological Adaptation

NEW QUESTION 64
- (Topic 1)
All of the following should be performed when fetal heart monitoring indicates fetal distress except:

A. increase maternal fluids.
B. administer oxygen.
C. decrease maternal fluids.
D. turn the mother.

Answer: C

Explanation:

Decreasing maternal fluids is the only intervention that shouldnotbe performed when fetal distress is indicated.Reduction of Risk Potential

NEW QUESTION 65
- (Topic 2)
The vast majority of deaths resulting from unintentional poisoning occur in:

A. infants.
B. toddlers.
C. teens.
D. adults.

Answer: B

Explanation:
The vast majority of deaths resulting from unintentional poisoning occur in toddlers.Safety and Infection Control

NEW QUESTION 68
- (Topic 2)
The nurse teaching an obese client about nutritional needs and weight loss should include all of the following except:

A. knowledge of food and food products.
B. development of a positive mental attitude.
C. adequate exercise.
D. starting a fast weight-loss diet.

Answer: D

Explanation:
Start a fast weight-loss diet.Health Promotion and Maintenance

NEW QUESTION 73
- (Topic 2)
A 57-year-old woman is recently widowed. She states, ??I will never be able to learn how to manage the finances. My husband did all of that.?? Select the nurse??s response that could help raise the client??s self-esteem.

A. ??You feel inadequate because you have never learned to balance a checkbook.??
B. ??You should have insisted your husband teach you about the finances.??
C. ??You are strong and will learn how to manage your finances after awhile.??
D. ??Why don??t you take a class in basic finance from the local college???

Answer: C

Explanation:
The nurse can raise the client??s self-esteem by communicating confidence the client can participate in actively finding solutions to the problem. The nurse also conveys the client is a worthwhile person by listening and accepting the client??s feelings and praising the client for seeking assistance.
Psychosocial Integrity

NEW QUESTION 77
- (Topic 2)
High uric acid levels can develop in clients who are receiving chemotherapy. This can be caused by:

A. the inability of the kidneys to excrete the drug metabolites.
B. rapid cell catabolism.
C. toxic effects of the prophylactic antibiotics that are given concurrently.
D. the altered blood pH from the acid medium of the drugs.

Answer: B

Explanation:
Chemotherapy causes damage to cells, and uric acid is a cell metabolite.Physiological Adaptation

NEW QUESTION 80
- (Topic 2)
Using clich??s in therapeutic communication leads the client toward:

A. viewing the nurse as human.
B. accepting himself as human.
C. self-disclosing.
D. feeling discounted.

Answer: D

Explanation:
The use of clich??s in therapeutic communication is commonly construed by the client as the nurse??s lack of understanding, involvement, and caring, so the

client might feel demeaned and discounted.
Psychosocial Integrity

NEW QUESTION 85
- (Topic 2)
Someone who has received a recent tattoo should be screened for:

A. tuberculosis.
B. herpes.
C. hepatitis.
D. syphilis.

Answer: C

Explanation:
Tattooing puts a client at risk for blood-borne hepatitis B or C if strict sterile procedures are not followed.
Tuberculosis is an airborne pathogen, while herpes and syphilis are spread directly (such as through sexual contact).Safety and Infection Control

NEW QUESTION 86
- (Topic 2)
A client goes to the Emergency Department with acute respiratory distress and the following arterial blood gases (ABGs): pH 7.35, PCO2 40 mmHg, PO2 63mmHg, HCO3 23, and oxygenation saturation (SaO2) 93%. Which of the following represents the best analysis of the etiology of these ABGs?

A. tuberculosis (TB)
B. pneumonia
C. pleural effusion
D. hypoxia

Answer: D

Explanation:
A combined low PO2 and lowSaO2 indicates hypoxia. The pH, PCO2, and HCO3 are normal. ABGs are not necessarily altered in TB or pleural effusion. Depending on the degree of the pneumonia, the PO2 and PCO2 might be low because hypoxia stimulates hyperventilation.Physiological Adaptation

NEW QUESTION 87
- (Topic 2)
The chemotherapeutic DNA alkylating agents such as nitrogen mustards are effective because they:

A. cross-link DNA strands with covalent bonds between alkyl groups on the drug and guanine bases on DNA.
B. have few, if any, side effects.
C. are used to treat multiple types of cancer.
D. are cell-cycle-specific agents.

Answer: A

Explanation:
Alkylating agents are highly reactive chemicals that introduce alkyl radicals into biologically active molecules and thereby prevent their proper functioning, replication, and transcription. Choice 2 is incorrect because alkylating agents have numerous side effects including alopecia, nausea, vomiting, and myelosuppression. Choice 3 is incorrect because nitrogen mustards have a broad spectrum of activity against chronic lymphocytic leukemia, non-Hodgkin??s lymphoma, and breast and ovarian cancer, but they are effective chemotherapeutic agents because of DNA crosslinkage. Choice 4 is incorrect because alkylating agents are non-cell-cycle- specific agents.PharmacologicalTherapies

NEW QUESTION 92
- (Topic 2)
A client with asthma develops respiratory acidosis. Based on this diagnosis, what should the nurse expect the client??s serum potassium level to be?

A. normal
B. elevated
C. low
D. unrelated to the pH

Answer: B

Explanation:
Hyperkalemia occurs in a state of acidosis because potassium moves from injured cells into the bloodstream.
Physiological Adaptation

NEW QUESTION 97
- (Topic 2)
A child comes to the clinic with a skin rash. The maculopapular lesions are distributed around the mouth and have honey-colored drainage. The caregiver states that the rash is getting worse and seems to spread with the child??s scratching. Which of the following advisory comments should be given?

A. The history and presentation might indicate chickenpox, a highly contagious disease.
B. The lesions might indicate a noncontagious infection that does not require isolation.
C. The history and presentation might indicate an infectious illness called impetigo.
D. The lesions are not contagious unless others have open wounds or lesions themselves.

Answer: C

Explanation:
The scenario describes classic impetigo for which the physician is likely to order antibiotic therapy.
Chickenpox is highly contagious but presents with a history of high fever followed by a vesicular rash.Safety and Infection Control

NEW QUESTION 101
- (Topic 2)
A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least likely to increase the risk of hemorrhage?

A. Test all excreta for occult blood.
B. Use a soft toothbrush or foam cleaner for oral hygiene.
C. Implement reverse isolation.
D. Avoid IM injections.

Answer: C

Explanation:
Reverse isolation does not affect the risk of hemorrhage.Physiological Adaptation

NEW QUESTION 106
- (Topic 2)
How often must physical restraints be released?

A. every 2 hours
B. between 1 and 3 hours
C. every 30 minutes
D. at least every 4 hours

Answer: A

Explanation:
Restraints must be released every 2 hours, and the client must be assessed every 30 minutes while restrained.
Safety and Infection Control

NEW QUESTION 109
- (Topic 2)
A client is given an opiate drug for pain relief following general anesthesia. The client becomes extremely somnolent with respiratory depression. The physician is likely to order the administration of:

A. naloxone (Narcan).
B. labetalol (Normodyne).
C. neostigmine (Prostigmin).
D. thiothixene (Navane).

Answer: A

Explanation:
Naloxone is an opiate antagonist. It attaches to opiate receptors and blocks or reverses the action of narcotic analgesics. Choice 2 is incorrect because Labetalol is a beta blocker. Choice 3 is incorrect because Neostigmine is an anticholinesterase agent. Choice 4 is incorrect because Thiothixene is an antipsychotic agent.Pharmacological Therapies

NEW QUESTION 114
- (Topic 2)
An assessment of the skull of a normal 10-monthold baby should identify which of the following?

A. closure of the posterior fontanel.
B. closure of the anterior fontanel.
C. overlap of cranial bones.
D. ossification of the sutures.

Answer: A

Explanation:
The posterior fontanel should close by the age of 2 months.Health Promotion and Maintenance

NEW QUESTION 116
- (Topic 2)
Which of the following observations is most important when assessing a client??s breathing?

A. presence of breathing and pulse rate
B. breathing pattern and adequacy of breathing
C. presence of breathing and adequacy of breathing
D. patient position and adequacy of breathing

Answer: C

Explanation:
It is not enough to simply make sure the client is breathing. The client must be breathing adequately. Physiological Adaptation

NEW QUESTION 119
- (Topic 2)
All of the following are common reasons that nurses are reluctant to delegate except:

A. lack of self-confidence.
B. desire to maintain authority.
C. confidence in subordinates.
D. getting trapped in the ??I can do it better myself?? mindset.

Answer: C

Explanation:
If a delegator has confidence in his subordinates and feels that a task will be performed correctly, he is more likely to delegate. Reasons that delegators are reluctant to delegate include their own lack of confidence, fear of losing authority or personal satisfaction, and feeling that the task can only be performed correctly if they do it themselves.Coordinated Care

NEW QUESTION 123
- (Topic 2)
A wrong committed by one person against another (or against the property of another) that might result in a civil trial is:

A. a tort.
B. a crime.
C. a misdemeanor.
D. a felony.

Answer: A

Explanation:
Torts are wrongs committed by one person against another person (or against the property of another), which might result in civil trials. A crime is also defined as a wrong against a person or their property but is considered to be against the public as well. Misdemeanors are crimes that are commonly punishable with fines or imprisonment for less than one year, with both or with parole. A felony is a serious crime punishable by imprisonment in a State or Federal penitentiary for more than one year.Coordinated Care

NEW QUESTION 126
- (Topic 2)
Distribution of a drug to various tissues is dependent on the amount of cardiac output to each type of tissue. Which tissue would receive the highest amount of cardiac output and thus the highest amount of a drug?

A. skin
B. adipose tissue
C. skeletal muscle
D. myocardium

Answer: D

Explanation:
Highly perfused tissue includes all vital organs: the brain, heart, kidneys, adrenal glands, and liver. Choices 1, 2, and 3 are incorrect because the skin and adipose tissue are poorly perfused, while the skeletal muscle is better perfused.Pharmacological Therapies

NEW QUESTION 129
- (Topic 2)
A 45-year-old client with type I diabetes is in need of support services upon discharge from
a skilled rehabilitation unit. Which of the following services is an example of a skilled support service?

A. shopping for groceries
B. house cleaning
C. transportation to physician??s visits
D. medication instruction

Answer: D

Explanation:
The only skilled service listed is medication instruction. Grocery shopping, house-cleaning services, and transportation services are all examples of unskilled services offered by volunteer and fee- for-service agencies.
Coordinated Care

NEW QUESTION 133
- (Topic 2)
According to the ANA Code of Ethics for Nurses, professional nurses have an ethical obligation to:

A. clients (patients).
B. the profession of nursing.
C. provide high-quality care.
D. all of the above.

Answer: D

Explanation:
All the choices are elements of the ANA Code of Ethics for Nurses.Coordinated Care

NEW QUESTION 137
- (Topic 2)
Medication bound to protein can have which of the following effects?

A. enhancement of drug availability
B. rapid distribution of the drug to receptor sites
C. less availability to produce desired medicinal effects
D. increased metabolism of the drug by the liver

Answer: C

Explanation:
Only an unbound drug can be distributed to active receptor sites. Therefore, the more of a drug that is bound to protein, the less it is available for the desired drug effect. Choice 1 is incorrect because less drug is available if it is bound to protein. Choice 2 is incorrect because distribution to receptor sites is irrelevant if the drug, which is bound to protein, cannot bind with a receptor site. Choice 4 is incorrect because metabolism is not increased. The liver first has to remove the drug from the protein molecule before metabolism can occur.
The protein is then free to return to circulation and be used again.Pharmacological Therapies

NEW QUESTION 140
- (Topic 2)
The nurse is teaching a client about the use of Rifampin for prophylaxis after an exposure to meningitis. What change in bodily functions should the nurse advise the client about?

A. The client??s urine might turn blue.
B. The client remains infectious to others for 48 hours.
C. The client??s contact lenses might be stained orange.
D. The client??s skin might take on a crimson glow.

Answer: C

Explanation:
Rifampin has the unusual effect of turning body fluids an orange color. Soft contact lenses might become
permanently stained. Clients should be taught about these side effects to avoid unnecessary concern.Safety and Infection Control

NEW QUESTION 142
- (Topic 2)
The 24-hour day-night cycle is known as:

A. circadian rhythm.
B. infradium rhythm.
C. ultradian rhythm.
D. non-REM rhythm.

Answer: A

Explanation:
Circadian rhythm is rhythmic repetition of patterns each 24 hours. The other options are incorrect.Basic Care and Comfort

NEW QUESTION 147
- (Topic 2)
On first meeting, a new nurse manager makes eye contact, smiles, initiates conversation about the previous work experience of nurses, and encourages active participation by nurses in the dialogue. Her behavior is an example of:

A. aggressiveness.
B. passive aggressiveness.
C. passiveness.
D. assertiveness.

Answer: D

Explanation:
This nurse manager is demonstrating assertive behavior. Aggressive behavior dominates or embarrasses.
Passive behavior is nervous or timid. Passive-aggressive behavior is dominating or manipulative without directness.
Coordinated Care

NEW QUESTION 149
- (Topic 2)
A 17-year-old female was raped by a young man in her neighborhood. She is in the Emergency Department for evaluation and tests. After the procedure is completed, a rape crisis counselor (nurse specialist) talks to the client in a conference room regarding the rape. Implementing counseling by the nurse specialist for the raped victim represents:

A. assessment.

B. crisis intervention.
C. empathetic concern.
D. unwarranted intrusion.

Answer: B

Explanation:
Choice 2 is part of the Crisis Intervention Model. Counseling by a nurse specialist at the time of a stressful event (rape) can strengthen the client??s coping. A nurse specialist in rape crisis intervention is educationally prepared in counseling and crisis intervention specific to rape victims.Coordinated Care

NEW QUESTION 151
- (Topic 2)
Support-system enhancement includes all of the following except:

A. determining the barriers to using support systems.
B. discussing ways to help with others who are concerned.
C. exploring life problems of the support-team members.
D. involving spouse, family, and friends in the care and planning.

Answer: C

Explanation:
The exploration of life problems of support-team members is not necessary to enhance the support system. Choices 1, 2, and 4 are all enhancements for a support system.Psychosocial Integrity

NEW QUESTION 153
- (Topic 2)
A 65-year-old female client is experiencing postmenopausal bleeding. Which type of physician should this client be encouraged to see?

A. a radiologist
B. a gynecologist
C. a physiatrist
D. an oncologist

Answer: B

Explanation:
A gynecologist is the physician who treats and manages disease of the female reproductive organs. A radiologist evaluates X-rays. A physiatrist is the physician manager of a rehabilitation team. An oncologist treats clients with cancer.Coordinated Care

NEW QUESTION 158
- (Topic 3)
Pulling is easier than pushing. So pulling a client rather than pushing him or her has which of the following advantages?

A. reduces workload
B. decreases opposition from gravity
C. maintains stability
D. prevents muscle strain

Answer: A

Explanation:
Pulling an object works with gravitational force not opposing it, lowering risk of muscle strain.Basic Care and Comfort

NEW QUESTION 161
- (Topic 3)
The nurse has completed client teaching about introducing solid foods to an infant. To evaluate teaching, the nurse asks the mother to identify an appropriate first solid food. Which of the following is an appropriate response?

A. pureed canned squash
B. pureed apples
C. yogurt
D. infant rice cereal

Answer: D

Explanation:
Single-grain infant cereals are recommended first because they are easily digestible and have added iron content. Choice 3 is incorrect because yogurt is a milk product and introduction should be delayed until the child is 12 months of age because of the risk of milk allergy. Choices 1 and 2 are incorrect because fruits and vegetables are usually given following the introduction of cereals.Basic Care and Comfort

NEW QUESTION 166
- (Topic 3)
A client with Parkinson??s disease has difficulty performing voluntary movements. This is known as:

A. akinesia.
B. dyskinesia.
C. chorea.
D. dystonia.

Answer: B

Explanation:
Dyskinesia is an impairment of the ability to execute voluntary muscles.Physiological Adaptation

NEW QUESTION 168
- (Topic 3)
Which of the following client groups should the nurse recognize as the fastest-growing segment of the homeless population?

A. single, adult men
B. single mothers with 2 or 3 children
C. runaway adolescents
D. single, adult women

Answer: B

Explanation:
Single mothers with two or three children are the fastest-growing segment of the homeless population. The majority of the children are under the age of five, and the total number of children who are homeless account for more than one-third of the homeless population in the United States. In the past, single adults were the largest group in the homeless population, with more men than women being homeless. Runaway adolescents account for another group of homeless children. Many are victims of abuse or long-term family or school problems.HealthPromotion and Maintenance

NEW QUESTION 172
- (Topic 3)
The method of splinting is always dictated by:

A. location of the injury and whether it is open or closed.
B. the severity of the client??s condition and the priority decision.
C. the number of available rescuers and the type of splints.
D. all of the above.

Answer: B

Explanation:
The method of splinting is always dictated by the severity of the client??s condition and the priority decision.
Basic Care and Comfort

NEW QUESTION 176
- (Topic 3)
Which of the following should not be included in the teaching for clients who take oral iron preparations?

A. Mix the liquid iron preparation with antacids to reduce GI distress.
B. Take the iron with meals if GI distress occurs.
C. Liquid forms should be taken with a straw to avoid discoloration of tooth enamel.
D. Oral forms should be taken with juice, not milk.

Answer: A

Explanation:
Iron should not be mixed with antacids.Physiological Adaptation

NEW QUESTION 181
- (Topic 3)
A client receiving drug therapy with furosemide and digitalis requires careful observation and care. In planning care for this client, the nurse should recognize that which of the following electrolyte imbalances is most likely to occur?

A. hyperkalemia
B. hypernatremia
C. hypokalemia
D. hypomagnesemia

Answer: C

Explanation:
Diuretics such as furosemide might deplete serum potassium. Additionally, the action of digitalis might be
potentiated by hypokalemia. These drugs are not associated with hyperkalemia. Diuretic therapy could cause hyponatremia, not hypernatremia. Choice 4 is generally associated with poor nutrition, alcoholism, and excessive GI or renal losses.Physiological Adaptation

NEW QUESTION 184
- (Topic 3)
An Rh-negative woman with previous sensitization has delivered an Rh-positive fetus. Which of the following nursing actions should be included in the client??s

care plan?

A. emotional support to help the family deal with feelings of guilt about the infant??s condition
B. administration of MICRhoGam to the woman within 72 hours of delivery
C. administration of Rh-immune globulin to the newborn within 1 hour of delivery
D. lab analysis of maternal Direct Coombs?? test

Answer: A

Explanation:
If a woman is sensitized to the Rh factor, it poses a threat to any Rh-positive fetus she delivers. The nurse needs to provide emotional support to help the family deal with the infant??s condition, which might involve a host of conditions that could lead to death or marked neurological damage. RhoGam is never given to a woman already sensitized. If not previously sensitized, MICRhoGam (a smaller dose of Rh immune globulin) is given after an abortion or ectopic pregnancy to prevent sensitization. If not sensitized, RhoGam is given to the woman within 72 hours of delivery. Rh-immune globulin is never given to the newborn. To determine if sensitization has occurred, an Indirect Coombs?? is drawn on the mother to measure the number of Rh- positive antibodies.Health Promotion and Maintenance

NEW QUESTION 186
- (Topic 3)
Incidences of child abuse apperar to be higher in the African-American community and might be explained by:

A. the increased number of African Americans viewing violence on television.
B. more single-parent households in African- American communities.
C. stricter child-rearing practices in African- American households.
D. a higher occurrence of rage in African Americans.

Answer: B

Explanation:
Child abuse is higher in households with lower socioeconomic status and single parents. The increased incidence might be due to increased stress and fewer support systems. Psychosocial Integrity

NEW QUESTION 189
- (Topic 3)
When a client with a major burn experiences body image disturbance, which of the following is an appropriate nursing intervention classification?

A. grief work facilitation
B. vital signs monitoring
C. medication administration: skin
D. anxiety reduction

Answer: A

Explanation:
Grief work facilitation is a nursing intervention classification for disturbed body image in burn clients. The expected outcome is grief resolution. Vital signs monitoring is a nursing intervention classification for deficient fluid volume in clients with major burns. Medication administration: skin is a nursing intervention classification for impaired skin integrity for clients with major burns. Anxiety reduction is a nursing intervention classification for anxiety experienced by clients with major burns.Health Promotion and Maintenance

NEW QUESTION 192
- (Topic 3)
Which of the following instructions should a nurse give a client who is about to undergo pelvic ultrasonography?

A. ??Urinate prior to the test.??
B. ??Have someone drive you home.??
C. ??Do not drink after midnight.??
D. ??Drink plenty of water.??

Answer: D

Explanation:
A full bladder is required to serve as a landmark to define pelvic organs. No sedation is given, so the client may drive herself home after the test.Reduction of Risk Potential

NEW QUESTION 196
- (Topic 3)
An 8-year-old Asian child is being examined during a school screening. The nurse notices small bruises on the anterior and posterior ribs. The nurse should ask the child:

A. if the family practices coining.
B. who hit him.
C. if the child has fallen.
D. how long the abuse has been occurring.

Answer: A

Explanation:
The nurse must be aware of cultural practices that resemble child abuse. These practices include coining, cupping, and fallen fontanella. Coining and cupping are

thought to draw infections from the body. Coining involves rubbing a heated coin on the chest and torso and might cause bruising. Cupping uses heated glasses that can produce erythematous and ecchymotic rounded lesions or linear streaks on the body from the suction. Fallen fontanella involves turning a child upside down to correct a depressed fontanelle; it can cause vomiting, diarrhea, and dehydration in infants. Retinal hemorrhages can also occur, and sometimes Shaken-Baby Syndrome is erroneously diagnosed.Psychosocial Integrity

NEW QUESTION 199
- (Topic 3)
Which of the following coping mechanisms protects an individual from anxiety?

A. denial and fantasy
B. rationalization and suppression
C. regression and displacement
D. reaction formation and projection

Answer: A

Explanation:
Denial, rationalization, regression, and fantasy are coping mechanisms that protect persons from anxiety.
Psychosocial Integrity

NEW QUESTION 201
- (Topic 3)
Which of the following NSAIDS is most commonly used for a brief time for acute pain?

A. Advil
B. Aleve
C. Toradol
D. Bextra

Answer: C

Explanation:
Toradol is an NSAID found to be very effective for brief periods of time for acute pain. It can be given IM, IV, or PO.Basic Care and Comfort

NEW QUESTION 205
- (Topic 3)
Which statement best describes electrolytes in intracellular and extracellular fluid?

A. There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
B. There is an equal concentration of sodium and potassium in extracellular fluid.
C. There is a greater concentration of potassium in extracellular fluid and sodium in intracellular fluid.
D. There is an equal concentration of sodium and potassium between intracellular and extracellular fluid.

Answer: A

Explanation:
There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
Physiological Adaptation

NEW QUESTION 207
- (Topic 3)
Client education by the nurse entails:

A. telling the client everything about his disease, what is going to happen in the course of the disease, and the outcome.
B. giving information to the client that is accurate and understandable.
C. telling the client that the pain he experiences might not be real.
D. giving the client medication when pain is experienced.

Answer: B

Explanation:
Client education entails giving the client accurate and understandable information.Basic Care and Comfort

NEW QUESTION 211
- (Topic 3)
Which of the following is true concerning human immunodeficiency virus (HIV)?

A. HIV infection involves CD4 receptor protein on the surface of helper T-cells.
B. The presence of circulating antibodies that neutralize HIV is evidence that the individual has immunity-HIV.
C. HIV replication occurs extracellularly.
D. DNA replication

Answer: A

Explanation:
The virus makes a DNA copy of its own RNA using the reverse transcriptase enzyme, and the DNA copy is

inserted into the genetic material of the infected cell.Physiological Adaptation

NEW QUESTION 213
- (Topic 3)
Which of the following statements is true about syphilis?

A. The cause and mode of transmission is unclear.
B. There is no known cure for the disease.
C. When the primary lesion heals, the disease is cured.
D. Syphilis can be cured with a course of antibiotic therapy.

Answer: D

Explanation:
Syphilis is an acute and chronic treponemal disease characterized clinically by a primary lesion, a secondary eruption involving skin and mucous membranes, long periods of latency, and late lesions of skin, bone viscera, the CNS, and the cardiovascular system. The primary lesion (chancre) appears about three weeks after exposure as an indurated, painless ulcer with serous exudate at the site of initial invasion. Invasion of the bloodstream precedes development of the initial lesion, and a firm, nonfluctuant, painless lymph node (bubo) commonly follows.
Infection might occur without a clinically evident chancre; that is, it might be in the rectum or on the cervix. After four–six weeks, even without specific treatment, the chancre begins to involute, and, in approximately one-third of untreated cases, a generalized secondary eruption appears, often accompanied by mild constitutional symptoms.
This symmetrical maculopapular rash involving the palms and soles, with associated lymphadenopathy is classic.
Secondary manifestations resolve spontaneously within weeks to 12 months. Again, about one-third of untreated cases of secondary syphilis become clinically latent for weeks to years. In the early years of latency, infectious lesions of the skin and mucous membranes might recur. Specific treatment includes long- acting penicillin G (benzathine penicillin), 2.4 million units given in a single IM dose on the day that primary, secondary or early latent syphilis is diagnosed. This ensures effective therapy, even if the client fails to return.
Serologic testing is important to ensure adequate therapy. Tests are repeated three and six months after treatment and later as needed.
In HIV-infected clients, testing should be repeated one, two, and three months after treatment, and at three-month intervals thereafter. Any fourfold titer rise indicates the need for retreatment.Physiological Adaptation

NEW QUESTION 215
- (Topic 3)
When discussing the patterns of use of alcohol and other drugs, the nurse should include which piece of information?

A. Lifetime prevalence and intensity of alcohol use is greater in women than men.
B. Hispanics and African Americans have higher levels of alcohol use than Caucasians.
C. Overuse of alcohol and other drugs increases into the mid-20s, then levels off and decreases with age.
D. Heavy use is more common in higher socioeconomic groups because they can afford to buy the drugs.

Answer: C

Explanation:
Recent research reveals that 83% of all persons in the United States, age 12 or older, report using alcohol sometime in their lives. Use of alcohol and illicit drugs appears to increase into the mid-20s, and then levels off and decreases with age. Both lifetime prevalence and intensity of alcohol use are greater in males. Caucasians report higher levels of alcohol use than African Americans or Hispanics. Those with more education are more likely to use alcohol, but heavy use is more common among the less educated and the unemployed.Psychosocial Integrity

NEW QUESTION 216
- (Topic 3)
A client with a nasogastric (NG) tube begins vomiting. What action should the nurse take?

A. Retape the NG tube.
B. Clamp the NG tube.
C. Remove the NG tube.
D. Check the NG tube placement.

Answer: D

Explanation:
For the client with an NG tube who begins vomiting, the nurse should check the tube placement because
it might be displaced, thereby leading to vomiting. The other responses are not appropriate.
Reduction of Risk Potential

NEW QUESTION 219
- (Topic 3)
A preschooler has successfully completed the test item ??counts 5 blocks?? on the Denver II test. This pass is evidence of which of the following developmental concepts?

A. centration
B. causality
C. C.nonreversibility
D. D.conservation

Answer: D

Explanation:
The ability to move five blocks to a piece of paper and state there are five blocks on the paper is evidence
that the preschooler has the ability of conservation. This concept refers to the fact that the quantity of something doesn??t change just because the shape, contour, and so on has changed. Five blocks are still five blocks, whether they are lying beside the paper, stacked on the paper or moved to the paper.Centrationis

the ability to concentrate on one feature of a situation while neglecting all other aspects.Causalityis based on the sequence of events, one event ordinarily following another.Nonreversibilityrefers to the inability of preschoolers to reverse their operations. They are only able to think forward, not retrace or reverse their thought processes.Health Promotion and Maintenance

NEW QUESTION 220
- (Topic 3)
An effective intervention for a client diagnosed with Obsessive-Compulsive Disorder is:

A. discussing the repetitive action.
B. insisting the client not perform the repetitive act.
C. informing the client that the act is not necessary.
D. encouraging daily exercise.

Answer: D

Explanation:
Obsessive-Compulsive Disorder is an anxiety disorder. Exercise releases emotional energy, limits time for the maladaptive behavior, and directs the client??s attention outward. Initially, nurses should not interfere with performance of the repetitive act, try reasoning the client out of the behavior, or ridicule the behavior.Psychosocial Integrity

NEW QUESTION 221
- (Topic 3)
Distraction therapy is:

A. focusing one??s attention on stimuli other than pain.
B. cognitive reappraisal.
C. the replacement of positive images of pain with other images.
D. the use of medication and meditation.

Answer: A

Explanation:
The focus of distraction therapy is on positive stimuli rather than negative input.Basic Care and Comfort

NEW QUESTION 225
- (Topic 3)
Milieu therapy is best employed to perform which activity?

A. investigating the client??s view of the world
B. promoting socialization skills
C. focusing on inappropriate behavior
D. providing repetitive ordinary experiences on a daily basis

Answer: D

Explanation:
Milieu therapy provides repetitive ordinary experiences on a daily basis, controls the environment by minimizing change as much as possible, and decreases disruptive behavior by keeping tasks simple.Psychosocial Integrity

NEW QUESTION 230
- (Topic 4)
A client and his family facing the end stage of a terminal illness might be best served by:

A. a rehabilitation center.
B. an extended care facility.
C. Hospice.
D. a crisis intervention center.

Answer: C

Explanation:
Hospice has the belief that more humanized alternative care for dying clients is needed than is being provided in hospitals, which focus mostly on medical cures. No matter where the care is delivered, Hospice provides a specialized interdisciplinary team of health care professionals who work together to manage client care.HealthPromotion and Maintenance

NEW QUESTION 232
- (Topic 4)
There are many types of torts that can be committed against clients. They include all of the following except:

A. assault.
B. battery.
C. negligence.
D. felony.

Answer: D

Explanation:

Felonies are serious crimes punishable by time in prison. Types of torts are assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.Coordinated Care

NEW QUESTION 233
- (Topic 4)
The physician??s role in case management includes all of the following except:

A. participating in interdisciplinary planning for clients.
B. serving as the expert for resource utilization.
C. consulting with the case management team to facilitate timely orders as needed.
D. contributing to the documentation of a client??s needs for services.

Answer: B

Explanation:
The physician is an integral part of the case-management process in terms of assisting with defining the client??s needs and the time frames for movement through the health care system; however, the physician is the expert for medical diagnosis and treatment rather than resource utilization.Coordinated Care

NEW QUESTION 235
- (Topic 4)
The intravenous route is potentially the most dangerous route of drug administration because:

A. the IV might infiltrate.
B. it is expensive and nursing intensive.
C. rapid administration of a drug can lead to toxicity.
D. the client always has more side effects.

Answer: C

Explanation:
The bioavailability of the injected medication is 100% and might lead to toxicity. An IV infiltration can cause serious problems with tissue necrosis, but this is not life threatening. Expensiveandtime consumingdo not equate withdangerous. Choice 4 is not always true. Pharmacological Therapies

NEW QUESTION 238
- (Topic 4)
An adolescent female reports being raped at a party where alcohol was served. The client admits to drinking alcohol before being raped by an acquaintance. The nurse should:

A. inform the client that because she is underage, she is at fault for attending a party where alcohol was served.
B. ask the client if anyone witnessed the event because the client was intoxicated and might not remember correctly.
C. inform the client that it was not her fault, and support the client through the physical examination.
D. question whether the woman had consensual sex and now just feels guilty.

Answer: C

Explanation:
Acquaintance rape remains a controversial topic because of lack of agreement on the definition of consent. Most acquaintance rapes take place in either the victim??s or the assailant??s home or apartment. Most victims of acquaintance rape inform someone close to them, but less than 30% report the incidence to the authorities. Survivors of acquaintance rape report similar levels of depression, anxiety, complications in subsequent relationships, and difficulty attaining prerape levels of sexual satisfaction to what survivors of stranger rape report. Coping is more difficult for victims of acquaintance rape if others fail to recognize that the emotional impact is just as serious.Psychosocial Integrity

NEW QUESTION 243
- (Topic 4)
During a routine health screening, the nurse should talk to the parents of a 1-year-old child about which of the following?

A. the potential hazards of accidents
B. appropriate nutrition now that the child has been weaned from breast-feeding
C. toilet training
D. how to purchase appropriate shoes now that the child is walking

Answer: A

Explanation:
Accidents are the primary source of injury in children and can be life threatening. Appropriate nutrition should have been discussed during the weaning process and while the purchase of appropriate shoes is important, it is not life threatening. One year of age is too early to discuss toilet training.Health Promotion and Maintenance

NEW QUESTION 246
- (Topic 4)
Which of the following factors can impact an individual??s ability to give informed consent?

A. IQ
B. educational level
C. pain medications
D. financial status

Answer: C

Explanation:
Pain medications might alter alertness, thought processes, and reactions. It is recommended that a client be approached for consent at least 4 hours after the last dose of pain medicine to allow minimal impact. Choices 1, 2, and 4 are incorrect. IQ and educational levels might have a bearing on how information is presented through the discussion process, but they do not have a bearing on informed-consent decision-making. Coordinated Care

NEW QUESTION 247
- (Topic 4)
A nurse is teaching a group of clients with a diagnosis of Schizophrenia who are nearing discharge from a residential care facility. An essential topic to include is:

A. pathophysiology of the disease and expected symptoms.
B. how to recognize and manage symptoms of relapse.
C. the need to take extra medication when feeling stressed.
D. the importance of contact with follow-up care daily.

Answer: B

Explanation:
Clients are usually aware of the symptoms that indicate relapse is occurring. The client needs to know how to find a safe environment and to seek help. The first two stages of relapse are more difficult to recognize because they do not present symptoms that indicate psychosis. Initially, the client feels anxious and overwhelmed, and might become withdrawn. This is the crucial period to intervene. The client needs to go to a safe environment with someone who is trusted, avoid negative people, and decrease stimuli and stress.Psychosocial Integrity

NEW QUESTION 250
- (Topic 4)
Which of the following vaccines are not part of the regular schedule of immunizations for children?

A. DTaP
B. MMR
C. Hib
D. hepatitis A

Answer: D

Explanation:
Hepatitis A is not part of the regular immunization schedule for children. DTaP, MMR, and Hib are all regularly scheduled vaccines for children.Health Promotion and Maintenance

NEW QUESTION 254
- (Topic 4)
The nurse can best communicate to a client that he or she has been listening by:

A. restating the main feeling or thought the client has expressed.
B. making a judgment about the client??s problem.
C. offering a leading question such as, ??And then what happened???
D. saying, ??I understand what you??re saying.??

Answer: A

Explanation:
Restating allows the client to validate the nurse??s understanding of what has been communicated. It??s an active listening technique. Regarding Choice 2, judgments should be suspended in a nurse-client relationship. Choice 3 is incorrect because leading questions ask for more information rather than showing understanding. Choice 4 communicates understanding, but the client has no way of measuring the understanding.
PsychosocialIntegrity

NEW QUESTION 259
- (Topic 4)
A client is assessed by the nurse as experiencing a crisis. The nurse plans to:

A. allow the client to work through independent problem-solving.
B. complete an in-depth evaluation of stressors and responses to the situation.
C. focus on immediate stress reduction.
D. recommend ongoing therapy.

Answer: C

Explanation:
A crisis is an acute, time-limited state of disequilibrium resulting from a situational, developmental, or societal source of stress. Utilizing the nursing process, the nurse should assist clients to work through a crisis to its resolution and restore their precrisis level of functioning.Psychosocial Integrity

NEW QUESTION 263
- (Topic 4)
A client asks the nurse what risk factors increase the changes of getting skin cancer. The risk factors include all except:

A. light or fair complexion.
B. exposure to sun for great periods of time.

C. certain diet and foods.
D. history of bad sunburns.

Answer: C

Explanation:
Conditions that increase risks for skin cancer are: light or fair complexion, history of having bad sunburns or scars from previous burns, personal or family history of skin cancer, frequently working or playing outdoors with exposure to the sun, exposure to X-rays or radiation, exposure to certain chemicals through work or hobbies (coal, pitch, asphalt, petroleum), repeated trauma or injury to an area resulting in scars, older than age 50, male gender, and living in a geographic location near the equator or at high altitudes. Ways to prevent skin cancer are avoiding exposure to the sun, wearing a hat to protect the face, avoiding all sun lamps, and using a sunscreen with a minimum of 15 sun protection factor (SPF) if exposure to the sun is unavoidable. Teaching clients how to recognize a potential problem involves inspecting the skin frequently; noting all birthmarks, freckles, and moles; and seeking medical assistance if any of the following are noted: change in color, change in shape, change in surface texture, change in size, change in the surrounding skin, or a new mole or a sore that does not heal.HealthPromotion and Maintenance

NEW QUESTION 264
- (Topic 4)
When questioning an elder about suspected abuse, the nurse should keep the questions:

A. nonjudgmental.
B. probing.
C. confrontational.
D. indirect.

Answer: A

Explanation:
Questions about suspected should be direct and nonconfrontational. Indirect questions encourage denial.
Psychosocial Integrity

NEW QUESTION 265
- (Topic 4)
Delegation of tasks to appropriate personnel allows the nurse to:

A. take a break.
B. keep other members of the team productive.
C. maintain tight control of all aspects of the workflow.
D. realize the importance of her role by making all decisions.

Answer: B

Explanation:
Maintaining the productivity of all team members by delegating tasks appropriate to the job descriptions of the personnel increases work effectiveness and efficiency.Coordinated Care

NEW QUESTION 270
- (Topic 4)
What is the reason for a contract between nurse and client?

A. Contracts state the roles the participants take.
B. Contracts are indicative of the feeling tone established between participants.
C. Contracts are binding and prevent either party from ending the relationship prematurely.
D. Contracts spell out the participation and responsibilities of both parties.

Answer: D

Explanation:
A contract emphasizes that the nurse works with the client, rather than doing something for the client.Working withsuggests that each party is expected to participate and share responsibility for outcomes. Contracts do not,however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.Psychosocial Integrity

NEW QUESTION 274
- (Topic 4)
An example of an extended care facility is a:

A. home health agency.
B. suicide prevention center.
C. state-owned psychiatric hospital.
D. nursing facility.

Answer: D

Explanation:
When an elderly client has been hospitalized for an illness, under Medicare he or she can be transferred to a nursing facility.Health Promotion and Maintenance

NEW QUESTION 279
- (Topic 4)

The nurse is working with families who have been displaced by a fire in an apartment complex. What is the priority intervention during the initial assessment?

A. Provide a liaison to meet housing needs.
B. Attentively listen when clients describe their feelings.
C. Offer nurturing support for clients who are confused by the events.
D. Provide structure for clients exhibiting moderate to severe anxiety.

Answer: A

Explanation:
After physical needs of housing, clothing and food are met, the nurse should focus on assisting clients to manage the psychological effects of loss.Psychosocial Integrity

NEW QUESTION 280
- (Topic 4)
The advanced directive in a client??s chart is dated August 12, 1998.The client??s daughter produces a Power of Attorney for Health Care, dated 2003, which contains different care direction(s). The nurse is supposed to:

A. follow the 1998 version because it??s part of the legal chart.
B. follow the 1998 version because the physician??s code order is based on it.
C. follow the 2003 version, place it in the chart, and communicate the update appropriately.
D. follow neither until clarified by the unitmanager.

Answer: C

Explanation:
The document dated 2003 supersedes the previous version and should be used as a basis for care direction.
Choices 1 and 2 are incorrect because the 1998 version is now outdated. Choice 4 is incorrect because the nurse can be held negligent for not responding to the 2003 document as directed.Coordinated Care

NEW QUESTION 284
- (Topic 4)
The nurse??s first action upon discovery of an electrical fire should be which of the following?

A. Disconnect the electrical power if it can be performed safely.
B. Smother the source with an object such as a blanket.
C. Saturate the source with water or other readily available liquid.
D. Activate the fire alarm immediately.

Answer: A

Explanation:
If it is safe to do so, the nurse should disconnect electrical devices from the power source.
Smothering with a blanket is not indicated in an electrical fire and might serve to fuel the fire,just as water or other liquids might incite an explosion or flames. The fire alarm should be activated promptly, and this should be the next action after disconnecting the electrically powered equipment.Safety and Infection Control

NEW QUESTION 288
- (Topic 4)
A serious complication of a total hip replacement is displacement of the prosthesis. What is the primary sign of displacement?

A. pain on movement and weight bearing
B. hemorrhage
C. affected leg appearing 1–2 inches longer
D. edema in the area of the incision

Answer: A

Explanation:
Pain on movement and weight bearing indicates pressure on the nerves or muscles caused by the dislocation. Other symptoms of dislocation include an inability to bear weight and a shortening of the affected leg. Edema is not a primary sign of displacement.Physiological Adaptation

NEW QUESTION 290
- (Topic 4)
A client??s central venous access device (CVAD) becomes infected. Why might the physician order antibiotics to be given through the line rather than through a peripheral IV line?

A. to prevent infiltration of the peripheral line
B. to reduce the pain and discomfort associated with antibiotic administration in a small vein
C. to lessen the chance of an allergic reaction to the antibiotic
D. to attempt to eliminate microorganisms in the catheter and prevent having to remove it

Answer: D

Explanation:
Microorganisms that infect CVADs are often coagulase-negative staphylococci, which can be eliminated by antibiotic administration through the catheter. If unsuccessful in eliminating the microorganism, the CVAD must be removed. CVAD use lessens the need for peripheral IV lines and thus the risk of infiltration. In this case, however, the antibiotics are given to eradicate microorganisms from the CVAD. CVAD use has the effect described in Choice 2, but in this case, the antibiotics are given through the CVAD to eliminate the infective agent. The route does not prevent an allergic reaction.Pharmacological Therapies

NEW QUESTION 293
- (Topic 4)
A female having her first child is experiencing which type of crisis event?

A. situational
B. maturational
C. adventitious
D. reactive

Answer: B

Explanation:
A maturational crisis occurs when an individual arrives at a new stage of development and must develop new coping strategies. Choice 1 arises from sources external to individuals. Choice 3 occurs when some event external to a person (floods, hurricanes) disrupts his or her coping behaviors. Choice 4 is not a crisis intervention.Psychosocial Integrity

NEW QUESTION 298
- (Topic 4)
Hearing screening of prematurely born infants is an effective means of identifying disease and is an example of:

A. primary prevention.
B. secondary prevention.
C. tertiary prevention.
D. disability prevention.

Answer: B

Explanation:
The three levels of prevention address disease and disability across all phases, from absence of disease and at risk for disease, to preventing further impairment. Hearing impairment associatedwith prematurity cannot be prevented by screening, but identifying the infants with hearing loss might prevent sequelae and further impairment by allowing early intervention.Safety and Infection Control

NEW QUESTION 303
- (Topic 5)
A physician orders a serum creatinine for a hospitalized client. The nurse should explain to the client and his family that this test:

A. is normal if the level is 4.0 to 5.5 mg/dl.
B. can be elevated with increased protein intake.
C. is a better indicator of renal function than the BUN.
D. reflects the fluid volume status of a person.

Answer: C

Explanation:
A serum creatinine level should be 0.7 to 1.5 mg/dl, and it does not vary with increased protein intake, so it is a better indicator of renal function than the BUN.Physiological Adaptation

NEW QUESTION 304
- (Topic 5)
With a breech presentation, the nurse must be particularly alert for which of the following?

A. quickening
B. ophthalmia neonatorum
C. pica
D. prolapsed umbilical cord

Answer: D

Explanation:
Prolapsed umbilical cord is the descent of the umbilical cord into the vagina before the fetal presenting part and compression of the cord between the presenting part and the maternal pelvis, compromising or completely cutting off fetoplacental perfusion. This is an emergency situation; immediate delivery should be attempted to save the fetus. Physiological Adaptation

NEW QUESTION 307
- (Topic 5)
Which of the following blood pressure parameters indicates PIH? Elevation over a baseline of:

A. 30 mmHg systolic and/or 15 mmHg diastolic.
B. 40 mmHg systolic and/or 20 mmHg diastolic.
C. 10 mmHg systolic and/or 5 mmHg diastolic.
D. 20 mmHg systolic and/or 20 mmHg diastolic.

Answer: A

Explanation:
These are the accepted parameters for mild PIH. Mild preclampsia includes an increase in systolic blood pressure higher than 30 mmHg or an increase in diastolic blood pressure higher than 15 mmHg, noted on two readings taken 6 hours apart (or 140/90). Physiological Adaptation

NEW QUESTION 311
- (Topic 5)
Which is an appropriate outcome for the nursing diagnosis of Body Image Disturbance for a client with anorexia nervosa?

A. The client verbalizes knowledge of a maintenance diet.
B. The client demonstrates assertiveness with family.
C. The client verbalizes her body size accurately.
D. The client demonstrates control of obsessive behaviors.

Answer: C

Explanation:
Part of the problem for anorexic clients is an altered view of their body appearance (visualizing themselves as fat even when they are emaciated). Choice 1 involves a knowledge deficit. Choice 2 involves possible resolution of family-dynamic issues. Choice 4 involves psychological adaptation.Basic Care and Comfort

NEW QUESTION 313
- (Topic 5)
Which of the following statements by a client indicates adequate preparation for magnetic resonance imaging?

A. ??I can leave my metal jewelry on during the test.??
B. ??I need to wear earplugs during the test.??
C. ??I can have the test even though I have a pacemaker.??
D. ??I can have the test even though I have an artificial hip.??

Answer: B

Explanation:
Due to the loud noises from the scanner moving to obtain images, earplugs need to be worn. No metal objects are allowed, including jewelry, pacemakers, and artificial joints. Reduction of Risk Potential

NEW QUESTION 317
- (Topic 5)
The anemias most often associated with pregnancy are:

A. folic acid and iron deficiency.
B. folic acid deficiency and thalassemia.
C. iron deficiency and thalassemia.
D. thalassemia and B12 deficiency.

Answer: A

Explanation:
Folic acid and iron deficiency anemia are the most common anemias, prevalent in women of childbearing age with 50% of pregnant women having this type of anemia. Iron deficiency anemia during pregnancy is a result (usually) of the increase in the plasma level during pregnancy but not in the constituent level. Also, if a woman has this type of anemia prepregnancy, it gets worse during pregnancy.Physiological Adaptation

NEW QUESTION 322
- (Topic 5)
The nurse should make which of the following responses when questioned by a client about the role of leptin in the body?

A. It increases food intake in clients, thereby promoting obesity.
B. It assists in the regulation of steroids.
C. It increases the total fat mass of people who are obese.
D. It might decrease the total fat mass in the bodies of people who are obese.

Answer: D

Explanation:
Leptin (recessive obesity gene—protein hormone) is expressed in fat cell coding for the protein that reacts to the percentage of fat cells in the body. Leptin is associated with increased energy expenditure and decreased food intake via hypothalamic control. Obese clients might have insensitivity or resistance to the effects of leptin. Leptin can affect other body hormones such as insulin. Genetic factors include leptin, uncoupling proteins, and the amount of brown/white fat in the body.Physiological Adaptation

NEW QUESTION 324
- (Topic 5)
When a middle-age woman says to the nurse, ??I??m really worried about menopause. When my mom went through it, she got really depressed.?? The nurse??s best response is:

A. ??It is a myth that women get depressed because of menopause.??
B. ??Menopause is a normal developmental process.??
C. ??It sounds like you are worried that you might become depressed during menopause.??
D. ??When women experience depression during menopause it is usually because of social stresses.??

Answer: C

Explanation:
Choice 3 not only acknowledges the client??s fear but invites more disclosure and discussion. Reflective listening is very therapeutic and in this case

acknowledges the woman??s unspoken fear that she might become depressed like her mother. When her fears have been acknowledged and she feels that the nurse understands, she will be more open to the teaching or interventions to follow. It is a myth that menopause causes depression, but to say that to this client does not acknowledge the fear she shared with the nurse and gives the impression the nurse doesn??t care about her concern. It closes down communication. It is also true that menopause is a normal developmental process. This can certainly be used in teaching but not to address her immediate concern; the client might feel the nurse doesn??t think her concern is appropriate because menopause is normal. If women experience depression during menopause, it is usually due to social stresses such as loss of loved ones, loss of roles, caregiver demands, and physical problems. Choice 4 is true but is a nontherapeutic response in this situation.Health Promotion and Maintenance

NEW QUESTION 329
- (Topic 5)
For a client requiring total oral care, it is important for the nurse to:

A. assemble all equipment, assist the client tosemi-Fowler??s position, and place a towel on his chest.
B. place client in Fowler??s position, prepare the equipment, and tell the client what to do.
C. assemble all equipment, place the client in a side-lying position, and place a towel under his chin.
D. use gloves and clean the client??s mouth, including the tongue.

Answer: C

Explanation:
Assemble all equipment first; place the client in a side-lying position so that fluid can easily flow out or pool in the side of the mouth for suctioning (to prevent aspiration); and then place a towel under the client??s chin and a curved basin against the chin. Gloves should be worn.Basic Care and Comfort

NEW QUESTION 330
- (Topic 5)
Herbal therapy has several indications for use. Primarily, herbal therapy is:

A. used to treat many common complaints and diseases.
B. used to promote certain types of low-carb diets.
C. used as an adjunct to medications.
D. used to create a diet without salt and carbohydrates.

Answer: A

Explanation:
Herbal therapy is used to treat many common complaints and diseases.Physiological Adaptation

NEW QUESTION 334
- (Topic 5)
Which cultural group has the highest incidence of inflammatory bowel disease (IBD)?

A. Asians
B. Caucasians
C. Hispanics
D. African Americans

Answer: B

Explanation:
Caucasians have the highest incidence of inflammatory bowel disease (IBD).Reduction of Risk Potential

NEW QUESTION 337
- (Topic 5)
A client is to have an enema to reduce flatus. The enema tube should be inserted:

A. 4 inches.
B. 6 inches.
C. 2 inches.
D. 8 inches.

Answer: A

Explanation:
Enema tubing must be passed beyond the internal sphincter. Two inches is not far enough to pass the internal sphincter. Both 6 and 8 inches are too far and might cause trauma to the bowel.Basic Care and Comfort

NEW QUESTION 340
- (Topic 5)
Which of the following nursing diagnoses is most appropriate for a client with a new colostomy?

A. Excess Fluid Volume
B. Risk for Aspiration
C. Disturbed Body Image
D. Urinary Retention

Answer: C

Explanation:
Disturbed Body Image is the most appropriate nursing diagnosis for a client with a new colostomy, due to the adjustments that need to be made with the physical alteration of a colostomy. The other diagnoses are not applicable.Reduction of Risk Potential

NEW QUESTION 344
- (Topic 5)
A female client complains to the nurse at the health department that she has fatigue, shortness of breath, and lightheadedness. Her history reveals no significant medical problems. She states that she is always on a fad diet without any vitamin supplements. Which tests should the nurse expect the client to have first?

A. peptic ulcer studies
B. complete blood count, including hematocrit and hemoglobin
C. genetic testing
D. hemoglobin electrophoresis

Answer: B

Explanation:
The initial tests to determine the basis for her symptoms (considering her fad dieting) should be a complete blood count, urinalysis, blood sugar, and other tests. The decision about further testing is then made based on these results, her history, and other factors. Physiological Adaptation

NEW QUESTION 349
- (Topic 5)
A nurse is caring for a client with an elevated cortisol level. The nurse can expect the client to exhibit symptoms of:

A. urinary excess.
B. hyperpituitarism.
C. urinary deficit.
D. hyperthyroidism.

Answer: C

Explanation:
High levels of cortisol can produce sodium and fluid retention and potassium deficit, thus creating urinary deficit.Physiological Adaptation

NEW QUESTION 351
- (Topic 5)
Which of the following is not a primary function of the kidneys?

A. blood pressure control
B. vitamin D activation
C. erythropoietin production
D. reabsorbing waste products

Answer: D

Explanation:
All of the choices are functions of the kidneys except reabsorbing waste products. The kidneys excrete waste products.Physiological Adaptation

NEW QUESTION 355
- (Topic 5)
A standard walker is used when clients:

A. have poor balance, cannot stand up, have weak arms, and have good hand strength.
B. have poor balance, have a broken leg, or have experienced amputation.
C. have poor balance, have cardiac problems, or cannot use crutches or a cane.
D. have poor balance, have an autoimmune disease, or have weak arms.

Answer: C

Explanation:
A walker is used for clients who have balance problems, cardiac problems, or cannot use crutches or a cane. The client needs to bear partial weight and have strength in her wrists and arms. The client uses her upper body to propel the walker forward.Basic Care and Comfort

NEW QUESTION 357
- (Topic 5)
A client who recently lost 50 pounds just received news that she is pregnant. A possible nursing diagnosis is:

A. Actual Chronic Low Self-Esteem (related to obesity).
B. Potential Chronic Low Self-Esteem (related to obesity).
C. Actual Situational Low Self-Esteem (related to fear of weight regain and pregnancy).
D. Potential Situational Low Self-Esteem (related to fear of weight regain and pregnancy).

Answer: D

Explanation:
If there are indications of a body image disturbance, the nursing care plan should include body disturbances, related to a functional or physical problem. The disturbance might be an anticipated one—that is, weight gain and pregnancy. Stressors can include a change in physical appearance, sexuality concerns, or an

unrealistic ideal self.
Psychosocial Integrity

NEW QUESTION 362
- (Topic 5)
The nurse should utilize data about which of the following to provide information about the nutritional status of a client being evaluated for malnutrition?

A. triceps skinfold measurement
B. fasting blood glucose level
C. hemoglobin A1c level
D. serum lipid profile results

Answer: A

Explanation:
Objective anthropometric measurements such as triceps skinfold and mid-arm circumference (MAC), along with weight, are usually used to diagnose malnutrition. While all the other choicesrepresent tests that might provide useful information, they also might be affected by variables other than malnutrition.Physiological Adaptation

NEW QUESTION 365
- (Topic 5)
When a woman is receiving postpartum epidural morphine, the nurse should plan to observe for which of the following side effects to occur within the first 3 hours?

A. nausea and vomiting
B. itching
C. urinary retention
D. somnolence

Answer: B

Explanation:
A side effect of postpartum epidural morphine is the onset of itching within 3 hours of injection and lasting up to 10 hours. Nausea and vomiting might occur 4–7 hours after injection. Urinary retention is a side effect of postpartum epidural morphine but is not assessed as such within the first 3 hours. Somnolence is a rare side effect.Health Promotion and Maintenance

NEW QUESTION 366
- (Topic 5)
The chemotherapeutic agent 5-fluorourcacil (5-FU) is ordered for a client as an adjunct measure to surgery. Which statement about chemotherapy is true?

A. It is a local treatment affecting only tumor cells.
B. It is a systemic treatment affecting both tumor and normal cells.
C. It has not yet been proved an effective treatment for cancer.
D. It is often the drug of choice because it causes few, if any, side effects.

Answer: B

Explanation:
5-FU is an antieoplastic, antimetabolic drug that inhibits DNA synthesis and interferes with cell replication. It is given intravenously and acts systemically. It affects all rapidly growing cells,both malignant and normal. It is used as adjuvant therapy for treating cancer of the colon, rectum, stomach, breast, and pancreas. This drug has many side effects, including bone marrow depression, anorexia, stomatitis, nausea, and vomiting.Physiological Adaptation

NEW QUESTION 368
- (Topic 5)
A successful resolution of the nursing diagnosis Negative Self-Concept (related to unrealistic selfexpectations) is when the client can:

A. report a positive self-concept.
B. identify negative thoughts.
C. recognize positive thoughts.
D. give one positive cue with each negative cue.

Answer: A

Explanation:
The problem statement is Negative Self Concept. A successful resolution of the problem is when the client can report a positive self-concept. When the nurse determines how the client perceives himself, effort should be directed to reinforce self-worth and promote a positive self-concept,including helping a client to identify areas of strength. Assisting the client to evaluate himself and make behavior changes is a nursing intervention. Psychosocial Integrity

NEW QUESTION 370
- (Topic 5)
As part of the teaching plan for a client with type I diabetes mellitus, the nurse should include that carbohydrate needs might increase when:

A. an infection is present.
B. there is an emotional upset.
C. a large meal is eaten.
D. active exercise is performed.

Answer: D

Explanation:
Active exercise increases insulin sensitivity, thus lowering blood glucose levels. Additional carbohydrates might be needed to balance the usual insulin dose. All of the other choices increase blood glucose levels.BasicCare and Comfort

NEW QUESTION 372
- (Topic 5)
Which of the following diseases places a client at risk for developing cirrhosis?

A. type I diabetes
B. alcoholism
C. leukemia
D. glaucoma

Answer: B

Explanation:
Alcoholism places a client at risk for developing cirrhosis. None of the other choices are related to cirrhosis.Physiological Adaptation

NEW QUESTION 377
- (Topic 5)
Which of the following medications should be held 24–48 hours prior to an electroencephalogram (EEG)?

A. Lasix (furosemide)
B. Cardizem (diltiazem)
C. Lanoxin (digoxin)
D. Dilantin (phenytoin)

Answer: D

Explanation:
Anticonvulsants (such as Dilantin), tranquilizers, barbiturates, and other sedatives should be held 24–48 hours prior to an EEG. The other medications do not fall into these classifications.Reduction of Risk Potential

NEW QUESTION 382
- (Topic 5)
A client with cirrhosis of the liver presents with ascites. The physician is to perform a parancentesis. For safety, the nurse should ask the client to:

A. drink 1000 cc prior to the procedure to affect fluid loss.
B. eat foods low in fat.
C. empty his bladder prior to the procedure.
D. assume the prone position.

Answer: C

Explanation:
When performing a parancentesis, the client must be sitting up to allow the fluid to settle to the lower abdomen. To prevent trauma to the bladder while inserting a needle to aspirate the fluid, the bladder must be empty.Basic Care and Comfort

NEW QUESTION 383
- (Topic 5)
Which of the following foods can cause diarrhea when eaten by a client with an ileostomy?

A. eggs
B. coffee
C. fish
D. garlic

Answer: B

Explanation:
Coffee might cause diarrhea in a client with an ileostomy. The other foods might cause odor.Reduction of
Risk Potential

NEW QUESTION 386
- (Topic 5)
Safety measures for using crutches must be taught to clients. Safety measures for the use of crutches include:

A. properly fitting crutches with rubber tips at the end that provide a four-point gait.
B. properly fitting crutches, education in the appropriate gait, and strength in the arms.
C. crutches that fit the way the client chooses and a gait chosen by client.
D. both legs touching the floor for all gaits.

Answer: B

Explanation:
In addition to the rubber tips on the ends of the crutches, the client needs to know the appropriate gait. Arm strength exercises are important, and it is critical that the client be fitted properly for the crutches.BasicCare and Comfort

NEW QUESTION 387
- (Topic 5)
The parents of a 2-year-old child ask the nurse how they can teach their child to quit taking toys away from other children. Which of the following statements by the nurse offers the parents the best explanation of their child??s behavior?

A. ??Your child is egocentri
B. Egocentricity is normal for 2-year-old childre
C. He believes other children want him to have their toys.??
D. ??Your child is showing negativit
E. He doesn??t want other children to have the toys he wants.??
F. ??Your child is demonstrating magical thinkin
G. He believes he can make the other children want him to play with their toys.??
H. ??Your child is engaging in domestic imitatio
I. He is doing what he has seen other children do.??

Answer: A

Explanation:
Two-year-old children are very egocentric. They believe everything and everyone is concerned about them. They believe other children want them to have their toys. This is different than believing they can make other children want them to have all the toys, as in magical thinking, which normally occurs in preschool-age children. Toddlers are very negative, but this is expressed by refusal of requests made to them. Domestic imitation does occur in preschool-age children, but it refers to the imitation of household chores and roles performed by adults, not the imitation of other children.Health Promotion and Maintenance

NEW QUESTION 390
- (Topic 5)
The presence of which hormone in the urine is specifically indicative of pregnancy?

A. estrogen
B. progesterone
C. testosterone
D. human chorionic gonadotropin

Answer: D

Explanation:
Human chorionic gonadotropin is found in the urine during pregnancy and specifically indicates pregnancy. The other hormones do not.Reduction of Risk Potential

NEW QUESTION 391
- (Topic 6)
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. The nurse who was not promoted tells a friend, ??Oh, well, I really didn??t want the job anyway.?? This is an example of:

A. rationalization.
B. denial.
C. projection.
D. compensation.

Answer: A

Explanation:
This is called the sour grapes form of rationalization. Rationalization is an unconscious form of self-deception in which excuses are made. Denial is an unconscious process that ignores the existence of the situation. Projection operates unconsciously and results in blaming behavior. Compensation is an attempt to make up for a perceived weakness by emphasizing a strong point.Psychosocial Integrity

NEW QUESTION 392
- (Topic 6)
The Token Economy is a type of therapy that focuses on:

A. play therapy.
B. behavior modification.
C. milieu therapy.
D. associative.

Answer: B

Explanation:
Behavior modification gives positive feedback and rewards for appropriate behavior. Behavior modification requires negative behavior if it??s not destructive or life threatening. Psychosocial Integrity

NEW QUESTION 393
- (Topic 6)
A nurse is assessing a patient in the rehab unit at shift change. The patient has suffered a TBI 3 weeks ago. Which of the following is the most distinguishing characteristic of a neurological disturbance?

A. LOC (level of consciousness)
B. Short term memory
C. + Babinski sign
D. + Clonus sign

Answer: A

Explanation:
LOC is the most critical indicator of impaired neurological capabilities.

NEW QUESTION 397
- (Topic 6)
Which direction given to the nursing assistant is most likely to accomplish the task of getting a urine specimen delivered to the lab immediately after collection?

A. ??Make it a stat delivery.??
B. ??Please do it as soon as you can after break.??
C. ??This client is delirious, and we??re worried about a urinary sepsis.??
D. ??Take this client to the bathroom now and collect a urine specimen from this voidin
E. Take the specimen to the lab immediately.??

Answer: D

Explanation:
Effective delegation depends on clear, concise direction that leaves no room for question or interpretation on the part of the one being delegated to. Nursing assistants have a limited understanding of medical conditions and terminology, and should not be relied on to prioritize such tasks.Coordinated Care

NEW QUESTION 402
- (Topic 6)
A nurse is teaching a client newly diagnosed with Emphysema about the disease process. Which of the following statements best explains the problems associated with emphysema and could be adapted for use in the nurse??s discussion with the client?

A. Hyperactivity of the medium-sized bronchi caused by an inflammatory response leads to wheezing and tightness in the chest.
B. Larger than normal air spaces and loss of elastic recoil cause air to be trapped in the lung and collapse airways.
C. Vasodilation, congestion, and mucosal edema cause a chronic cough and sputum production.
D. Chloride is not being transported properly, producing excess absorption of water and sodium, and thick viscous mucus.

Answer: B

Explanation:
Larger-than-normal air spaces and loss of elastic recoil cause air to be trapped in the lung and collapse airways. Emphysema is a breakdown of the elastin and fiber network of the alveoli where the alveoli enlarge or the walls are destroyed. This alveolar destruction leads to the formation of larger-than-normal air spaces. Emphysema is one of a group of pulmonary diseases of a chronic nature characterized by increased resistance to airflow; the entity is part of chronic obstructive pulmonary disease (COPD).Physiological Adaptation

NEW QUESTION 406
- (Topic 6)
Which of the following microorganisms are considered normal body flora?

A. staphylococcus on the skin
B. streptococcus in the nares
C. candida albicans in the vagina
D. pseudomonas in the blood

Answer: A

Explanation:
Of the choices given, only staphylococcus is considered a normal resident of the body.
Safety and Infection Control

NEW QUESTION 410
- (Topic 6)
A primigravida begins labor when her family is unavailable and she is alone. She is very upset that her family is not with her. Which approach can the nurse take to meet the client??s needs at this time?

A. asking whether another individual wants to be her support person
B. assuring her that the nursing triage group will be with her at all times
C. telling her you will try to locate her family
D. reinforcing the woman??s confidence in her own abilities to cope and maintain a sense of control

Answer: A

Explanation:
Allow the client to select another individual to give support. This allows her to have someone with her until her family can be with her.Safety and Infection Control

NEW QUESTION 414
- (Topic 6)
A nurse is assessing a 18 year-old female who has recently suffered a TBI. The nurse notes a slower pulse and impaired respiration. The nurse should report these findings immediately to the physician, due to the possibility the patient is experiencing which of the following conditions?

A. Increased intracranial pressure
B. Increased function of cranial nerve X
C. Sympathetic response to activity

D. Meningitis

Answer: A

Explanation:
The patient is at high risk of developing increased intracranial pressure (ICP).

NEW QUESTION 417
- (Topic 6)
A nurse who is assessing the health-related physical fitness of a client as part of a health assessment should focus on which of the following aspects of the assessment?

A. agility
B. speed
C. body composition
D. risk factors

Answer: D

Explanation:
A health assessment should focus on possible risk factors of the client. A risk factor is something that increases a person??s chance for illness or injury. A health-risk appraisal is an assessment of the total person, including lifestyle and health behaviors.Health Promotion and Maintenance

NEW QUESTION 420
- (Topic 6)
Medical records indicate a patient has developed a condition of respiratory alkalosis. Which of the following clinical signs would not apply to a condition of respiratory alkalosis?

A. Muscle tetany
B. Syncope
C. Numbness
D. Anxiety

Answer: D

Explanation:
Anxiety is a clinical sign associated with respiratory acidosis.

NEW QUESTION 421
- (Topic 6)
A nurse is caring for a retired MD. The MD asks the question, ??What type of cells secrete insulin??? The correct answer is:

A. alpha cells
B. beta cells
C. CD4 cells
D. helper cells

Answer: B

Explanation:
Beta cells secrete insulin.

NEW QUESTION 426
- (Topic 6)
A nurse at outpatient clinic is returning phone calls that have been made to the clinic. Which of the following calls should have the highest priority for medical intervention?

A. A home health patient reports, ??I am starting to have breakdown of my heels.??
B. A patient that received an upper extremity cast yesterday reports, ??I can??t feel my fingers in my right hand today.??
C. A young female reports, ??I think I sprained my ankle about 2 weeks ago.??
D. A middle-aged patient reports, ??My knee is still hurting from the TKR.??

Answer: B

Explanation:
The patient experiencing neurovascular changes should have the highest priority. Pain following a TKR is normal, and breakdown over the heels is a gradual process. Moreover, a subacute ankle sprain is almost never a medical emergency.

NEW QUESTION 430
- (Topic 6)
A newborn baby exhibits a reflex that includes: hand opening, abducted and extended extremities following a jarring motion. Which of the following correctly identifies the reflex?

A. ATNR reflex
B. Startle reflex
C. Grasping reflex
D. Moro reflex

Answer: D

Explanation:
The moro reflex has all of the listed characteristics.

NEW QUESTION 434
- (Topic 6)
A 60-year-old widower is hospitalized after complaining of difficulty sleeping, extreme apprehension, shortness of breath, and a sense of impending doom. What is the best response by the nurse?

A. ??You have nothing to worry abou
B. You are in a safe plac
C. Try to relax.??
D. ??Has anything happened recently or in the past that might have triggered these feelings???
E. ??We have given you a medication that helps to decrease feelings of anxiety.??
F. ??Take some deep breaths and try to calm down.??

Answer: B

Explanation:
Choice 2 provides support, reassurance, and an opportunity to gain insight into the cause of the anxiety. Choice 1 dismisses the client??s feelings and offers false reassurance. Choices 3 and 4 do not allow the client to discuss his feelings, which he must do in order to understand and resolve the cause of his anxiety.PsychosocialIntegrity

NEW QUESTION 439
- (Topic 6)
The nurse is teaching a client about communicable diseases and explains that a portal of entry is:

A. a vector.
B. a source, like contaminated water.
C. food.
D. the respiratory system.

Answer: D

Explanation:
The path by which a microorganism enters the body is the portal of entry. A vector is a carrier of disease, a source (like bad water or food) can be a reservoir of disease.Safety and Infection Control

NEW QUESTION 440
- (Topic 6)
A man expresses surprise that his wife has become very withdrawn during hospitalization for pneumonia. Which response helps the husband understand how some people cope with hospitalization?

A. ??Hospitalization might cause a crisi
B. Has your wife had to cope with problems before this???
C. ??Some people react that wa
D. She will be more talkative when she feels better.??
E. ??Your wife might be feeling concern that she cannot fulfill her normal roles.??
F. ??This is typical behavior for someone who is as ill as your wife.??

Answer: A

Explanation:
Hospitalization might precipitate a crisis in either the client or family. Clients might become demanding or withdrawn. Family members might become demanding to help them cope with insecurity.Psychosocial Integrity

NEW QUESTION 441
- (Topic 6)
A nurse is performing a screening on a patient that has been casted recently on the left lower extremity. Which of the following statements should the nurse be most concerned about?

A. The patient reports, ??I didn??t keep my extremity elevated like the doctor asked me to.??
B. The patient reports, ??I have been having pain in my left calf.??
C. The patient reports, ??My left leg has really been itching.??
D. The patient reports, ??The arthritis in my wrists is flaring up, when I put weight on my crutches.??

Answer: B

Explanation:
Pain may be indicating neurovascular complication.

NEW QUESTION 446
- (Topic 6)
A case management clinical pathway for congestive heart failure might include all of the following except:

A. physician follow-up appointments with transportation.

B. client education regarding medication use.
C. a nutritional consult for diet review and accommodation.
D. insurance review for reimbursement.

Answer: D

Explanation:
Clinical pathways include maps of care outcomes to be achieved prior to discharge or movement through a health care system. Insurance review for reimbursement is a function of an outside agency from the health care provider related to the amount of expected monetary compensation for services rendered to a client.CoordinatedCare

NEW QUESTION 450
- (Topic 6)
A client who has a known history of cardiac problems and is still smoking enters the clinic complaining of sudden onset of sharp, stabbing pain that intensifies with a deep breath. The pain is occurring on only one side and can be isolated upon general assessment. The nurse concludes that this description is most likely caused by:

A. pleurisy.
B. pleural effusion.
C. atelectasis.
D. tuberculosis.

Answer: A

Explanation:
Pleurisy is an inflammation of the pleura and is often accompanied by abrupt onset of pain. Symptoms of pleurisy are abrupt pain that is usually unilateral and localized to a specific portion of the chest. The pain is sharp, stabbing, and might radiate to the neck or shoulder. Pressure changes caused by breathing, movement, or coughing intensify the pain. Other symptoms might include fever, cough (dry, hacking), localized tenderness, diminished breath sounds, tachypnea, and pleural friction rub.Physiological Adaptation

NEW QUESTION 451
- (Topic 6)
A nurse reviewed the arterial blood gas reading of a 25 year-old male. The nurse should be able to conclude the patient is experiencing which of the following conditions?
Bicarbonate ion-25 mEq/l PH-7.41
PaCO2-29 mmHg PaO2-54 mmHg (FiO2)-.22

A. metabolic acidosis
B. respiratory acidosis
C. metabolic alkalosis
D. respiratory alkalosis

Answer: D

Explanation:
Respiratory alkalosis-elevated pH, and low carbon dioxide levels, no compensation noted.

NEW QUESTION 454
- (Topic 6)
After the client discusses her relationship with her father, the nurse says, ??Tell me whether I am understanding your relationship with your father. You feel dominated and controlled by him??? This is an example of:

A. verbalizing the implied.
B. seeking consensual validation.
C. encouraging evaluation.
D. suggesting collaboration.

Answer: B

Explanation:
Consensual validation is a technique used to check one??s understanding of what the client has said. Consensual validation is the process by which people come to agreement about the meaning and significance of specific symbols. Through this experience, individuals develop the ability to relate effectively.Psychosocial Integrity

NEW QUESTION 457
- (Topic 6)
How many feet should separate the nurse and the source when extinguishing a small, wastebasket fire with an appropriate extinguisher?

A. 1 foot
B. 2 feet
C. 4 feet
D. 6 feet

Answer: D

Explanation:
The nurse should stand about 6 feet from the source of the fire. Getting closer might put the nurse in danger.Safety and Infection Control

NEW QUESTION 461
- (Topic 6)
A patient has a history of cardiac arrhythmia. A nurse has been ordered to give 2 units of blood to this patient. The nurse should take which of the following actions?

A. Prep the patient with pain medication.
B. Notify the patient??s family about the procedure via the telephone.
C. Decrease the temperature of the blood to be given.
D. Increase the temperature of the blood to be given.

Answer: D

Explanation:
Warming the blood will reduce the risk of additional cardiac arrhythmia.

NEW QUESTION 463
- (Topic 6)
A patient has been ordered to get Klonapin for the first time. Which of the following side effects is not associated with Klonapin?

A. Drowsiness
B. Ataxia
C. Salivation elevated
D. Diplopia

Answer: D

Explanation:
A-C are associated side effects of Klonapin.

NEW QUESTION 467
- (Topic 6)
A twenty-one year old man suffered a concussion and the MD ordered a MRI. The patient asks, ??Will they allow me to sit up during the MRI??? The correct response by the nurse should be.

A. ??I will have to talk to the doctor about letting you sit upright during the test.??
B. ??You will be positioned in the reverse Trendelenburg position to maximizethe view of the brain.??
C. ??The radiologist will let you know.??
D. ??You will have to lie down on your back during the test.??

Answer: D

Explanation:
The MRI will require supine positioning.

NEW QUESTION 468
- (Topic 6)
If Ms. Barrett??s distance vision is 20/30, which of the following statements is true?

A. The client can read from 20' what a person with normal vision can read at 30'.
B. The client can read from 30' what a person with normal vision can read at 20'.
C. The client can read the entire chart from 30'.
D. The client can read the chart from 20' with the left eye and from 30' with the right eye.

Answer: A

Explanation:
The numerator, which is always 20, is the distance in feet between the chart and the client. The denominator, which ranges from 10 to 200, indicates the distance at which a normal eye can read the chart. The eye chart the nurse uses is the Snellen chart, which assesses distance vision.Health Promotion and Maintenance

NEW QUESTION 470
- (Topic 6)
A client receives a cervical intracavity radium implant as part of her therapy. A common side effect of a cervical implant is:

A. creamy, pink-tinged vaginal drainage.
B. stomatitis.
C. constipation.
D. xerostomia.

Answer: A

Explanation:
Creamy, pink-tinged vaginal drainage persists for 1 to 2 months after removal of a cervical implant. Diarrhea, not constipation, is usually a side effect of cervical implants. Stomatitis and xerostomia are local side effects of radiation to the mouth.Physiological Adaptation

NEW QUESTION 473
- (Topic 6)
A violation of a patient??s confidentiality occurs if two nurses are discussing client information in which of the following scenarios?

A. With a physical therapist treating the patient
B. With a social worker planning for discharge
C. With another nurse on duty to plan for break time
D. In the hallway outside the patient??s room.

Answer: D

Explanation:
Hallway discussions should not occur, because you do not who is listening, even though it may be a professional discussion.

NEW QUESTION 475
- (Topic 6)
The physician wants to know if a client is tolerating his total parenteral nutrition. Which of the following laboratory tests is likely to be ordered?

A. triglyceride level
B. liver function tests
C. a glucose tolerance test
D. a complete blood count

Answer: B

Explanation:
The liver is the primary organ for digestion. Liver function tests measure the blood level of enzymes produced by the liver: prothrombin time/partial prothrombin time, serum glutamic oxaloacetic and pyruvic transaminases, gamma glutamyl transpeptidase, albumin, and alkalinephosphatase. Choice 1 measures the body??s ability to clear triglycerides, the primary component of fats. Failure to clear triglycerides from the bloodstream indicates a problem with storage or the ingestion of too much fat. Choice 3 measures the blood glucose at intervals after a glucose-rich solution is ingested; it is used for diagnosing diabetes. Choice 4 is used to evaluate blood components.Pharmacological Therapies

NEW QUESTION 479
- (Topic 6)
During a well-baby check of a 6-month-old infant, the nurse notes abrasions and petechaie of the palate. The nurse should:

A. inquire about foods the child is eating.
B. ask about the possibility of sexual abuse.
C. request to see the type of bottle used for feedings.
D. question the parent about objects the child plays with.

Answer: B

Explanation:
Generally oral sex leaves little physical evidence. Injury to the soft palate (such as bruising, abrasions, and petechaie) and pharyngeal gonorrhea are the only signs. Infants are at risk for sexual abuse.Psychosocial Integrity

NEW QUESTION 482
- (Topic 6)
A nurse is setting up a vision-screening program for a new school. At what age will vision be 20/20 in children?

A. 4 years old
B. 5 years old
C. 6 years old
D. 7 years old

Answer: C

Explanation:
6 years of age is the standard age of 20/20 vision potential.

NEW QUESTION 487
- (Topic 6)
The nurse is developing a care plan for a client with severe anxiety. An appropriate outcome for the client is that within 4 days the client should:

A. Have decreased anxiety.
B. Talk to the nurse for 10 minutes.
C. Sit quietly for 30 minutes.
D. Develop an adaptive coping mechanism.

Answer: B

Explanation:
Outcome criteria need to be specific, measurable, and realistic. Talking for 10 minutes meets all of these conditions. It is not realistic to expect a severely anxious client to sit quietly for 30 minutes.
The other statements are vague and not measurable.Psychosocial Integrity

NEW QUESTION 488
- (Topic 6)
When planning intervention for a client during a crisis, which of the following outcomes is most appropriate?

A. The client should explore deep psychological problems.
B. The client should express positive feelings about event.
C. The client should identify needs that are threatened by the event.
D. The client should use constructive coping mechanisms.

Answer: D

Explanation:
The primary goal of crisis intervention is to relieve the symptoms of anxietyand foster constructive coping.Previous psychological issues might recur during crisis, but the focus is onshort-term resolution of the currentproblem. At the end, the nurse credits a client for positive changes and helps him or her understand what was learned. This allows the client to use the learned coping mechanisms when new problems arise.Psychosocial Integrity

NEW QUESTION 492
- (Topic 6)
The nurse observes a staff member not following the plan of care for a client with an antisocial personality disorder. The nurse should:

A. confront the staff member immediately and say, ??You know that is not the treatment plan.??
B. write an incident report to create a paper trail of the staff member??s failure to follow the planned program.
C. ask the staff member to talk in private, and reinforce how antisocial clients try to divide staff.
D. bring up the incident during the weekly conference so that this staff member is not assigned to work with antisocial persons again.

Answer: C

Explanation:
It is essential that the treatment program be followed exactly for clients with antisocial personality disorder because they are very manipulative and attempt to divide staff. However, confronting the staff member in front of the client enhances the division of staff. Talking with the staff member in private allows the person to develop skills to work with this client population.Psychosocial Integrity

NEW QUESTION 496
- (Topic 6)
A 27 year-old woman has delivered twins in the OB unit. The patient develops a condition of 5 centimeter diastasis recti abdominis. Which of the following statements is the most accurate when instructing the patient?

A. Sit-ups are o.
B. to do as long as you don??t strain
C. This condition leads to surgery in 80% of cases.
D. Guarding the abdominal region is important at this time.
E. Antibiotics are required for this condition in 70% of patients.

Answer: C

Explanation:
Protection of the abdominal wall is critical at this point in time.

NEW QUESTION 501
- (Topic 6)
Which of the following lab values would indicate symptomatic AIDS in the medical chart? (T4 cell count per deciliter)

A. Greater than 1000 cells per deciliter
B. Less than 500 cells per deciliter
C. Greater than 2000 cells per deciliter
D. Less than 200 cells per deciliter

Answer: D

Explanation:
<200 T4 cells/deciliter

NEW QUESTION 504
- (Topic 6)
A nurse working in a pediatric clinic and observes the following situations. Which of the following may indicate a delayed child to the nurse?

A. A 12-month old that does not ??cruise??.
B. A 8-month old that can sit upright unsupported.
C. A 6-month old that is rolling prone to supine.
D. A 3-month old that does not roll supine to prone.

Answer: A

Explanation:
At 12 months a child should at least be ??cruising?? (holding on to objects to walk). Cruising is considered pre-walking.

NEW QUESTION 507
- (Topic 6)
A 14 year-old boy has been admitted to a mental health unit for observation and treatment. The boy becomes agitated and starts yelling at nursing staff members. What should the nurse first response be?

A. Create an atmosphere of seclusion for the boy according to procedures.
B. Remove other patients from the area via wheelchairs for added speed.
C. Ask the patient, ??What is making you mad???
D. Ask the patient, ??Why are you doing this, have you thought about what yourparents might say???

Answer: A

Explanation:
Seclusion is your best option in this scenario.

NEW QUESTION 508
- (Topic 6)
When choosing a needle gauge for an intramuscular injection in a 12 year old boy. Which of the following gauges would you choose?

A. 27 gauge
B. 25 gauge
C. 22 gauge
D. 20 gauge

Answer: C

Explanation:
22 gauge is recommended for school age children, toddlers, and adolescents while 23-25 gauge is recommended for infants.

NEW QUESTION 512
- (Topic 6)
A 21-year-old college student has just learned that she contracted genital herpes from her sexual partner. After completing the initial history and assessment, the nurse has data concerning areas pertinent to the disease. The data is likely to include all but which of the following?

A. voiding patterns
B. characteristics of lesions
C. vaginal discharge
D. prior history of varicella

Answer: D

Explanation:
The other choices are common reasons for which clients with herpes seek care.
Physiological Adaptation

NEW QUESTION 516
- (Topic 6)
An appropriate question when assessing a client??s self-expectations about weight loss is:

A. ??What makes you think you can change your eating habits???
B. ??How do you feel about losing weight???
C. ??How important is it that you lose weight???
D. ??What do you think is a realistic weekly weight loss for you???

Answer: D

Explanation:
Nurses should assist clients to evaluate themselves and make behavior changes. Listening to clients, supporting clients?? strengths, assisting clients to look at themselves in totality, and encouraging clients to set attainable goalsshould be part of the nurse-client relationship.Psychosocial Integrity

NEW QUESTION 521
- (Topic 6)
A nurse taking a patient??s history realizes the patient is complaining of SOB and weakness in the lower extremities. The patient has a history of hyperlipidemia, and hypertension. Which of the following may be occurring?

A. The patient is developing CHF
B. The patient may be having a MI
C. The patient may be developing COPD
D. The patient may be having an onset of PVD

Answer: B

Explanation:
Myocardial infarction may be associated with SOB and muscle weakness.

NEW QUESTION 524
- (Topic 6)
Priorities to be considered intermediate are:

A. the nonemergency, non-life-threatening needs of the client.
B. those tasks that can be delegated to assistive personnel.
C. those tasks that can be performed at the end of the shift.

D. those task that can be performed at any time.

Answer: A

Explanation:
Priorities designated asintermediateby the nurse are those that are not urgent. They do not affect the client??s immediate physiological status. This does not imply that they are not important or not necessary. Intermediate priorities might still require the skill level of an RN for completion. There might be specific time requirements for completion as well. Coordinated Care

NEW QUESTION 527
- (Topic 6)
A nurse assesses a 83 year-old female??s venous ulcer for the second time that is located near the right medial malleolus. The wound is exhibiting purulent drainage and the patient has limited mobility in her home. Which of the options is the best course of action?

A. Encourage warm water soaks to the right foot.
B. Notify the case manager of the purulent drainage.
C. Determine the patient??s pulse in the right ankle.
D. Recommend increased activity to reduce the purulent drainage.

Answer: A

Explanation:
A determination of arterial blood flow should be made, prior to encouraging increased activity, or notifying additional team members.

NEW QUESTION 528
- (Topic 6)
To manage time most effectively, the nurse responds to which of the following stimuli first:

A. the physician??s loud verbal direction.
B. the nursing supervisor who is going to a meeting.
C. unit staff leaving on a break.
D. the care needs of the returning postoperative client just exiting the elevator.

Answer: D

Explanation:
While many environmental stimuli might compete for attention and time, the client care needs of complex or unstable clients and those requiring assessment and care must take priority.Coordinated Care

NEW QUESTION 529
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