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National Council Licensure Examination(NCLEX-RN)

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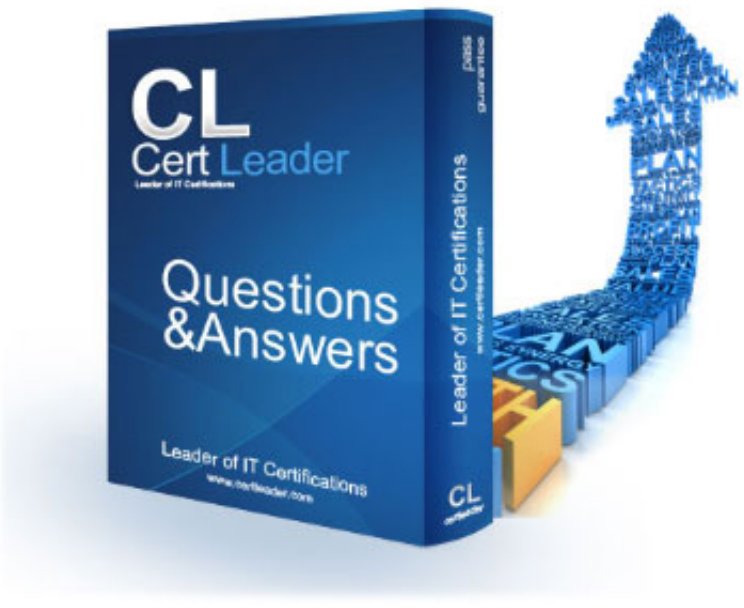

NEW QUESTION 1
- (Topic 1)
A laboratory technique specific for diagnosing Lyme disease is:

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

Answer: A

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

NEW QUESTION 2
- (Topic 1)
Provide the 1-minute Apgar score for an infant born with the following findings: Heart rate: Above 100 Respiratory effort: Slow, irregular Muscle tone: Some flexion of extremities Reflex irritability: Vigorous cry Color: Body pink, blue extremities

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

Answer: A

Explanation:
(A) Seven out of a possible perfect score of 10 is correct. Two points are given for heart rate above 100; 1 point is given for slow, irregular respiratory effort; 1 point is given for some flex- ion of extremities in assessing muscle tone; 2 points are given for vigorous cry in assessing reflex irritability; 1 point is assessed for color when the body is pink with blue extremities (acrocyanosis). (B) For a perfect Apgar score of 10, the infant would have a heart rate over 100 but would also have a good cry, active motion, and be completely pink.
(C) For an Apgar score of 8 the respiratory rate, muscle tone, or color would need to fall into the 2-point rather than the 1-point category. (D) For this infant to receive an Apgar score of 9, four of the areas evaluated would need ratings of 2 points and one area, a rating of 1 point.

NEW QUESTION 3
- (Topic 1)
A diagnosis of hepatitis C is confirmed by a male client??s physician. The nurse should be knowledgeable of the differences between hepatitis A, B, and C. Which of the following are characteristics of hepatitis C?

A. The potential for chronic liver disease is minimal.
B. The onset of symptoms is abrupt.
C. The incubation period is 2–26 weeks.
D. There is an effective vaccine for hepatitis B, but not for hepatitis C.

Answer: C

Explanation:
(A) Hepatitis C and B may result in chronic liver disease. Hepatitis A has a low potential for chronic liver disease. (B) Hepatitis C and B have insidious onsets. Hepatitis A has an abrupt onset. (C) Incubation periods are as follows: hepatitis C is 2–26 weeks, hepatitis B is 6–20 weeks, and hepatitis A is 2–6 weeks. (D) Only hepatitis B has an effective vaccine.

NEW QUESTION 4
- (Topic 1)
Which of the following statements relevant to a suicidal client is correct?

A. The more specific a client??s plan, the more likely he or she is to attempt suicide.
B. A client who is unsuccessful at a first suicide attempt is not likely to make future attempts.
C. A client who threatens suicide is just seeking attention and is not likely to attempt suicide.
D. Nurses who care for a client who has attempted suicide should not make any reference to the word ??suicide?? in order to protect the client??s ego.

Answer: A

Explanation:
(A) This is a high-risk factor for potential suicide. (B) A previous suicide attempt is a definite risk factor for subsequent attempts. (C) Every threat of suicide should be taken seriously.
(D) The client should be asked directly about his or her intent to do bodily harm. The client is never hurt by direct, respectful questions.

NEW QUESTION 5
- (Topic 1)
During burn therapy, morphine is primarily administered IV for pain management because this route:

A. Delays absorption to provide continuous pain relief
B. Facilitates absorption because absorption from muscles is not dependable
C. Allows for discontinuance of the medication if respiratory depression develops
D. Avoids causing additional pain from IM injections

Answer: B

Explanation:
(A) Absorption would be increased, not decreased. (B) IM injections should not be used until the client is hemodynamically stable and has adequate tissue perfusion. Medications will remain in the subcutaneous tissue with the fluid that is present in the interstitial spaces in the acute phase of the thermal injury. The client will have a poor response to the medication administered, and a ??dumping?? of the medication can occur when the medication and fluid are shifted back into the intravascular spaces in the next phase of healing. (C) IV administration of the medication would hasten respiratory compromise, if present. (D) The desire to avoid causing the client additional pain is not a primary reason
for this route of administration.

NEW QUESTION 6
- (Topic 1)
The therapeutic blood-level range for lithium is:

A. 0.25–1.0 mEq/L
B. 0.5–1.5 mEq/L
C. 1.0–2.0 mEq/L
D. 2.0–2.5 mEq/L

Answer: B

Explanation:
(A) This range is too low to be therapeutic. (B) This is the therapeutic range for lithium. (C)
This range is above the therapeutic level. (D) This range is toxic and may cause severe side effects.

NEW QUESTION 7
- (Topic 1)
The following medications were noted on review of the client??s home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

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

Answer: C

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

NEW QUESTION 8
- (Topic 1)
Discharge teaching was effective if the parents of a child with atopic dermatitis could state the importance of:

A. Maintaining a high-humidified environment
B. Furry, soft stuffed animals for play
C. Showering 3–4 times a day
D. Wrapping hands in soft cotton gloves

Answer: D

Explanation:
(A) Maintaining a low-humidified environment. (B) Avoiding furry, soft stuffed animals for play, which may increase symptoms of allergy. (C) Avoiding showering, which irritates the dermatitis, and encouraging bathing 4 times a day in colloid bath for temporary relief. (D) Wrapping hands in soft cotton gloves to prevent skin damage during scratching.

NEW QUESTION 9
- (Topic 1)
Which classification of drugs is contraindicated for the client with hypertrophic cardiomyopathy?

A. Positive inotropes
B. Vasodilators
C. Diuretics
D. Antidysrhythmics

Answer: A

Explanation:
(A) Positive inotropic agents should not be administered owing to their action of increasing myocardial contractility. Increased ventricular contractility would increase outflow tract obstruction in the client with hypertrophic cardiomyopathy. (B) Vasodilators are not typically prescribed but are not contraindicated. (C) Diuretics are used with caution to avoid causing hypovolemia. (D) Antidysrhythmics are typically needed to treat both atrial and ventricular dysrhythmias.

NEW QUESTION 10
- (Topic 1)
Hypoxia is the primary problem related to near-drowning victims. The first organ that sustains irreversible damage after submersion in water is the:

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

Answer: B

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

NEW QUESTION 10
- (Topic 1)
What is the most effective method to identify early breast cancer lumps?

A. Mammograms every 3 years
B. Yearly checkups performed by physician
C. Ultrasounds every 3 years
D. Monthly breast self-examination

Answer: D

Explanation:
(A) Mammograms are less effective than breast self-examination for the diagnosis of abnormalities in younger women, who have denser breast tissue. They are more effective forwomen older than 40. (B) Up to 15% of early-stage breast cancers are detected by physical examination; however, 95% are detected by women doing breast self- examination. (C) Ultrasound is used primarily to determine the location of cysts and to distinguish cysts from solid masses. (D) Monthly breast self-examination has been shown to be the most effective method for early detection of breast cancer. Approximately 95% of lumps are detected by women themselves.

NEW QUESTION 15
- (Topic 1)
A six-month-old infant has been admitted to the emergency room with febrile seizures. In the teaching of the parents, the nurse states that:

A. Sustained temperature elevation over 103F is generally related to febrile seizures
B. Febrile seizures do not usually recur
C. There is little risk of neurological deficit and mental retardation as sequelae to febrile seizures
D. Febrile seizures are associated with diseases of the central nervous system

Answer: C

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

NEW QUESTION 17
- (Topic 1)
A 30-year-old male client is admitted to the psychiatric unit with a diagnosis of bipolar disorder. For the last 2 months, his family describes him as being ??on the move,?? sleeping 3–4 hours nightly, spending lots of money, and losing approximately 10 lb. During the initial assessment with the client, the nurse would expect him to exhibit which of the following?

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

Answer: C

Explanation:
(A) During the manic phase of bipolar disorder, clients have short attention spans and may be abusive toward authority figures. (B) Introspection requires focusing and concentration; clients with mania experience flight of ideas, which prevents concentration.
(C) Grandiosity and an inflated sense of self-worth are characteristic of this disorder. (D) Feelings of helplessness and hopelessness are symptoms of the depressive stage of bipolar disorder.

NEW QUESTION 19
- (Topic 1)
Which of the following nursing orders should be included in the plan of care for a client with hepatitis C?

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

Answer: A

Explanation:
(A) The source of infection with hepatitis C is contaminated blood products. (B) Modified bed rest should be maintained while the client is symptomatic. Routine activities can be slowly resumed once the client is asymptomatic. (C) Nausea and vomiting occur frequently with hepatitis C. A high Fowler position may decrease

the tendency to vomit. (D) The buildup of bilirubin in the client??s skin may cause pruritus. Alcohol is a drying agent.

NEW QUESTION 21
- (Topic 1)
A child sustains a supracondylar fracture of the femur. When assessing for vascular injury, the nurse should be alert for the signs of ischemia, which include:

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

Answer: C

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

NEW QUESTION 25
- (Topic 1)
Proper positioning for the child who is in Bryant??s traction is:

A. Both hips flexed at a 90-degree angle with the knees extended and the buttocks elevated off the bed
B. Both legs extended, and the hips are not flexed
C. The affected leg extended with slight hip flexion
D. Both hips and knees maintained at a 90-degree flexion angle, and the back flat on the bed

Answer: A

Explanation:
(A) The child??s weight supplies the countertraction for Bryant??s traction; the buttocks are
slightly elevated off the bed, and the hips are flexed at a 90-degree angle. Both legs are suspended by skin traction. (B) The child in Buck??s extension traction maintains the legs extended and parallel to the bed. (C) The child in Russell traction maintains hip flexion of the affected leg at the prescribed angle with the leg extended. (D) The child in ??90–90?? traction maintains both hips and knees at a 90-degree flexion angle and the back is flat on the bed.

NEW QUESTION 26
- (Topic 1)
When administering phenytoin (Dilantin) to a child, the nurse should be aware that a toxic effect of phenytoin therapy is:

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

Answer: A

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

NEW QUESTION 28
- (Topic 1)
The nurse practitioner determines that a client is approximately 9 weeks?? gestation. During the visit, the practitioner informs the client about symptoms of physical changes that she will experience during her first trimester, such as:

A. Nausea and vomiting
B. Quickening
C. A 6–8 lb weight gain
D. Abdominal enlargement

Answer: A

Explanation:
(A) Nausea and vomiting are experienced by almost half of all pregnant women during the first 3 months of pregnancy as a result of elevated human chorionic gonadotropin levels and changed carbohydrate metabolism. (B) Quickening is the mother??s perception of fetal movement and generally does not occur until 18–20 weeks after the last menstrual period in primigravidas, but it may occur as early as 16 weeks in multigravidas. (C) During the first trimester there should be only a modest weight gain of 2–4 lb. It is not uncommon for women to lose weight during the first trimester owing to nausea and/or vomiting. (D) Physical changes are not apparent until the second trimester, when the uterus rises out of the pelvis.

NEW QUESTION 32
- (Topic 1)
Which of the following procedures is necessary to establish a definitive diagnosis of breast cancer?

A. Diaphanography
B. Mammography
C. Thermography
D. Breast tissue biopsy

Answer: D

Explanation:
(A) Diaphanography, also known as transillumination, is a painless, noninvasive imaging technique that involves shining a light source through the breast tissue to visualize the interior. It must be used in conjunction with a mammogram and physical examination. (B) Mammography is a useful tool for screening but is not considered a means of diagnosing breast cancers. (C) Thermography is a pictorial representation of heat patterns on the surface of the breast. Breast cancers appear as a ??hot spot?? owing to their higher metabolic rate. (D) Biopsy either by needle aspiration or by surgical incision is the primary diagnostic technique for confirming the presence of cancer cells.

NEW QUESTION 36
- (Topic 1)
Which of the following would differentiate acute from chronic respiratory acidosis in the assessment of the trauma client?

A. Increased PaCO2
B. Decreased PaO2
C. Increased HCO3
D. Decreased base excess

Answer: C

Explanation:
(A) Increased CO2 will occur in both acute and chronic respiratory acidosis. (B) Hypoxia does not determine acid-base status. (C) Elevation of HCO3 is a compensatory mechanism in acidosis that occurs almost immediately, but it takes hours to show any effect and days to reach maximum compensation. Renal disease and diuretic therapy may impair the ability of the kidneys to compensate. (D) Base excess is a nonrespiratory contributor to acid-base balance. It would increase to compensate for acidosis.

NEW QUESTION 37
- (Topic 1)
The cardiac client who exhibits the symptoms of disorientation, lethargy, and seizures may be exhibiting a toxic reaction to:

A. Digoxin (Lanoxin)
B. Lidocaine (Xylocaine)
C. Quinidine gluconate or sulfate (Quinaglute,Quinidex)
D. Nitroglycerin IV (Tridil)

Answer: B

Explanation:
(A) Side effects of digoxin include headache, hypotension, AV block, blurred vision, and yellow-green halos. (B) Side effects of lidocaine include heart block, headache, dizziness, confusion, tremor, lethargy, and convulsions. (C) Side effects of quinidine include heart block, hepatotoxicity, thrombocytopenia, and respiratory depression. (D) Side effects of nitroglycerin include postural hypotension, headache, dizziness, and flushing.

NEW QUESTION 42
- (Topic 1)
The predominant purpose of the first Apgar scoring of a newborn is to:

A. Determine gross abnormal motor function
B. Obtain a baseline for comparison with the infant??s future adaptation to the environment
C. Evaluate the infant??s vital functions
D. Determine the extent of congenital malformations

Answer: C

Explanation:
(A) Apgar scores are not related to the infant??s care, but to the infant??s physical condition.
(B) Apgar scores assess the current physical condition of the infant and are not related to future environmental adaptation. (C) The purpose of the Apgar system is to evaluate the physical condition of the newborn at birth and to determine if there is an immediate need for resuscitation. (D) Congenital malformations are not one of the areas assessed with Apgar scores.

NEW QUESTION 46
- (Topic 1)
The most important reason to closely assess circumferential burns at least every hour is that they may result in:

A. Hypovolemia
B. Renal damage
C. Ventricular arrhythmias
D. Loss of peripheral pulses

Answer: D

Explanation:
(A) Hypovolemia could be a result of fluid loss from thermal injury, but not as a result of the circumferential injury. (B) Renal damage is typically seen because of prolonged hypovolemia or myoglobinuria. (C) Electrical injuries and electrolyte changes typically cause arrhythmias in the burn client. (D) Full-thickness circumferential burns are nonelastic and result in an internal tourniquet effect that compromises distal blood flow when the area involved is an extremity.Circumferential full-thickness torso burns compromise respiratory motion and, when extreme, cardiac return.

NEW QUESTION 48

- (Topic 1)
A 27-year-old man was diagnosed with type I diabetes 3 months ago. Two weeks ago he complained of pain, redness, and tenderness in his right lower leg. He is admitted to the hospital with a slight elevation of temperature and vague complaints of ??not feeling well.?? At 4:30 PM on the day of his admission, his blood glucose level is 50 mg; dinner will be served at 5:00 PM. The best nursing action would be to:

A. Give him 3 tbsp of sugar dissolved in 4 oz of grape juice to drink
B. Ask him to dissolve three pieces of hard candy in his mouth
C. Have him drink 4 oz of orange juice
D. Monitor him closely until dinner arrives

Answer: C

Explanation:
(A) The combination of sugar and juice will increase the blood sugar beyond the normal range. (B) Concentrated sweets are not absorbed as fast as juice; consequently, they elevate the blood sugar beyond the normal limit. (C) Four ounces of orange juice will act immediately to raise the blood sugar to a normal level and sustain it for 30 minutes until supper is served. (D) There is an increased potential for the client??s blood sugar to decrease even further, resulting in diabetic coma.

NEW QUESTION 52
- (Topic 1)
A type I diabetic client is diagnosed with cellulitis in his right lower extremity. The nurse would expect which of the following to be present in relation to his blood sugar level?

A. A normal blood sugar level
B. A decreased blood sugar level
C. An increased blood sugar level
D. Fluctuating levels with a predawn increase

Answer: C

Explanation:
(A) Blood sugar levels increase when the body responds to stress and illness. (B) Blood sugar levels increase when the body responds to stress and illness. (C) Hyperglycemia occurs because glucose is produced as the body responds to the stress and illness of cellulitis. (D) Blood sugar levels remain elevated as long as the body responds to stress and illness.

NEW QUESTION 55
- (Topic 1)
When assessing fetal heart rate status during labor, the monitor displays late decelerations with tachycardia and decreasing variability. What action should the nurse take?

A. Continue monitoring because this is a normal occurrence.
B. Turn client on right side.
C. Decrease IV fluids.
D. Report to physician or midwife.

Answer: D

Explanation:
(A) This is not a normal occurrence. Late decelerations need prompt intervention for immediate infant recovery. (B) To increase O2 perfusion to the unborn infant, the mother should be placed on her left side. (C) IV fluids should be increased, not decreased. (D) Immediate action is warranted, such as reporting findings, turning mother on left side, administering O2, discontinuing oxytocin (Pitocin), assessing maternal blood pressure and the labor process, preparing for immediate cesarean delivery, and explaining plan of action to client.

NEW QUESTION 57
- (Topic 1)
In the client with a diagnosis of coronary artery disease, the nurse would anticipate the complication of bradycardia with occlusion of which coronary artery?

A. Right coronary artery
B. Left main coronary artery
C. Circumflex coronary artery
D. Left anterior descending coronary artery

Answer: A

Explanation:
(A) Sinus bradycardia and atrioventricular (AV) heart block are usually a result of right coronary artery occlusion. The right coronary artery perfuses the sinoatrial and AV nodes in mostindividuals. (B) Occlusion of the left main coronary artery causes bundle branch blocks and premature ventricular contractions. (C) Occlusion of the circumflex artery does not cause bradycardia. (D) Sinus tachycardia occurs primarily with left anterior descending coronary artery occlusion because this form of occlusion impairs left ventricular function.

NEW QUESTION 60
- (Topic 1)
Diabetes during pregnancy requires tight metabolic control of glucose levels to prevent perinatal mortality. When evaluating the pregnant client, the nurse knows the recommended serum glucose range during pregnancy is:

A. 70 mg/dL and 120 mg/dL
B. 100 mg/dL and 200 mg/dL
C. 40 mg/dL and 130 mg/dL
D. 90 mg/dL and 200 mg/dL

Answer: A

Explanation:
(A) The recommended range is 70–120 mg/dL to reduce the risk of perinatal mortality. (B, C, D) These levels are not recommended. The higher the blood glucose, the worse the prognosis for the fetus. Hypoglycemia can also have detrimental effects on the fetus.

NEW QUESTION 62
- (Topic 1)
The nurse assists a client with advanced emphysema to the bathroom. The client becomes extremely short of breath while returning to bed. The nurse should:

A. Increase his nasal O2 to 6 L/min
B. Place him in a lateral Sims?? position
C. Encourage pursed-lip breathing
D. Have him breathe into a paper bag

Answer: C

Explanation:
(A) Giving too high a concentration of O2 to a client with em-physema may remove his stimulus to breathe. (B) The client should sit forward with his hands on his knees or an overbed table and with shoulders elevated. (C) Pursed-lip breathing helps the client to blow off CO2 and to keep air passages open. (D) Covering the face of a client extremely short of breath may cause anxiety and further increase dyspnea.

NEW QUESTION 64
- (Topic 1)
A 25-year-old client believes she may be pregnant with her first child. She schedules an obstetric examination with the nurse practitioner to determine the status of her possible pregnancy. Her last menstrual period began May 20, and her estimated date of confinement using Nägele??s rule is:

A. March 27
B. February 1
C. February 27
D. January 3

Answer: C

Explanation:
(A)March 27 is a miscalculation. (B) February 1 is a miscalculation. (C) February 27 is the correct answer. To calculate the estimated date of confinement using Nagele??s rule, subtract 3 months from the date that the last menstrual cycle began and then add 7 days to the result. (D) January 3 is a miscalculation.

NEW QUESTION 69
- (Topic 1)
When teaching a sex education class, the nurse identifies the most common STDs in the United States as:

A. Chlamydia
B. Herpes genitalis
C. Syphilis
D. Gonorrhea

Answer: A

Explanation:
(A) Chlamydia trachomatis infection is the most common STD in the United States. The Centers for Disease Control and Prevention recommend screening of all high-risk women, such as adolescents and women with multiple sex partners. (B) Herpes simplex genitalia is estimated to be found in 5–20 million people in the United States and is rising in occurrence yearly. (C) Syphilis is a chronic infection caused by Treponema pallidum. Over the last several years the number of people infected has begun to increase. (D) Gonorrhea is a bacterial infection caused by the organism Neisseria gonorrhoeae. Although gonorrhea is common, chlamydia is still the most common STD.

NEW QUESTION 74
- (Topic 1)
Assessment of the client with pericarditis may reveal which of the following?

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

Answer: C

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

NEW QUESTION 76
- (Topic 1)
The priority nursing goal when working with an autistic child is:

A. To establish trust with the child

B. To maintain communication with the family
C. To promote involvement in school activities
D. To maintain nutritional requirements

Answer: A

Explanation:
(A) The priority nursing goal when working with an autistic child is establishing a trusting relationship. (B) Maintaining a relationship with the family is important but having the trust of the child is a priority. (C) To promote involvement in school activities is inappropriate for a child who is autistic. (D) Maintaining nutritional requirements is not the primary problem of the autistic child.

NEW QUESTION 79
- (Topic 1)
Which of the following should be included in discharge teaching for a client with hepatitis C?

A. He should take aspirin as needed for muscle and joint pain.
B. He may become a blood donor when his liver enzymes return to normal.
C. He should avoid alcoholic beverages during his recovery period.
D. He should use disposable dishes for eating and drinking.

Answer: C

Explanation:
(A) Aspirin is hepatotoxic, may increase bleeding, and should be avoided. (B) Blood should not be donated by a client who has had hepatitis C because of the possibility of transmission of disease. (C) Alcohol is detoxified in the liver. (D) Hepatitis C is not spread through the oral route.

NEW QUESTION 80
- (Topic 1)
To ensure proper client education, the nurse should teach the client taking SL nitroglycerin to expect which of the following responses with administration?

A. Stinging, burning when placed under the tongue
B. Temporary blurring of vision
C. Generalized urticaria with prolonged use
D. Urinary frequency

Answer: A

Explanation:
(A) Stinging or burning when nitroglycerin is placed under the tongue is to be expected. This effect indicates that the medication is potent and effective for use. Failure to have this response means that the client needs to get a new bottle of nitroglycerin. (B, C, D) The other responses are not expected in this situation and are not even side effects.

NEW QUESTION 85
- (Topic 1)
A male client receives 10 U of regular human insulin SC at 9:00 AM. The nurse would expect peak action from this injection to occur at:

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

Answer: C

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

NEW QUESTION 90
- (Topic 1)
When a client questions the nurse as to the purpose of exercise electrocardiography (ECG)
in the diagnosis of cardiovascular disorders, the nurse??s response should be based on the fact that:

A. The test provides a baseline for further tests
B. The procedure simulates usual daily activity and myocardial performance
C. The client can be monitored while cardiac conditioning and heart toning are done
D. Ischemia can be diagnosed because exercise increasesO2 consumption and demand

Answer: D

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

NEW QUESTION 95
- (Topic 1)

When assessing a child with diabetes insipidus, the nurse should be aware of the cardinal signs of:

A. Anemia and vomiting
B. Polyuria and polydipsia
C. Irritability relieved by feeding formula
D. Hypothermia and azotemia

Answer: B

Explanation:
(A) Anemia and vomiting are not cardinal signs of diabetes insipidus. (B) Polyuria and polydipsia are the cardinal signs of diabetes insipidus. (C) Irritability relieved by feeding water, not formula, is a common sign, but not the cardinal sign, of diabetes insipidus. (D) Hypothermia and azotemia are signs, but not cardinal signs, of diabetes insipidus.

NEW QUESTION 99
- (Topic 1)
The day following his admission, the nurse sits down by a male client on the sofa in the dayroom. He was admitted for depression and thoughts of suicide. He looks at the nurse and says, ??My life is so bad no one can do anything to help me.?? The most helpful initial response by the nurse would be:

A. ??It concerns me that you feel so badly when you have so many positive things in your life.??
B. ??It will take a few weeks for you to feel better, so you need to be patient.??
C. ??You are telling me that you are feeling hopeless at this point???
D. ??Let??s play cards with some of the other clients to get your mind off your problems for now.??

Answer: C

Explanation:
(A) This response does not acknowledge the client??s feelings and may increase his feelings of guilt. (B) This response denotes false reassurance. (C) This response acknowledges the client??s feelings and invites a response. (D) This response changes the subject and does not allow the client to talk about his feelings.

NEW QUESTION 103
- (Topic 2)
Prenatal clients are routinely monitored for early signs of pregnancy-induced hypertension (PIH). For the prenatal client, which of the following blood pressure changes from baseline would be most significant for the nurse to report as indicative of PIH?

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

Answer: C

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

NEW QUESTION 107
- (Topic 2)
Which of the following changes in blood pressure readings should be of greatest concern to the nurse when assessing a prenatal client?

A. 130/88 to 144/92
B. 136/90 to 148/100
C. 150/96 to 160/104
D. 118/70 to 130/88

Answer: D

Explanation:
(A, B, C) The individual??s systolic and diastolic changes are more significant than the relatively high initial blood pressure readings. (D) The systolic pressure went up 12 mm Hg and the diastolic pressure 18 mm Hg. This is a more significant rise than the increases in A–C choices, and client should receive more frequent evaluations and care.

NEW QUESTION 112
- (Topic 2)
A mother frantically calls the emergency room (ER) asking what to do about her 3-year-old girl who was found eating pills out of a bottle in the medicine cabinet. The ER nurse tells the mother to:

A. Give the child 15 mL of syrup of ipecac.
B. Give the child 10 mL of syrup of ipecac with a sip of water.
C. Give the child 1 cup of water to induce vomiting.
D. Bring the child to the ER immediately.

Answer: D

Explanation:

(A) Before giving any emetic, the substance ingested must be known. (B) At least 8 oz of water should be administered along with ipecac syrup to increase volume in the stomach and facilitate vomiting. (C) Water alone will not induce vomiting. An emetic is necessary to facilitate vomiting. (D) Vomiting should never be induced in an unconscious client because of the risk of aspiration.

NEW QUESTION 116
- (Topic 2)
A client is pregnant with her second child. Her last menstrual period began on January 15. Her expected date of delivery would be:

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

Answer: C

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

NEW QUESTION 118
- (Topic 2)
In evaluating the laboratory results of a client with severe pressure ulcers, the nurse finds that her albumin level is low. A decrease in serum albumin would contribute to the formation of pressure ulcers because:

A. The proteins needed for tissue repair are diminished.
B. The iron stores needed for tissue repair are inadequate.
C. A decreased serum albumin level indicates kidney disease.
D. A decreased serum albumin causes fluid movement into the blood vessels, causing dehydration.

Answer: A

Explanation:
(A) Serum albumin levels indicate the adequacy of protein stores available for tissue repair.
(B) Serum albumin does not measure iron stores. (C) Serum albumin levels do not measure kidney function. (D) A decreased serum albumin level would cause fluid movement out of blood vessels, not into them.

NEW QUESTION 122
- (Topic 2)
During a client??s first postpartum day, the nurse assessed that the fundus was located laterally to the umbilicus.
This may be due to:

A. Endometritis
B. Fibroid tumor on the uterus
C. Displacement due to bowel distention
D. Urine retention or a distended bladder

Answer: D

Explanation:
(A, B) Endometritis, urine retention, or bladder distention provide good distractors because they may delay involution but do not usually cause the uterus to be lateral. (C) Bowel distention and constipation are common in the postpartum period but do not displace the uterus laterally. (D) Urine retention or bladder distention commonly displaces the uterus to the right and may delay involution.

NEW QUESTION 127
- (Topic 2)
With a geriatric client, the nurse should also assess whether he has been obtaining a yearly vaccination against influenza. Why is this assessment important?

A. Influenza is growing in our society.
B. Older clients generally are sicker than others when stricken with flu.
C. Older clients have less effective immune systems.
D. Older clients have more exposure to the causative agents.

Answer: C

Explanation:
(A) Although influenza is common, the elderly are more at risk because of decreased effectiveness of their immune system, not because the incidence is increasing. (B) Older clients have the same degree of illness when stricken as other populations. (C) As people age, their immune system becomes less effective, increasing their risk for influenza. (D) Older clients have no more exposure to the causative agents than do school-age children, for example.

NEW QUESTION 130
- (Topic 2)
A pregnant client comes to the office for her first prenatal examination at 10 weeks. She has been pregnant twice before; the first delivery produced a viable baby girl at 39 weeks 3 years ago; the second pregnancy produced a viable baby boy at 36 weeks 2 years ago. Both children are living and well. Using the GTPAL system to record her obstetrical history, the nurse should record:

A. 3-2-0-0-2

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

Answer: C

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

NEW QUESTION 131
- (Topic 2)
A 68-year-old woman is admitted to the hospital with chronic obstructive pulmonary disease (COPD). She is started on an aminophylline infusion. Three days later she is breathing easier. A serum theophylline level is drawn. Which of the following values represents a therapeutic level?

A. 14 µ g/mL
B. 25 µ g/mL
C. 4 µ g/mL
D. 30 µ g/mL

Answer: A

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

NEW QUESTION 132
- (Topic 2)
The nurse observes that a client has difficulty chewing and swallowing her food. A nursing response designed to reduce this problem would include:

A. Ordering a full liquid diet for her
B. Ordering five small meals for her
C. Ordering a mechanical soft diet for her
D. Ordering a pur??ed diet for her

Answer: C

Explanation:
(A) Full liquids would be difficult to swallow if the muscle control of the swallowing act is affected; this is a probable reason for her difficulties, given her medical diagnosis of multiple sclerosis. (B) Five small meals would do little if anything to decrease her swallowing difficulties, other than assure that she tires less easily. (C) A mechanical soft diet should be easier to chew and swallow, because foods would be more evenly consistent. (D) A pureed diet would cause her to regress more than might be needed; the mechanical soft diet should be tried first.

NEW QUESTION 133
- (Topic 2)
A 54-year-old client is admitted to the hospital with a possible gastric ulcer. He is a heavy smoker. When discussing his smoking habits with him, the nurse should advise him to:

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

Answer: C

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

NEW QUESTION 135
- (Topic 2)
MgSO4 is ordered IV following the established protocol for a client with severe PIH. The anticipated effects of this therapy are anticonvulsant and:

A. Vasoconstrictive
B. Vasodilative
C. Hypertensive
D. Antiemetic

Answer: B

Explanation:
(A) An anticonvulsant effect is the goal of drug therapy for PIH. However, we would not want to increase the vasoconstriction that is already present. This would make the symptoms more severe. (B) An anticon-vulsant effect and vasodilation are the desired outcomes when administering this drug. (C) An anticonvulsant effect is the goal of drug therapy for PIH; however, hypertensive drugs would increase the blood pressure even more. (D) An anticonvulsant effect is the goal of drug therapy for PIH. MgSO4is not classified as an antiemetic. Antiemetics are not indicated for PIH treatment.

NEW QUESTION 140
- (Topic 2)
Which one of the following is considered a reliable indicator for assessing the adequacy of fluid resuscitation in a 3-year-old child who suffered partial- and fullthickness burns to 25% of her body?

A. Urine output
B. Edema
C. Hypertension
D. Bulging fontanelle

Answer: A

Explanation:
(A) Urinary output is a reliable indicator of renal perfusion, which in turn indicates that fluid
resuscitation is adequate. IV fluids are adjusted based on the urinary output of the child during fluid resuscitation. (B) Edema is an indication of increased capillary permeability following a burn injury. (C) Hypertension is an indicator of fluid volume excess. (D) Fontanelles close by 18 months of age.

NEW QUESTION 141
- (Topic 2)
A 23-year-old borderline client is admitted to an inpatient psychiatric unit following an impulsive act of self-mutilation. A few hours after admission, she requests special privileges, and when these are not granted, she stands up and angrily shouts that the people on the unit do not care, and she storms across the room. The nurse should respond to this behavior by:

A. Placing her in seclusion until the behavior is under control
B. Walking up to the client and touching her on the arm to get her attention
C. Communicating a desire to assist the client to regain control, offering a one-to-one session in a quiet area
D. Confronting the client, letting her know the consequences for getting angry and disrupting the unit

Answer: C

Explanation:
(A) Threatening a client with punitive action is violating a client??s rights and could escalate the client??s anger. (B) Angry clients need respect for personal space, and physical contact may be perceived as a threatening gesture escalating anger. (C) Client lacks sufficient self- control to limit own maladaptive behavior; she may need assistance from staff. (D) Confronting an angry client may escalate her anger to further acting out, and consequences are for acting out anger aggressively, not for getting angry or feeling angry.

NEW QUESTION 146
- (Topic 2)
A client tells the nurse that she has had a history of urinary tract infections. The nurse would do further health teaching if she verbalizes she will:

A. Drink at least 8 oz of cranberry juice daily
B. Maintain a fluid intake of at least 2000 mL daily
C. Wash her hands before and after voiding
D. Limit her fluid intake after 6 PM so that there is not a great deal of urine in her bladder while she sleeps

Answer: D

Explanation:
(A) Cranberry juice helps to maintain urine acidity, thereby retarding bacterial growth. (B) A generous fluid intake will help to irrigate the bladder and to prevent bacterial growth within the bladder. (C) Hand washing is an effective means of preventing pathogen transmission.
(D) Restricting fluid intake would contribute to urinary stasis, which in turn would contribute to bacterial growth.

NEW QUESTION 151
- (Topic 2)
A 5-year-old child has suffered second-degree thermal burns over 30% of her body. Forty- eight hours after the burn injury, the nurse must begin to monitor the child for which one of the following complications?

A. Fluid volume deficit
B. Fluid volume excess
C. Decreased cardiac output
D. Severe hypotension

Answer: B

Explanation:
(A) Fluid volume deficit resulting from fluid shifts to the interstitial spaces occurs in the first 48 hours. (B) Forty-eight hours to 72 hours after the burn injury and fluid resuscitation, capillary permeability is restored and fluid requirements decrease. Interstitial fluid returns rapidly to the vascular compartment, and the nurse must monitor the child for signs and symptoms of hypervolemia. (C) Increased cardiac output results as fluids shift back to the vascular compartment. (D) Hypertension is the result of hypervolemia.

NEW QUESTION 153
- (Topic 2)
A 26-year-old client is in a treatment center for aprazolam (Xanax) abuse and continues to manifest moderate levels of anxiety 3 weeks into the rehabilitation program, often requesting medication for ??his nerves.?? Included in the client??s plan of care is to identify alternate methods of coping with stress and anxiety other than use of medication. After intervening with assistance in stress reduction techniques, identifying feelings and past coping, the nurse evaluates the outcome as being met if:

A. Client promises that he will not abuse aprazolam after discharge

B. Client demonstrates use of exercise or physical activity to handle nervous energy following conflicts of everyday life
C. Client is able to verbalize effects of substance abuse on the body
D. Client has remained substance free during hospitalization and is discharged

Answer: B

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

NEW QUESTION 157
- (Topic 2)
A six-month-old infant is receiving ribavirin for the treatment of respiratory syncytial virus. Ribavirin is administered via which one of the following routes?

A. Oral
B. IM
C. IV
D. Aerosol

Answer: D

Explanation:
(A) Ribavirin is not supplied in an oral form. (B) Ribavirin is administered by aerosol in order to decrease the duration of viral shedding within the infected tissue. (C) Ribavirin is not approved for IV use to treat respiratory syncytial virus. (D) Ribavirin is a synthetic antiviral agent supplied as a crystalline powder that is reconstituted with sterile water. A Small Aerosol Particle Generator unit aerosolizes the medication for delivery by oxygen hood, croup tent, or aerosol mask.

NEW QUESTION 160
- (Topic 2)
To prevent fungal infections of the mouth and throat, the nurse should teach clients on inhaled steroids to:

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

Answer: B

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

NEW QUESTION 164
- (Topic 2)
Assessment of severe depression in a client reveals feelings of hopelessness, worthlessness; inability to feel pleasure; sleep, psychomotor, and nutritional alterations; delusional thinking; negative view of self; and feelings of abandonment. These clinical features of the client??s depression alert the nurse to prioritize problems and care by addressing which of the following problems first:

A. Nutritional status
B. Impaired thinking
C. Possible harm to self
D. Rest and activity impairment

Answer: C

Explanation:
(A) Anorexia and weight loss are problems that need attention in severe depression, but they can be addressed secondary to immediate concerns. (B) Impaired thinking and confusion are problems in severe depression that are addressed with administration of medication, through group and individual psychotherapy, and through activity therapy as motivation and interest increase. (C) Possible harm to self as with suicidal ideation; a suicide plan, means to execute plan; and/or overt gestures or an attempt must be addressed as an immediate concern and safety measures implemented appropriate to the risk of suicide. (D) Rest and activity impairment may take time and further assessment to determine client??s sleep pattern and amount of psychomotor retardation with the more immediate concern for safety present.

NEW QUESTION 169
- (Topic 2)
In addition to changing the mother??s position to relieve cord pressure, the nurse may employ the following measure (s) in the event that she observes the cord out of the vagina:

A. Immediately pour sterile saline on the cord, and repeat this every 15 minutes to prevent drying.
B. Cover the cord with a wet sponge.
C. Apply a cord clamp to the exposed cord, and cover with a sterile towel.
D. Keep the cord warm and moist by continuous applications of warm, sterile saline compresses.

Answer: D

Explanation:

(A) Saline should be warmed; waiting 15 minutes may not keep the cord moist. (B) This choice does not specify what the sponge was ??wet?? with. (C) This measure would stop circulation to the fetus. (D) The cord should be kept warm and moist to maintain fetal circulation. This measure is an accepted nursing action.

NEW QUESTION 172
- (Topic 2)
A nasogastric (NG) tube inserted preoperatively is attached to low, intermittent suctions. A client with an NG tube exhibits these symptoms: He is restless; serum electrolytes are Na 138, K 4.0, blood pH 7.53. This client is most likely experiencing:

A. Hyperkalemia
B. Hyponatremia
C. Metabolic acidosis
D. Metabolic alkalosis

Answer: D

Explanation:
(A) Sodium level is within normal limits. (B) Sodium level is within normal limits. (C) pH level is consistent with alkalosis. (D) With an NG tube attached to low, intermittent suction, acids are removed and a client will develop metabolic alkalosis.

NEW QUESTION 177
- (Topic 2)
The nurse provides a male client with diet teaching so that he can help prevent constipation in the future. Which food choices indicate that this teaching has been understood?

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

Answer: D

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

NEW QUESTION 180
- (Topic 2)
A 26-year-old client is admitted to the labor, delivery, recovery, postpartum unit. The nurse completes her assessment and determines the client is in the first stage of labor. The nurse should instruct her:

A. To hold her breath during contractions
B. To be flat on her back
C. Not to push with her contractions
D. To push before becoming fully dilated

Answer: C

Explanation:
(A) This nursing action may cause hyperventilation. (B) This nursing action could cause inferior vena cava syndrome. (C) The client is allowed to push only after complete dilation during the second stage of labor. The nurse needs to know the stages of labor. (D) If the client pushes before dilation, it could cause cervical edema and/or edema to the fetal scalp; both of these could contribute to increased risk of complications.

NEW QUESTION 181
- (Topic 2)
A pregnant client comes to the office for her first prenatal examination at 10 weeks. She has been pregnant twice before; the first delivery produced a viable baby girl at 39 weeks 3 years ago; the second pregnancy produced a viable baby boy at 36 weeks 2 years ago. Both children are living and well. Using the gravida and para system to record the client??s obstetrical history, the nurse should record:

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

Answer: B

Explanation:
(A) This answer is an incorrect application of gravida and para. The client has had two prior deliveries of more than 20 weeks?? gestation; therefore, para equals 2, not 1. (B) This answer is the correct application of gravida and para. The client is currently pregnant for the third time (G = 3), regardless of the length of the pregnancy, and has had two prior pregnancies with birth after the 20th week (P = 2), whether infant was alive or dead. (C) This answer is an incorrect application of gravida and para. The client is currently pregnant for the third time (G = 3, not 2); prior pregnancies lasted longer than 20 weeks (therefore, P = 2, not 1). (D) This is an incorrect application of gravida and para. Client is currently pregnant for third time (G = 3, not 2).

NEW QUESTION 182
- (Topic 2)
A client is taught to eat foods high in potassium. Which food choices would indicate that this teaching has been successful?

A. Pork chop, baked acorn squash, brussel sprouts

B. Chicken breast, rice, and green beans
C. Roast beef, baked potato, and diced carrots
D. Tuna casserole, noodles, and spinach

Answer: A

Explanation:
(A) Both acorn squash and brussels sprouts are potassium-rich foods. (B) None of these foods is considered potassium rich. (C) Only the baked potato is a potassium-rich food. (D) Spinach is the only potassium-rich food in this option.

NEW QUESTION 186
- (Topic 2)
In cleansing the perineal area around the site of catheter insertion, the nurse would:

A. Wipe the catheter toward the urinary meatus
B. Wipe the catheter away from the urinary meatus
C. Apply a small amount of talcum powder after drying the perineal area
D. Gently insert the catheter another 12 inch after cleansing to prevent irritation from the balloon

Answer: B

Explanation:
(A) Wiping toward the urinary meatus would transport microorganisms from the external tubing to the urethra, thereby increasing the risk of bladder infection. (B) Wiping away from the urinary meatus would remove microorganisms from the point of insertion of the catheter, thereby decreasing the risk of bladder infection. (C) Talcum powder should not be applied following catheter care, because powders contribute to moisture retention and infection likelihood. (D) The catheter should never be inserted further into the urethra, because this would serve no useful purpose and would increase the risk of infection.

NEW QUESTION 188
- (Topic 2)
A client delivered her first-born son 4 hours ago. She asks the nurse what the white cheeselike substance is under the baby??s arms. The nurse should respond:

A. ??This is a normal skin variation in newborn
B. It will go away in a few days.??
C. ??Let me have a closer look at i
D. The baby may have an infection.??
E. ??This material, called vernix, covered the baby before it was bor
F. It will disappear in a few days.??
G. ??Babies sometimes have sebaceous glands that get plugged at birt
H. This substance is an example of that condition.??

Answer: C

Explanation:
(A) This response identifies the fact that vernix is a normal neonatal variation, but it does not teach the client medical terms that may be useful in understanding other healthcare personnel. (B) This response may raise maternal anxiety and incorrectly identifies a normal neonatal variation. (C) This response correctly identifies this neonatal variation and helps the client to understand medical terms as well as the characteristics of her newborn. (D) Blocked sebaceous glands produce milia, particularly present on the nose.

NEW QUESTION 191
- (Topic 2)
In performing the initial nursing assessment on a client at the prenatal clinic, the nurse will know that which of the following alterations is abnormal during pregnancy?

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

Answer: C

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

NEW QUESTION 192
- (Topic 2)
A client is in early labor. Her fetus is in a left occipitoanterior (LOA) position; fetal heart sounds are best auscultated just:

A. Below the umbilicus toward left side of mother??s abdomen
B. Below the umbilicus toward right side of mother??s abdomen
C. At the umbilicus
D. Above the umbilicus to the left side of mother??s abdomen

Answer: A

Explanation:
(A) LOA identifies a fetus whose back is on its mother??s left side, whose head is the presenting part, and whose back is toward its mother??s anterior. It is

easiest to auscultate fetal heart tones (FHTs) through the fetus??s back. (B) The identified fetus??s back is on its mother??s left side, not right side. It is easiest to auscultate FHTs through the fetus??s back.
(C) In an LOA position, the fetus??s head is presenting with the back to the left anterior side of the mother. The umbilicus is too high of a landmark for auscultating the fetus??s heart rate through its back. (D) This is the correct auscultation point for a fetus in the left sacroanterior position, where the sacrum is presenting, not LOA.

NEW QUESTION 193
- (Topic 2)
The nurse working in a prenatal clinic needs to be alert to the cardinal signs and symptoms of PIH because:

A. Immediate treatment of mild PIH includes the administration of a variety of medications
B. Psychological counseling is indicated to reduce the emotional stress causing the blood pressure elevation
C. Self-discipline is required to control caloric intake throughout the pregnancy
D. The client may not recognize the early symptoms of PIH

Answer: D

Explanation:
(A) Mild PIH is not treated with medications. (B) Emotional stress is not the cause of blood pressure elevation in PIH. (C) Excessive caloric intake is not the cause of weight gain in PIH. (D) The client most frequently is not aware of the signs and symptoms in mild PIH.

NEW QUESTION 196
- (Topic 2)
The nurse is teaching a mother care of her child??s spica cast. The mother states that he complains of itching under the edge of the cast. One nonpharmacological technique the nurse might suggest would be:

A. ??Blowing air under the cast using a hair dryer on cool setting often relieves itching.??
B. ??Slide a ruler under the cast and scratch the area.??
C. ??Guide a towel under and through the cast and moveit back and forth to relieve the itch.??
D. ??Gently thump on cast to dislodge dried skin that causes the itching.??

Answer: A

Explanation:
(A) Cool air will often relieve pruritus without damaging the cast or irritating the skin. (B) The nurse should never force anything under the cast, because the cast may become damaged and skin breakdown may occur. (C) Forcing an object under the cast could lead to cast damage and skin breakdown. The object may become lodged under the cast necessitating cast removal. (D) This technique does not dislodge skin cells. It could damage the cast and cause skin breakdown.

NEW QUESTION 201
- (Topic 2)
A 74-year-old obese man who has undergone open reduction and internal fixation of the right hip is 8 days postoperative. He has a history of arthritis and atrial fibrillation. He admits to right lower leg pain, described as ??a cramp in my leg.?? An appropriate nursing action is to:

A. Assess for pain with plantiflexion
B. Assess for edema and heat of the right leg
C. Instruct him to rub the cramp out of his leg
D. Elevate right lower extremity with pillows propped under the knee

Answer: B

Explanation:
(A) Calf pain with dorsiflexion of the foot (Homans?? sign) can be a sign of a deep venous thrombosis; however, it is not diagnostic of the condition. (B) Swelling and warmth along the affected vein are commonly observed clinical manifestations of a deep venous thrombosis as a result of inflammation of the vessel wall. (C) Rubbing or massaging of the affected leg is contraindicated because of the risk of the clot breaking loose and becoming an embolus. (D) A pillow behind the knee can be constricting and further impair blood flow.

NEW QUESTION 203
- (Topic 3)
After performing a sterile vaginal exam on a client who has just been admitted to the unit in active labor and placed on an electronic fetal monitor, the RN assesses that the fetal head is at 21 station. She documents this on the monitor strip. Fetal head at 21 station means that the fetal head is located where in the pelvis?

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

Answer: B

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

NEW QUESTION 205

- (Topic 3)
In client teaching, the nurse should emphasize that fetal damage occurs more frequently with ingestion of drugs during:

A. First trimester
B. Second trimester
C. Third trimester
D. Every trimester

Answer: A

Explanation:
(A) Organogenesis occurs in the first trimester. Fetus is most susceptible to malformation during this period. (B) Organogenesis has occurred by the second trimester. (C) Fetal development is complete by this time. (D) The dangerous period for fetal damage is the first trimester, not the entire pregnancy.

NEW QUESTION 208
- (Topic 3)
When planning care for the passive-aggressive client, the nurse includes the following goal:

A. Allow the client to use humor, because this may be the only way this client can express self.
B. Allow the client to express anger by using ??I?? messages, such as ??I was angry when . . .,?? etc.
C. Allow the client to have time away from therapeutic responsibilities.
D. Allow the client to give excuses if he forgets to give staff information.

Answer: B

Explanation:
(A) Ceasing to use humor and sarcasm is a more appropriate goal, because this client uses these behaviors covertly to express aggression instead of being open with anger. (B) Use of ??I?? messages demonstrates proper use of assertive behavior to express anger instead of passive-aggressive behavior. (C) Client is expected to complete share of work in therapeutic community because he has often obstructed other??s efforts by failing to do his share. (D) Client has used conveniently forgetting or withholding information as a passive- aggressive behavior, which is not acceptable.

NEW QUESTION 212
- (Topic 3)
On a mother??s 2nd postpartum day after having a vaginal delivery, the RN is preparing to assess her perineum and anus as part of her daily assessment. The best position for the client to be placed in for this assessment is:

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

Answer: A

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

NEW QUESTION 213
- (Topic 3)
A 16-month-old infant is being prepared for tetralogy of Fallot repair. In the nursing assessment, which lab value should elicit further assessment and requires notification of physician?

A. pH 7.39
B. White blood cell (WBC) count 10,000 WBCs/mm3
C. Hematocrit 60%
D. Bleeding time of 4 minutes

Answer: C

Explanation:
(A) Normal pH of arterial blood gases for an infant is 7.35–7.45. (B) Normal white blood cell count in an infant is 6,000–17,500 WBCs/mm3. (C) Normal hematocrit in infant is 28%–42%. A 60% hematocrit may indicate polycythemia, a common complication of cyanotic heart disease. (D) Normal bleeding time is 2–7 minutes.

NEW QUESTION 217
- (Topic 3)
A client??s congestive heart failure has been treated, and he will soon be discharged. Discharge teaching should include instruction to call the physician if he notices a 2-lb weight gain in a 24-hour period. Increased weight gain may indicate:

A. A diet too high in calories and saturated fat
B. Decreasing cardiac output
C. Decreasing renal function
D. Development of diabetes insipidus

Answer: B

Explanation:
(A) Increased calories may result in weight gain, but there is no indication in this question that this man??s diet has changed in a way that would result in increased

calories. (B) Decreasing cardiac output stimulates the renin-angiotensin-aldosterone cycle and results in fluid retention, which is reflected by weight gain. (C) Decreasing renal function may result in fluid retention, but this question gives no indication that this man has any renal problems.
(D) Profound diuresis occurs with diabetes insipidus, which results in weight loss.

NEW QUESTION 220
- (Topic 3)
A client is diagnosed with organic brain disorder. The nursing care should include:

A. Organized, safe environment
B. Long, extended family visits
C. Detailed explanations of procedures
D. Challenging educational programs

Answer: A

Explanation:
(A) A priority nursing goal is attending to the client??s safety and well-being. Reorient frequently, remove dangerous objects, and maintain consistent environment. (B) Short, frequent visits are recommended to avoid overstimulation and fatigue. (C) Short, concise, simple explanations are easier to understand. (D) Mental capability and attention span deficits make learning difficult and frustrating.

NEW QUESTION 223
- (Topic 3)
At 38 weeks?? gestation, a client is in active labor. She is using her Lamaze breathing techniques. The RN is coaching her breathing and encouraging her to relax and work with her contractions. Which one of the following complaints by the client will alert the RN that she is beginning to hyperventilate with her breathing?

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

Answer: C

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

NEW QUESTION 224
- (Topic 3)
A physician??s order reads: 0.25 normal saline at 50 mL/hr until discontinued. The nurse is using a microdrip tubing set. How many drops per minute should the nurse administer?

A. 1 gtt/min
B. 5 gtt/min
C. 50 gtt/min
D. 100 gtt/min

Answer: C

Explanation:
(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C)50 gtt/min. (D) This answer is a miscalculation.

NEW QUESTION 225
- (Topic 3)
At 32 weeks?? gestation, a client is scheduled for a fetal activity test (nonstress test). She calls the clinic and asks the RN, ??How do I prepare for the test I am scheduled for??? The RN will most likely inform her of the following instructions to help prepare her for the test:

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

Answer: D

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

NEW QUESTION 228
- (Topic 3)
The client has been in active labor for the last 12 hours. During the last 3 hours, labor has been augmented with oxytocin because of hypoactive uterine contractions. Her physician assesses her cervix as 95% effaced, 8 cm dilated, and the fetus is at 0 station. Her oral temperature is 100.2F at this time. The physician orders that she be prepared for a cesarean delivery. In preparing the client for the cesarean delivery, which one of the following physician??s orders should the RN question?

A. Administer meperidine (Demerol) 100 mg IM 1 hour prior to the delivery.
B. Discontinue the oxytocin infusion.
C. Insert an indwelling Foley catheter prior to delivery.
D. Prepare abdominal area from below the nipples to below the symphysis pubis area.

Answer: A

Explanation:
(A) Meperidine is a narcotic analgesic medication that crosses the placental barrier and reaches the fetus, causing respiratory depression in the fetus. A narcotic medication should never be included in the preoperative order for a cesarean delivery. (B) Oxytocin infusion would be discontinued if client is being prepared for a cesarean delivery because the medication would not be needed. (C) The bladder is always emptied prior to and during the surgical intervention to prevent the urinary bladder from accidentally being incised while the uterine incision is made. (D) The abdominal area is always prepared to rid the area of hair before the abdominal incision is made. Abdominal hair cannot be sterilized and could become a source for postoperative incisional infection.

NEW QUESTION 232
- (Topic 3)
The physician is preparing to induce labor on a 40-week multigravida. The nurse should anticipate the administration of:

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

Answer: A

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

NEW QUESTION 234
- (Topic 3)
A 30-year-old client has a history of several recent traumatic experiences. She presents at the physician??s office with a complaint of blindness. Physical exam and diagnostic testing reveal no organic cause. The nurse recognizes this as:

A. Delusion
B. Illusion
C. Hallucination
D. Conversion

Answer: D

Explanation:
(A) The client??s blindness is real. Delusion is a false belief. (B) Illusion is the misrepresentation of a real, external sensory experience. (C) Hallucination is a false sensory perception involving any of the senses. (D) Conversion is the expression of intrapsychic conflict through sensory or motor manifestations.

NEW QUESTION 236
- (Topic 3)
A 66-year-old female client has smoked 2 packs of cigarettes per day for 20 years. Her arterial blood gases on room air are as follows: pH 7.35; PO2 70 mm Hg; PCO2 55 mm Hg; HCO3 32 mEq/L. These blood gases reflect:

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

Answer: B

Explanation:
(A) In compensated metabolic acidosis, the pH level is normal, the PCO2level is decreased, and the HCO3level is decreased. The client??s primary alteration is an inability to remove excess acid via the kidneys. The lungs compensate by hyperventilating and decreasing PCO2. (B) In compensated respiratory acidosis, the pH level is normal, the PCO2level is elevated, and the HCO3level is elevated. The client??s primary alteration is an inability to remove CO2from the lungs, so over time, the kidneys increase reabsorption of HCO3to buffer the CO2. (C) In compensated respiratory alkalosis, the pH level is normal, the PCO2level is decreased, and the HCO3level is decreased. The client??s primary alteration is hyperventilation, which decreases PCO2. The client compensates by increasing the excretion of HCO3from the body. (D) In uncompensated respiratory acidosis, the pH level is decreased, the PCO2level is increased, and the HCO3level is normal. The client??s primary alteration is an inability to remove CO2from the lungs. The kidneys have not compensated by increasing HCO3reabsorption.

NEW QUESTION 239
- (Topic 3)
A client experiencing delusions states, ??I came here because there were people surrounding my house that wanted to take me away and use my body for science.?? The best response by the nurse would be:

A. ??Describe the people surrounding your house that want to take you away.??
B. ??I need more information on why you think others want to use your body for science.??
C. ??There were no people surrounding your house, your relatives brought you here, and no one really wants your body for science.??
D. ??I know that must be frightening for you; let the staff know when you are having thoughts that trouble you.??

Answer: D

Explanation:
(A) Focusing on the delusional content does not reinforce reality. (B) Pursuing details or more information on the delusion reinforces the false belief and further distances the client from reality. (C) Challenging the client??s delusional system may force the client to defend it, and you cannot change the delusion through logic. (D) Focusing on the feeling can reinforce reality and discourage the false belief. Seeking out staff when thoughts are troublesome can help to decrease anxiety.

NEW QUESTION 243
- (Topic 3)
A 19-year-old client has sustained a C-7 fracture, which resulted in his spinal cord being partially transected. By 2 weeks?? postinjury, his neck has been surgically stabilized, and he has been transferred from the intensive care unit. A potential life-threatening complication the nurse monitors the client for is:

A. Autonomic dysreflexia
B. Bradycardia
C. Central cord syndrome
D. Spinal shock

Answer: A

Explanation:
(A) Autonomic dysreflexia is the exaggerated sympathetic nervous system response to various stimuli in the anesthetized area. Sympathetic stimulation results in severe, uncontrolled hypertension, which may result in myocardial infarction or cerebral hemorrhage. (B) Bradycardia occurs as a result of sympathetic blockade in the immediate postinjury period. After spinal shock recedes, cardiovascular stability returns, but the client will be bradycardiac for life. (C) Central cord syndrome is a specific type of spinal cord injury that occurs as a result of either hyperextension injuries or disrupted blood flow to the spinal cord. (D) Spinal shock occurs in the immediate postinjury phase and usually resolves in approximately 72 hours.

NEW QUESTION 244
- (Topic 3)
Painless vaginal bleeding in the last trimester may be caused by:

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

Answer: C

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

NEW QUESTION 246
- (Topic 3)
A primigravida is at term. The nurse can recognize the second stage of labor by the client??s desire to:

A. Push during contractions
B. Hyperventilate during contractions
C. Walk between contractions
D. Relax during contractions

Answer: A

Explanation:
(A) The second stage of labor is characterized by uterine contractions, which cause the client to bear down. (B) Slow, deep, rhythmic breathing facilitates the laboring process. Hyperventilation is abnormal breathing resulting from loss of pain control. (C) The client should remain on bed rest during labor. (D) Contractions result in discomfort.

NEW QUESTION 248
- (Topic 3)
A 70-year-old client has pneumonia and has just had a respiratory arrest. He has just been intubated with an 8- mm endotracheal tube. During auscultation of his chest, breath sounds were found to be absent on the left side. The nurse identifies the most likely cause of this as:

A. Inappropriate endotracheal tube size
B. Left-sided pneumothorax
C. Right mainstem bronchus intubation
D. Pneumonia

Answer: C

Explanation:
(A) Appropriate endotracheal tube sizes for adults range from 7.0–8.5 mm. (B) Pneumothorax could be indicated by an absence of breath sounds on the affected side. However, in a recently intubated client, the first priority would be to consider tube malposition. (C) During intubation, the right mainstem bronchus can be inadvertently entered if the endotracheal tube is inserted too far. Left mainstem bronchus intubation almost never occurs because of the angle of the left mainstem bronchus. (D) Breath sounds for someone with pneumonia may be decreased over the areas of consolidation. However, in a recently intubated client, the first priority would be to consider tube malposition.

NEW QUESTION 253

- (Topic 3)
A male client has asthma and his physician has prescribed beclomethasone (Vanceril) 3 puffs tid in addition to his other medications. After taking his beclomethasone, the client should be instructed to:

A. Clean his inhaler with warm water and soak it in a10% bleach solution
B. Drink a glass of water
C. Sit and rest
D. Use his bronchodilator inhaler

Answer: B

Explanation:
(A) Inhalers should be cleaned once a day. They should be taken apart, washed in warm water, and dried according to manufacturer??s instructions. Soaking in bleach is inappropriate. (B) A common side effect of inhaled steroid preparations is oral candidal infection. This can be prevented by drinking a glass of water or gargling after using a steroid inhaler. (C) There is nothing wrong with sitting and resting after using a steroid inhaler, but it is not necessary. (D) If a person is using a steroid inhaler as well as a bronchodilator inhaler, the bronchodilator shouldalways be used first. The reason for this is that the bronchodilator opens up the person??s airways so that when the steroid inhaler is used next, there will be better distribution of medication.

NEW QUESTION 256
- (Topic 3)
A 16-year-old client reports a weight loss of 20% of her previous weight. She has a history of food binges followed by self-induced vomiting (purging). The nurse should suspect a diagnosis of:

A. Anorexia nervosa
B. Anorexia hysteria
C. Bulimia
D. Conversion reaction

Answer: C

Explanation:
(A) Anorexia nervosa is characterized by self-starvation. (B) Anorexia hysteria is not a known disease or disorder. (C) Bulimia is characterized by food binges and self-induced vomiting. (D) Conversion reaction is a defense mechanism.

NEW QUESTION 261
- (Topic 3)
A client presents to the psychiatric unit crying hysterically. She is diagnosed with severe anxiety disorder. The first nursing action is to:

A. Demand that she relax
B. Ask what is the problem
C. Stand or sit next to her
D. Give her something to do

Answer: C

Explanation:
(A) This nursing action is too controlling and authoritative. It could increase the client??s anxiety level. (B) In her anxiety state, the client cannot rationally identify a problem. (C) This nursing action conveys a message of caring and security. (D) Giving the client a task would increase her anxiety. This would be a late nursing action.

NEW QUESTION 265
- (Topic 3)
A client has been in labor for 10 hours. Her contractions have become hypoactive and slowed in duration. The fetus is at 0 station, cervix is dilated 8 cm and effaced 90%. The physician orders an oxytocin (Pitocin) infusion to be started at once. The RN begins the oxytocin infusion. It is important that the RN discontinue the infusion if which one of the following occur?

A. The client??s contractions are <2 minutes apart.
B. Duration of the contractions are 60 seconds.
C. The uterus relaxes between contractions.
D. The client complains that she is tired.

Answer: A

Explanation:
(A) It is very important that there is a resting phase or relaxation period between the contractions. During this period, the uterus, placenta, and umbilical vessels re-establish blood flow. No resting phase between contractions can lead to fetal bradycardia, fetal hypoxia, and acidosis. It can also result in a tetanic contraction, which can cause uterine rupture. (B) The goal of the oxytocin infusion is to help establish a contraction pattern lasting 45–60 seconds occurring every 2 minutes and a uterine tonus of 60–70 mm Hg. (C) This choice is correct. The uterus has time to recover from the contraction. (D) The client??s tiring is no indication to stop the infusion. She will be tired even without the infusion.

NEW QUESTION 268
- (Topic 3)
A 40-year-old client is admitted to the hospital for tests to diagnose cancer. Since his admission, he has become dependent and demanding to the nursing staff. The nurse identifies this behavior as which defense mechanism?

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

Answer: C

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

NEW QUESTION 269
- (Topic 3)
A 79-year-old client with Alzheimer??s disease is exhibiting significant memory impairment, cognitive impairment, extremely impaired judgment in social situations, and agitation when placed in a new situation or around unfamiliar people. The nurse should include the following strategy in the client??s care:

A. Maintain routines and usual structure and adhere to schedules.
B. Encourage the client to attend all structured activities on the unit, whether she wants to or not.
C. Ask the client to go to an activity onc
D. If she gives no response right away, change the question around, asking the same thing.
E. Give the client two or three choices to decide what she wants to do.

Answer: A

Explanation:
(A) Alzheimer??s clients cope poorly with changes in routine because of memory deficits. Schedule changes cause confusion and frustration, whereas adhering to schedules is helpful and supports orientation. (B) Insisting that the client go to all unit activities may antagonize her and increase her agitation because of cognitive impairments. It may be better to allow the client time for calming down or distraction rather than to insist that she attend every activity. (C) When repeating a question, allow time first for a response; then use the same words the second time to avoid further confusion. (D) The nurse should avoid giving several choices at once. Cognitively impaired clients will become more frustrated with making decisions.

NEW QUESTION 271
- (Topic 3)
A 19-year-old client fell off a ladder approximately 3 ft to the ground. He did not lose consciousness but was taken to the emergency department by a friend to have a scalp laceration sutured. The nurse instructs the client to:

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

Answer: C

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

NEW QUESTION 276
- (Topic 3)
At 16 weeks?? gestation, a pregnant client is admitted to the maternity unit to have a McDonald procedure (cerclage) done. She tells the RN who is admitting her to the unit that her physician had explained what this procedure was, but that she did not understand. The RN explains to the client that the purpose for this procedure is to:

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

Answer: A

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

NEW QUESTION 277
- (Topic 3)
A client was not using his seat belt when involved in a car accident. He fractured ribs 5, 6, and 7 on the left and developed a left pneumothorax. Assessment findings include:

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

Answer: B

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

occur with pulmonary edema. (D) Wheezing is caused by fluid in large airways already narrowed by mucus or bronchospasm. Dry cough could indicate a cardiac problem.

NEW QUESTION 279
- (Topic 3)
A 52-year-old client??s abdominal aortic aneurysm ruptured. She received rapid massive blood transfusions for bleeding. One potential complication of blood administration
for which she is especially at risk is:

A. Air embolus
B. Circulatory overload
C. Hypocalcemia
D. Hypokalemia

Answer: C

Explanation:
(A) Air embolism is a potential complication of blood administration, but it is fairly rare and can be prevented by using good IV technique. (B) Circulatory overload is a potential complication of blood administration, but because this client is actively bleeding, she is not at high risk for overload. (C) Hypocalcemia is a potential complication of blood administration that occurs in situations where massive transfusion has occurred over a short period of time. It occurs because the citrate in stored blood binds with the client??s calcium. Another potential complication for which this client is especially at risk is hypothermia, which can be prevented by using a blood warmer to administer the blood. (D) Hypokalemia is not a complication of blood administration.

NEW QUESTION 282
- (Topic 3)
A burn victim??s immunization history is assessed by the nurse. Which immunization is of priority concern?

A. Oral poliovirus vaccine
B. Inactivated poliovirus vaccine
C. Tetanus toxoid
D. Hepatitis B vaccine

Answer: C

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

NEW QUESTION 283
- (Topic 3)
A 2-month-old infant is receiving IV fluids with a volume control set. The nurse uses this type of tubing because it:

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

Answer: C

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

NEW QUESTION 285
- (Topic 3)
A client was admitted with rib fractures and a pneumothorax, which were sustained as a result of a motor vehicle accident. A chest tube was placed on the left side to reinflate his lung, and he was transferred to a client unit. Twenty-four hours after admission he continues to have bloody sputum, develops increasing hypoxemia, and his chest x-ray shows patchy infiltrates. The nurse analyzes these symptoms as being consistent with:

A. Pneumonia
B. Pulmonary contusions
C. Pulmonary edema
D. Tension pneumothorax

Answer: B

Explanation:
(A) Pneumonia may be reflected by patchy infiltrates. In addition, fever, an increasing white blood cell count, and copious sputum production would be present. (B) Blunt chest traumacauses a bruising process in which interstitial and alveolar edema and hemorrhage occur. This is manifest by gradual deterioration over 24 hours of arterial blood gases and the continued production of bloody sputum. Patchy infiltrates are evident on chest xray 24 hours postinjury. (C) Pulmonary edema usually results from left heart failure. It is manifest by pink, frothy sputum; increasing dyspnea; tachycardia; and crackles on auscultation. (D) Tension pneumothorax is a potential complication for someone with rib fractures and a chest tube. It is manifest by diminished breath sounds on the affected side, rapidly deteriorating arterial blood gases in the presence of an open airway, and shock that is unexplained by other injuries.

NEW QUESTION 287

- (Topic 3)
At 30 weeks?? gestation, a client is admitted to the unit in premature labor. Her physician orders that an IV be started with 500 mL D5W mixed with 150 mg of ritodrine stat. The RN prepares the IV solution with the medication. The RN knows that clients receiving the medication ritodrine IV should be observed closely for which one of the following side effects:

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

Answer: C

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

NEW QUESTION 291
- (Topic 3)
On admission, the client has signs and symptoms of pulmonary edema. The nurse places the client in the most appropriate position for a client in pulmonary edema, which is:

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

Answer: A

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

NEW QUESTION 295
- (Topic 4)
An obstructing stone in the renal pelvis or upper ureter causes:

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

Answer: C

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

NEW QUESTION 299
- (Topic 4)
Before completing a nursing diagnosis, the nurse must first:

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

Answer: B

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

NEW QUESTION 300
- (Topic 4)
A 9-month-old infant visits her pediatrician for a routine visit. A developmental assessment was initiated by the nurse. Which skill would cause the nurse to be concerned about the infant??s developmental progression?

A. She sits briefly alone with assistance.
B. She creeps and crawls.
C. She pulls herself to her feet with help.
D. She stands while holding onto furniture.

Answer: A

Explanation:
(A) The 9-month-old infant can sit alone for long periods. By the age of 6 months, many infants can pull themselves to a sitting position. (B, C, D) This skill represents normal development.

NEW QUESTION 301
- (Topic 4)
An 18-year-old client enters the emergency room complaining of coughing, chest tightness, dyspnea, and sputum production. On physical assessment, the nurse notes agitation, nasal flaring, tachypnea, and expiratory wheezing. These signs should alert the nurse to:

A. A tension pneumothorax
B. An asthma attack
C. Pneumonia
D. Pulmonary embolus

Answer: B

Explanation:
(A) A tension pneumothorax is an accumulation of air in the pleural space. Important physical assessment findings to confirm this condition include cyanosis, jugular vein distention, absent breath sounds on the affected side, distant heart sounds, and lowered blood pressure. (B) Asthma is a disorder in which there is an airflow obstruction in the bronchioles and smaller bronchi secondary to bronchospasm, swelling of mucous membranes, and increased mucus production.Physical assessment reveals some important findings: agitation, nasal flaring, tachypnea, and expiratory wheezing. (C) Pneumonia is an acute bacterial or viral infection that causes inflammation of the lung in the alveolar and interstitial tissue and results in consolidation. Specific assessment findings to confirm this condition include decreased chest expansion caused by pleuritic pain, dullness on percussion over consolidated areas, decreased breath sounds, and increased vocal fremitus. (D) A pulmonary embolus is the passage of a foreign substance (blood clot, fat, air, or amniotic fluid) into the pulmonary artery or its branches, with subsequent obstruction of blood supply to lung tissue. Specific assessment findings that confirm this condition include tachypnea, tachycardia, crackles (rales), transient friction rub, diaphoresis, edema, and cyanosis.

NEW QUESTION 304
- (Topic 4)
A client is having a pneumonectomy done today, and the nurse is planning her postoperative care. Nursing interventions for a postoperative left pneumonectomy would include:

A. Monitoring the chest tubes
B. Positioning the client on the right side
C. Positioning the client in semi-Fowler position with a pillow under the shoulder and back
D. Monitoring the right lung for an increase in rales

Answer: D

Explanation:
(A) Chest tubes are usually not necessary in a pneumonectomy because there is no lung to re-expand on the operative side. (B) The pneumonectomy client should be positioned on the back or operated side because the sutured bronchial stump may open, allowing fluid to drain into the unoperated side and drown the client. (C) The client should not have a pillow under the shoulder and back because of the subscapular incision. (D) Rales are commonly heard over the base of the remaining lung, but an increase could indicate circulatory overload and therefore should be closely monitored.

NEW QUESTION 308
- (Topic 4)
A child becomes neutropenic and is placed on protective isolation. The purpose of protective isolation is to:

A. Protect the child from infection
B. Provide the child with privacy
C. Protect the family from curious visitors
D. Isolate the child from other clients and the nursing staff

Answer: A

Explanation:
(A) The child no longer has normal white blood cells and is extremely susceptible to infection. (B) There are more appropriate ways to provide privacy, and there is no need to protect the child from healthy visitors. (C) Visitors and visiting hours may be at the client??s and/or family??s request without regard to the isolation precaution. (D) The child may have strong positive relationships with other clients or staff. As long as proper precautions are observed, there is no reason to isolate her from them.

NEW QUESTION 313
- (Topic 4)
A 2-day-old infant boy has been diagnosed with an atrial septal defect due to a persistent patent foramen ovale.
When explaining the diagnosis to the mother, the nurse includes in the discussion the function of the foramen ovale. In fetal circulation, the foramen ovale allows a portion of the blood to bypass the:

A. Left ventricle
B. Pulmonary system
C. Liver
D. Superior vena cava

Answer: B

Explanation:

(A) The foramen ovale permits a percentage of the blood to shunt from the right atrium to the left atrium. The blood then goes to the left ventricle, permitting systemic fetal circulation with blood containing a higher O2 saturation. (B) As the blood shunts from the right atrium to the left atrium, the pulmonary system is bypassed. The fetus receives O2 from the maternal circulation, thereby permitting the partial bypass of the pulmonary system. (C) The foramen ovale is locatedin the atrial septum of the heart and does not affect the liver.
(D) The superior vena cava returns blood to the heart, bringing blood to the location of the foramen ovale.

NEW QUESTION 316
- (Topic 4)
A client returns to the cardiovascular intensive care unit following his coronary artery bypass graft. In planning his care, the most important electrolyte the nurse needs to monitor will be:

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

Answer: C

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

NEW QUESTION 317
- (Topic 4)
A 15-year-old client was diagnosed as having cystic fibrosis at 8 months of age. He is in the hospital for a course of IV antibiotic therapy and vigorous chest physiotherapy. He has a poor appetite. The nurse can best help him to meet the desired outcome of consuming a prescribed number of calories by:

A. Including the client in planning sessions to select the type of meal plan and foods for his diet
B. Working with the nutritionist to devise a diet with significantly increased calories
C. Selecting foods for the client??s diet that are high in calories and instituting a strict calorie count
D. Constantly providing him with chips, dips, and candies, because the number of calories consumed is more important than the quality of foods

Answer: A

Explanation:
(A) The adolescent knows what he likes and will be more likely to eat if he has some control over his diet. (B) The nurses and nutritionist can plan an excellent diet, but it will not help the adolescent unless he eats it. (C) Eating is already a chore for this client. Adding a strict calorie count could make it even more burdensome. (D) Fats are particularly difficult for the cystic fibrosis client to digest. He does need a healthful diet, not just more calories.

NEW QUESTION 319
- (Topic 4)
A neonate was admitted to the hospital with projectile vomiting. According to the parents, the baby had experienced vomiting episodes after feeding for the last 2 days. A medical diagnosis of hypertrophic pyloric stenosis was made. On assessment, the infant had poor skin turgor, sunken eyeballs, dry skin, and weight loss. Identify the number-one priority nursing diagnosis.

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

Answer: A

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

NEW QUESTION 323
- (Topic 4)
In the coronary care unit, a client has developed multifocal premature ventricular contractions. The nurse should anticipate the administration of:

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

Answer: C

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

NEW QUESTION 327
- (Topic 4)
A hyperactive client is experiencing flight of ideas. The most therapeutic activity for him would be:

A. Doing crafts in occupational therapy
B. Working a 1000-piece puzzle
C. Playing bridge with three other clients
D. Playing basketball in the gym

Answer: D

Explanation:
(A) This activity requires motor skills and therefore would be difficult for a hyperactive client. (B) This activity would take too long, and the client would have difficulty concentrating owing to a limited attention span. (C) This client would not be able to concentrate enough to play card games. He would respond to all the stimuli in the area, become distracted, and leave the table. (D) This activity would allow the client to channel his energy in a positive way.

NEW QUESTION 332
- (Topic 4)
A 74-year-old client seen in the emergency room is exhibiting signs of delirium. His family states that he has not slept, eaten, or taken fluids for the past 24 hours. The planning of nursing care for a delirious client is based on which of the following premises?

A. The delirious client is capable of returning to his previous level of functioning.
B. The delirious client is incapable of returning to his previous level of functioning.
C. Delirium entails progressive intellectual and behavioral deterioration.
D. Delirium is an insidious process.

Answer: A

Explanation:
(A) This answer is correct. If the cause is removed, the delirious client will recover completely. (B) This answer is incorrect. The demented client is incapable of returning to previous level of functioning. The delirious client is capable of returning to previous functioning. (C) This answer is incorrect. The demented client, not the delirious client, has progressive intellectual and behavioral deterioration. (D) This answer is incorrect. Delirium develops rapidly, whereas dementia is insidious.

NEW QUESTION 333
- (Topic 4)
A client had a renal transplant 3 months ago. He has suddenly developed graft tenderness, an increased white blood cell count, and malaise. The client is experiencing which type of rejection?

A. Acute
B. Chronic
C. Hyperacute
D. Hyperchronic

Answer: A

Explanation:
(A) The sudden development of fever, graft tenderness, increased white blood count, and malaise are signs and symptoms of an acute rejection that commonly occurs at 3 months.
(B) Chronic rejection occurs slowly over a period of months to years and mimics chronic renal failure. (C) Hyperacute rejection occurs immediately after surgery up to 48 hours postoperatively. (D) Hyperchronic rejection is not a type of rejection.

NEW QUESTION 334
- (Topic 4)
A postoperative TURP client is ordered continuous bladder irrigations. Later in the evening on the first postoperative day, he complains of increasing suprapubic pain. When assessing the client, the nurse notes diminished flow of bloody urine and several large blood clots in the drainage tubing. Which one of the following should be the initial nursing intervention?

A. Call the physician about the problem.
B. Irrigate the Foley catheter.
C. Change the Foley catheter.
D. Administer a prescribed narcotic analgesic.

Answer: B

Explanation:
(A) The physician should be notified as problems arise, but in this case, the nurse can attempt to irrigate the Foley catheter first and call the physician if irrigation is unsuccessful. Notifying the physician of problems is a subsequent nursing intervention. (B) This answer is correct. Assessing catheter patency and irrigating as prescribed are the initial priorities to maintain continuous bladder irrigation. Manual irrigation will dislodge blood clots that have blocked the catheter and prevent problems of bladder distention, pain, and possibly fresh bleeding. (C) The Foley catheter would not be changed as an initial nursing intervention, but irrigation of the catheter should be done as ordered to dislodge clots that interfere with patency. (D) Even though the client complains of increasing suprapubic pain, administration of a prescribed narcotic analgesic is not the initial priority. The effect of the medication may mask the symptoms of a distended bladder and lead to more serious complications.

NEW QUESTION 336
- (Topic 4)
Prior to an amniocentesis, a fetal ultrasound is done in order to:

A. Evaluate fetal lung maturity
B. Evaluate the amount of amniotic fluid
C. Locate the position of the placenta and fetus
D. Ensure that the fetus is mature enough to perform the amniocentesis

Answer: C

Explanation:
(A) Amniocentesis can be performed to assess for lung maturity. Fetal ultrasound can be used for gestational dating, although it does not separately determine lung maturity. (B) Ultrasound can evaluate amniotic fluid volume, which may be used to determine congenital anomalies. (C) Amniocentesis involves removal of amniotic fluid for evaluation. The needle, inserted through the abdomen, is guided by ultrasound to avoid needle injuries, and the test evaluates the position of the placenta and the fetus. (D) Amniocentesis can be performed as early as the 15th–17th week of pregnancy.

NEW QUESTION 339
- (Topic 4)
A 50-year-old depressed client has recently lost his job. He has been reluctant to leave his hospital room. Nursing care would include:

A. Forcing the client to attend all unit activities
B. Encouraging the client to discuss why he is so sad
C. Monitoring elimination patterns
D. Providing sensory stimulation

Answer: C

Explanation:
(A) The client should be encouraged to attend the unit activities. The nurse and client should choose a few activities for the client to attend that will be positive experiences for him. (B) The nurse should encourage the client to discuss his feelings and to begin to deal with the depression. (C) Depressed persons often have little appetite and poor fluid intake. Constipation is common. (D) A calm, consistent level of stimuli is most effective. Sensory deprivation and overstimulation should be avoided.

NEW QUESTION 340
- (Topic 4)
The health team needs to realize that the compulsive concern with cleanliness that a client with severe anxiety exhibits is most likely an attempt to:

A. Reduce his anxiety
B. Avoid going to psychotherapy
C. Manipulate the health team members
D. Increase his self-image by showing higher standards than the fellow clients

Answer: A

Explanation:
(A) These behaviors are attempts to relieve anxiety. (B) Avoidance is not a pattern in the obsessive client. (C) Although these behaviors may seem to manipulate others, that is not the purpose behind the activity. (D) Inflated self-esteem is not a characteristic of the severely anxious client.

NEW QUESTION 344
- (Topic 4)
A post-lung surgery client is placed on a chest tube drainage system. When explaining to the family how the system works, the nurse states that the water-seal bottle of a three- bottle chest drainage system serves which of the following purposes?

A. Collection bottle for drainage
B. Pressure regulator
C. Preventing accumulation of blood around the heart
D. Preventing air from entering the chest upon inspiration

Answer: D

Explanation:
(A) There is a separate collection bottle for drainage as part of a chest drainage system.
(B) In a three-bottle chest drainage system, one bottle serves only as a pressure regulator.
(C) Mediastinal chest tubes prevent accumulation of blood around the heart immediately following heart surgery. (D) The purpose of the water-seal bottle in any chest drainage setup is to allow air out of the chest, but not back in. This negative pressure promotes lung expansion.

NEW QUESTION 348
- (Topic 4)
A client is being treated for congestive heart failure. His medical regimen consists of digoxin (Lanoxin) 0.25 mg po daily and furosemide 20 mg po bid. Which laboratory test should the nurse monitor?

A. Intake and output
B. Calcium
C. Potassium
D. Magnesium

Answer: C

Explanation:
(A) Intake and output are not laboratory tests. (B) Serum calcium levels are not affected by digoxin or furosemide. (C) Furosemide is a non–potassium-sparing loop diuretic. Hypokalemia is a common side effect of furosemide and may enhance digoxin toxicity. (D) Serum magnesium levels are not affected by digoxin or furosemide.

NEW QUESTION 350
- (Topic 4)
A 14-year-old client has a history of lying, stealing, and destruction of property. Personal items of peers have been found missing. After group therapy, a peer approaches the nurse to report that he has seen the 14- year-old with some of the missing items. The best response of the nurse is to:

A. Request that he explain to the group why he took personal items from peers
B. Approach him when he is alone to inquire about his involvement in the incident
C. Imply to him that you doubt his involvement in the incident and request his denial
D. Confront him openly in group and request an apology

Answer: B

Explanation:
(A) This answer is incorrect. There is no proof that he removed the missing items. (B) This answer is correct. Anxiety and defensiveness are lessened if the individual is approached in this manner. (C) This answer is incorrect. It is difficult for one to admit to wrongdoing with this approach. (D) This answer is incorrect. He has not yet been proved guilty. Confrontation will only increase defensiveness and anxiety.

NEW QUESTION 351
- (Topic 4)
An 8-year-old child is admitted to the hospital for surgery. She has had no previous hospitalizations, and both she and her family appear anxious and fearful. It will be most helpful for the nurse to:

A. Take the child to her room and calmly and matter-offactly begin to get her ready to go to the operating room
B. Take time to orient the child and her family to the hospital and the forthcoming events
C. Explain that as soon as the child goes to the operating room she will have time to answer any questions the family has
D. Tell the child and her family that there is nothing to worry about, that the operation will not take long, and she will soon be as ??good as new??

Answer: B

Explanation:
(A) This action does nothing to prepare the child and her family for what will happen or to relieve their anxiety and fear. (B) This action provides security by preparing the child and the family for what will happen and will help to relieve fear and anxiety. (C) This action does nothing to help prepare the child for what will happen and does not give the parents permission to ask questions until later. (D) This action provides possibly false reassurance and may prevent the child and/or the family from asking pressing questions.

NEW QUESTION 355
- (Topic 4)
A successful executive left her job and became a housewife after her marriage to a plastic surgeon. She started doing volunteer work for a charity organization. She developed pain in her legs that advanced to the point of paralysis. Her physicians can find no organic basis for the paralysis. The client??s behavior can be described as:

A. Housework phobia
B. Malingering
C. Conversion reaction
D. Agoraphobia

Answer: C

Explanation:
(A) A typical phobia does not result in physical symptoms (i.e., paralysis). (B) Malingering is pretending to be ill. This person has a true paralysis. (C) A conversion reaction is a physical expression of an emotional conflict. It has no organic basis. (D) Agoraphobia is fear of public places.

NEW QUESTION 360
- (Topic 4)
The nurse caring for a client who has pneumonia, which is caused by a gram-positive bacteria, inspects her sputum. Because the client??s pneumonia is caused by a gram- positive bacteria, the nurse experts to find the sputum to be:

A. Bright red with streaks
B. Rust colored
C. Green colored
D. Pink-tinged and frothy

Answer: B

Explanation:
(A) Bright red sputum with streaks is associated with pneumonia caused by gram-negative bacteria, such asKlebsiellapneumonia. (B) Pneumococcal pneumonia, caused by gram- positive bacteria, has a characteristic productive cough with green or rust-colored sputum.
(C) Green-colored sputum is more characteristic ofPseudomonasthan of gram-positive bacterial pneumonia. (D) Pink-tinged and frothy sputum is more characteristic of pulmonary edema than of gram-positive bacterial pneumonia.

NEW QUESTION 364
- (Topic 4)
A postoperative prostatectomy client is preparing for discharge from the hospital the next morning. The nurse realizes that additional instructions are necessary when he states:

A. ??If I drink 10 to 12 glasses of fluids each day, that will help to prevent any clot formation in my urine.??
B. ??The isometric exercises will help to strengthen my perineal muscles and help me control my urine.??
C. ??If I feel as though I have developed a fever, I will take a rectal temperature, which is the most accurate.??
D. ??I do not plan to do any heavy lifting until I visit my doctor again.??

Answer: C

Explanation:

(A) This is correct health teaching. Drinking 10–12 glasses of clear liquid will help increase urine volumes and prevent clot formation. (B) This is correct health teaching. These types of exercises are prescribed by physicians to assist postprostatectomy clients to strengthen their perineal muscles. (C) This action is not recommended post-TURP because of the close proximity of the prostate and rectum. (D) This is correct healthcare teaching. The client should limit walking long distances, lifting heavy objects, or driving a car until these activities are cleared by the physician at the first office visit.

NEW QUESTION 365

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