

Exam Questions NCLEX-RN

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)

In assessing cardiovascular clients with progression of aortic stenosis, the nurse should be aware that there is typically:

- A. Decreased pulmonary blood flow and cyanosis
- B. Increased pressure in the pulmonary veins and pulmonary edema
- C. Systemic venous engorgement
- D. Increased left ventricular systolic pressures and hypertrophy

Answer: D

Explanation:

(A) These signs are seen in pulmonic stenosis or in response to pulmonary congestion and edema and mitral stenosis. (B) These signs are seen primarily in mitral stenosis or as a late sign in aortic stenosis after left ventricular failure. (C) These signs are seen primarily in right-sided heart valve dysfunction. (D) Left ventricular hypertrophy occurs to increase muscle mass and overcome the stenosis; left ventricular pressures increase as left ventricular volume increases owing to insufficient emptying.

NEW QUESTION 3

- (Topic 1)

Which of the following findings would be abnormal in a postpartal woman?

- A. Chills shortly after delivery
- B. Pulse rate of 60 bpm in morning on first postdelivery day
- C. Urinary output of 3000 mL on the second day after delivery
- D. An oral temperature of 101F (38.3C) on the third day after delivery

Answer: D

Explanation:

(A) Frequently the mother experiences a shaking chill immediately after delivery, which is related to a nervous response or to vasomotor changes. If not followed by a fever, it is clinically innocuous. (B) The pulse rate during the immediate postpartal period may be low but presents no cause for alarm. The body attempts to adapt to the decreased pressures intra-abdominally as well as from the reduction of blood flow to the vascular bed. (C) Urinary output increases during the early postpartal period (12–24 hours) owing to diuresis. The kidneys must eliminate an estimated 2000–3000 mL of extracellular fluid associated with a normal pregnancy. (D) A temperature of 100.4F (38C) may occur after delivery as a result of exertion and dehydration of labor. However, any temperature greater than 100.4F needs further investigation to identify any infectious process.

NEW QUESTION 4

- (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 5

- (Topic 1)

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

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

Answer:

B

Explanation:

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

NEW QUESTION 6

- (Topic 1)

The child with iron poisoning is given IV deferoxamine mesylate (Desferal). Following administration, the child suffers hypotension, facial flushing, and urticaria. The initial nursing intervention would be to:

- A. Discontinue the IV
- B. Stop the medication, and begin a normal saline infusion
- C. Take all vital signs, and report to the physician
- D. Assess urinary output, and if it is 30 mL an hour, maintain current treatment

Answer: B**Explanation:**

- (A) The IV line should not be discontinued because other IV medications will be needed. (B) Stop the medication and begin a normal saline infusion. The child is exhibiting signs of an allergic reaction and could go into shock if the medication is not stopped. The line should be kept opened for other medication. (C) Taking vital signs and reporting to the physician is not an adequate intervention because the IV medication continues to flow. (D) Assessing urinary output and, if it is 30 mL an hour, maintaining current treatment is an inappropriate intervention owing to the child's obvious allergic reaction.

NEW QUESTION 7

- (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 8

- (Topic 1)

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

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

Answer: B**Explanation:**

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

NEW QUESTION 9

- (Topic 1)

In a client with chest trauma, the nurse needs to evaluate mediastinal position. This can best be done by:

- A. Auscultating bilateral breath sounds
- B. Palpating for presence of crepitus
- C. Palpating for trachial deviation
- D. Auscultating heart sounds

Answer: C**Explanation:**

- (A) No change in the breath sounds occurs as a direct result of the mediastinal shift. (B) Crepitus can occur owing to the primary disorder, not to the mediastinal shift. (C) Mediastinal shift occurs primarily with tension pneumothorax, but it can occur with very large hemothorax or pneumothorax. Mediastinal shift causes trachial deviation and deviation of the heart's point of maximum impulse. (D) No change in the heart sounds occurs as a result of the mediastinal shift.

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)

A client with a diagnosis of C-4 injury has been stabilized and is ready for discharge. Because this client is at risk for autonomic dysreflexia, he and his family should be instructed to assess for and report:

- A. Dizziness and tachypnea
- B. Circumoral pallor and lightheadedness
- C. Headache and facial flushing
- D. Pallor and itching of the face and neck

Answer: C

Explanation:

(A) Tachypnea is not a symptom. (B) Circumoral pallor is not a symptom. (C) Autonomic dysreflexia is an uninhibited and exaggerated reflex of the autonomic nervous system to stimulation, which results in vasoconstriction and elevated blood pressure. (D) Pallor and itching are not symptoms.

NEW QUESTION 12

- (Topic 1)

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

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

Answer: A

Explanation:

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

NEW QUESTION 14

- (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 15

- (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 19

- (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 24

- (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 26

- (Topic 1)

Nursing care for the substance abuse client experiencing alcohol withdrawal delirium includes:

- A. Maintaining seizure precautions
- B. Restricting fluid intake
- C. Increasing sensory stimuli
- D. Applying ankle and wrist restraints

Answer: A

Explanation:

(A) These clients are at high risk for seizures during the 1st week after cessation of alcohol intake. (B) Fluid intake should be increased to prevent dehydration. (C) Environmental stimuli should be decreased to prevent precipitation of seizures. (D) Application of restraints may cause the client to increase his or her physical activity and may eventually lead to exhaustion.

NEW QUESTION 27

- (Topic 1)

The medication that best penetrates eschar is:

- A. Mafenide acetate (Sulfamylon)
- B. Silver sulfadiazine (Silvadene)
- C. Neomycin sulfate (Neosporin)
- D. Povidone-iodine (Betadine)

Answer: A

Explanation:

(A) Mafenide acetate is bacteriostatic against gram-positive and gram-negative organisms and is the agent that best penetrates eschar. (B) Silver sulfadiazine poorly penetrates eschar. (C) Neomycin sulfate does not penetrate eschar. (D) Povidoneiodine does not penetrate eschar.

NEW QUESTION 31

- (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 32

- (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 35

- (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 38

- (Topic 1)

Which of the following medications requires close observation for bronchospasm in the client with chronic obstructive pulmonary disease or asthma?

- A. Verapamil (Isoptin)
- B. Amrinone (Inocor)
- C. Epinephrine (Adrenalin)
- D. Propranolol (Inderal)

Answer: D**Explanation:**

(A) Verapamil has the respiratory side effect of nasal or chest congestion, dyspnea, shortness of breath (SOB), and wheezing. (B) Amrinone has the effect of increased contractility and dilation of the vascular smooth muscle. It has no noted respiratory side effects. (C) Epinephrine has the effect of bronchodilation through stimulation. (D) Propranolol, esmolol, and labetalol are all - blocking agents, which can increase airway resistance and cause bronchospasms.

NEW QUESTION 40

- (Topic 1)

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

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

Answer: A**Explanation:**

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

NEW QUESTION 45

- (Topic 1)

The nurse would expect to include which of the following when planning the management of the client with Lyme disease?

- A. Complete bed rest for 6–8 weeks
- B. Tetracycline treatment
- C. IV amphotericin B
- D. High-protein diet with limited fluids

Answer: B

Explanation:

(A) The client is not placed on complete bed rest for 6 weeks. (B) Tetracycline is the treatment of choice for children with Lyme disease who are over the age of 9. (C) IV amphotericin B is the treatment for histoplasmosis. (D) The client is not restricted to a high-protein diet with limited fluids.

NEW QUESTION 50

- (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 most individuals. (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 55

- (Topic 1)

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

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

Answer: D

Explanation:

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

NEW QUESTION 58

- (Topic 1)

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

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

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

Answer: B

Explanation:

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

NEW QUESTION 59

- (Topic 1)

A client diagnosed with bipolar disorder continues to be hyperactive and to lose weight. Which of the following nutritional interventions would be most therapeutic for him at this time?

- A. Small, frequent feedings of foods that can be carried
- B. Tube feedings with nutritional supplements
- C. Allowing him to eat when and what he wants
- D. Giving him a quiet place where he can sit down to eat meals

Answer: A

Explanation:

(A) The manic client is unable to sit still long enough to eat an adequate meal. Small, frequent feedings with finger foods allow him to eat during periods of activity. (B) This type of therapy should be implemented when other methods have been exhausted. (C) The manic client should not be in control of his treatment plan. This type of client may forget to eat. (D) The manic client is unable to sit down to eat full meals.

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)

A client is 6 weeks pregnant. During her first prenatal visit, she asks, "How much alcohol is safe to drink during pregnancy?" The nurse's response is:

- A. Up to 1 oz daily
- B. Up to 2 oz daily
- C. Up to 4 oz weekly
- D. No alcohol

Answer: D

Explanation:

(A, B, C) No amount of alcohol has been determined safe for pregnant women. Alcohol should be avoided owing to the risk of fetal alcohol syndrome. (D) The recommended safe dosage of alcohol consumption during pregnancy is none.

NEW QUESTION 67

- (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 emphysema 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 72

- (Topic 1)

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

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

Answer: A

Explanation:

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

NEW QUESTION 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 75

- (Topic 1)

To appropriately monitor therapy and client progress, the nurse should be aware that increased myocardial work and O2 demand will occur with which of the following?

- A. Positive inotropic therapy
- B. Negative chronotropic therapy
- C. Increase in balance of myocardial O2 supply and demand
- D. Afterload reduction therapy

Answer: A

Explanation:

(A) Inotropic therapy will increase contractility, which will increase myocardial O2 demand. (B) Decreased heart rate to the point of bradycardia will increase coronary artery filling time. This should be used cautiously because tachycardia may be a compensatory mechanism to increase cardiac output. (C) The goal in the care of the MI client with angina is to maintain a balance between myocardial O2 supply and demand. (D) Decrease in systemic vascular resistance by drug therapy, such as IV nitroglycerin or nitroprusside, or intra-aortic balloon pump therapy, would decrease myocardial work and O2 demand.

NEW QUESTION 78

- (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 80

- (Topic 1)

The nurse notes hyperventilation in a client with a thermal injury. She recognizes that this may be a reaction to which of the following medications if applied in large amounts?

- A. Neosporin sulfate
- B. Mafenide acetate
- C. Silver sulfadiazine
- D. Povidone-iodine

Answer: B

Explanation:

(A) The side effects of neomycin sulfate include rash, urticaria, nephrotoxicity, and ototoxicity. (B) The side effects of mafenide acetate include bone marrow suppression, hemolytic anemia, eosinophilia, and metabolic acidosis. The hyperventilation is a compensatory response to the metabolic acidosis. (C) The side effects of silver sulfadiazine include rash, itching, leukopenia, and decreased renal function. (D) The primary side effect of povidone-iodine is decreased renal function.

NEW QUESTION 84

- (Topic 1)

One of the most dramatic and serious complications associated with bacterial meningitis is Waterhouse- Friderichsen syndrome, which is:

- A. Peripheral circulatory collapse
- B. Syndrome of inappropriate antidiuretic hormone
- C. Cerebral edema resulting in hydrocephalus
- D. Auditory nerve damage resulting in permanent hearing loss

Answer: A

Explanation:

(A) Waterhouse-Friderichsen syndrome is peripheral circulatory collapse, which may result in extensive and diffuse intravascular coagulation and thrombocytopenia resulting in death. (B) Syndrome of inappropriate antidiuretic hormone is a complication of meningitis, but it is not Waterhouse-Friderichsen syndrome. (C) Cerebral edema resulting in hydrocephalus is a complication of meningitis, but it is not Waterhouse-Friderichsen syndrome. (D) Auditory nerve damage resulting in permanent hearing loss is a complication of meningitis, but it is not Waterhouse- Friderichsen syndrome.

NEW QUESTION 89

- (Topic 1)

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

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

Answer: D

Explanation:

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

NEW QUESTION 94

- (Topic 1)

The nurse should know that according to current thinking, the most important prognostic factor for a client with breast cancer is:

- A. Tumor size
- B. Axillary node status
- C. Client's previous history of disease
- D. Client's level of estrogen-progesterone receptor assays

Answer: B

Explanation:

(A) Although tumor size is a factor in classification of cancer growth, it is not an indicator of lymph node spread. (B) Axillary node status is the most important indicator for predicting how far the cancer has spread. If the lymph nodes are positive for cancer cells, the prognosis is poorer. (C) The client's previous history of cancer puts her at an increased risk for breast cancer recurrence, especially if the cancer occurred in the other breast. It does not predict prognosis, however. (D) The estrogen-progesterone assay test is used to identify present tumors being fed from an estrogen site within the body. Some breast cancers grow rapidly as long as there is an estrogen supply such as from the ovaries. The estrogen-progesterone assay test does not indicate the prognosis.

NEW QUESTION 96

- (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 98

- (Topic 1)

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

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

Answer: B

Explanation:

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

NEW QUESTION 99

- (Topic 2)

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 100

- (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 105

- (Topic 2)

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

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

Answer: B

Explanation:

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

NEW QUESTION 109

- (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 114

- (Topic 2)

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

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

Answer: C

Explanation:

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

NEW QUESTION 115

- (Topic 2)

The nurse is teaching a 10-year-old insulin-dependent diabetic how to administer insulin. Which one of the following steps must be taught for insulin administration?

- A. Never use abdominal site for a rotation site.
- B. Pinch the skin up to form a subcutaneous pocket.
- C. Avoid applying pressure after injection.
- D. Change needles after injection.

Answer: B

Explanation:

(A) Sites for injection need to be rotated, including abdominal sites, to enhance insulin absorption. (B) The pinch technique is the most effective method for obtaining skin tightness to allow easy entrance of the needle to subcutaneous tissues. (C) Massaging the site of injection facilitates absorption of the insulin. (D) Changing the needle will break the sterility of the system. It has become acceptable practice to reuse disposable needles and syringes for 3–7 days.

NEW QUESTION 116

- (Topic 2)

The nurse would be concerned if a client exhibited which of the following symptoms during her postpartum stay?

- A. Pulse rate of 50–70 bpm by her third postpartum day
- B. Diuresis by her second or third postpartum day
- C. Vaginal discharge or rubra, serosa, then rubra
- D. Diaphoresis by her third postpartum day

Answer: C

Explanation:

(A) Bradycardia is an expected assessment during the postpartum period. (B) Diuresis can occur during labor and the postpartum period and is an expected physiological adaptation. (C) A return of rubra after the serosa period may indicate a postpartal complication. (D) Diaphoresis, especially at night, is an expected physiological change and does not indicate an infectious process. Bradycardia, diuresis, and diaphoresis are normal postpartum physiological responses to adjust the cardiac output and blood volume to the nonpregnant state.

NEW QUESTION 117

- (Topic 2)

Assessment of parturient reveals the following: cervical dilation 6 cm and station 22; no progress in the last 4 hours. Uterine contractions decreasing in frequency and intensity. Marked molding of the presenting fetal head is described. The physician orders, "Begin oxytocin induction at 1 mU/min." The nurse should:

- A. Begin the oxytocin induction as ordered
- B. Increase the dosage by 2 mU/min increments at 15-minute intervals
- C. Maintain the dosage when duration of contractions is 40–60 seconds and frequency is at 2–4 minute intervals
- D. Question the order

Answer: D

Explanation:

(A) Oxytocin stimulates labor but should not be used until CPD (cephalopelvic disproportion) is ruled out in a dysfunctional labor. (B) This answer is the correct protocol for oxytocin administration, but the medication should not be used until CPD is ruled out. (C) This answer is the correct manner to interpret effective stimulation, but oxytocin should not be used until CPD is ruled out. (D) This answer is the appropriate nursing action because the scenario presents a dysfunctional labor pattern that may be caused by CPD. Oxytocin administration is contraindicated in CPD.

NEW QUESTION 122

- (Topic 2)

The nurse would teach a male client ways to minimize the risk of infection after eye surgery. Which of the following indicates the client needs further teaching?

- A. "I will wash my hands before instilling eye medications."
- B. "I will wear sunglasses when going outside."
- C. "I will wear an eye patch for the first 3 postoperative days."
- D. "I will maintain the sterility of the eye medications."

Answer: C

Explanation:

(A) Hand washing would be an important action designed to prevent transmission of pathogens from the hands to the eye. (B) Wearing sunglasses when going outside will prevent airborne pathogens from entering the eye. (C) Eye patches are most frequently ordered to be worn while the client sleeps or naps, not constantly for this length of time. (D) Eye medications are sterile; clients need to be taught how to maintain this sterility.

NEW QUESTION 125

- (Topic 2)

A client decided early in her pregnancy to breast-feed her first baby. She gave birth to a normal, full-term girl and is now progressing toward the establishment of successful lactation. To remove the baby from her breast, she should be instructed to:

- A. Gently pull the infant away
- B. Withdraw the breast from the infant's mouth
- C. Compress the areolar tissue until the infant drops the nipple from her mouth
- D. Insert a clean finger into the baby's mouth beside the nipple

Answer: D

Explanation:

(A) In pulling the infant away from the breast without breaking suction, nipple trauma is likely to occur. (B) In pulling the breast away from the infant without breaking suction, nipple trauma is likely to occur. (C) Compressing the maternal tissue does not break the suction of the infant on the breast and can cause nipple trauma. (D) By inserting a finger into the infant's mouth beside the nipple, the lactating mother can break the suction and the nipple can be removed without trauma.

NEW QUESTION 126

- (Topic 2)

Which nursing implication is appropriate for a client undergoing a paracentesis?

- A. Have the client void before the procedure.
- B. Keep the client NPO.
- C. Observe the client for hypertension following the procedure.
- D. Place the client on the right side following the procedure.

Answer: A

Explanation:

(A) A full bladder would impede withdrawal of ascitic fluid. (B) Keeping the client NPO is not necessary. (C) The client may exhibit signs and symptoms of shock and hypertension. (D) No position change is needed after the procedure.

NEW QUESTION 129

- (Topic 2)

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

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

Answer: A

Explanation:

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

NEW QUESTION 131

- (Topic 2)

A dose of theophylline may need to be altered if a client with COPD:

- A. Is allergic to morphine
- B. Has a history of arthritis
- C. Operates machinery
- D. Is concurrently on cimetidine for ulcers

Answer: D

Explanation:

(A) The effects of morphine or an allergic response to the drug will not affect theophylline clearance. (B) Xanthines are used cautiously in clients with severe cardiac disease, liver disease, cor pulmonale, hypertension, or hyperthyroidism. Arthritis does not influence the dosage of theophylline. (C) Theophylline does not cause sedation or drowsiness. Conversely, its side effects may be exhibited by central nervous system stimulation. (D) Cimetidine decreases theophylline clearance from the system and increases theophylline levels in the blood, thus increasing the risk of toxicity.

NEW QUESTION 134

- (Topic 2)

The nurse enters the playroom and finds an 8-year-old child having a grand mal seizure. Which one of the following actions should the nurse take?

- A. Place a tongue blade in the child's mouth.
- B. Restrain the child so he will not injure himself.
- C. Go to the nurses station and call the physician.
- D. Move furniture out of the way and place a blanket under his head.

Answer: D

Explanation:

(A) The nurse should not put anything in the child's mouth during a seizure; this action could obstruct the airway. (B) Restraining the child's movements could cause constrictive injury. (C) Staying with the child during a seizure provides protection and allows the nurse to observe the seizure activity. (D) The nurse should provide safety for the child by moving objects and protecting the head.

NEW QUESTION 139

- (Topic 2)

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

- A. The client is restless.
- B. The elevated blood pressure causes photophobia.

- C. Noise or bright lights may precipitate a convulsion.
- D. External stimuli are annoying to the client with PIH.

Answer: C

Explanation:

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

NEW QUESTION 143

- (Topic 2)

A client is being discharged and will continue enteral feedings at home. Which of the following statements by a family member indicates the need for further teaching?

- A. ??If he develops diarrhea lasting for more than 2–3 days, I will contact the doctor or nurse.??
- B. ??I should anticipate that he will gain about 1 lb/day now that he is on continuous feedings.??
- C. ??It is important to keep the head of his bed elevated or sit him in the chair during feedings.??
- D. ??I should use prepared or open formula within 24 hours and store unused portions in the refrigerator.??

Answer: B

Explanation:

(A) Diarrhea is a complication of tube feedings that can lead to dehydration. Diarrhea may be the result of hypertonic formulas that can draw fluid into the bowel. Other causes of diarrhea may be bacterial contamination, fecal impaction, medications, and low albumin. (B) A consistent weight gain of more than 0.22 kg/day (12 lb/day) over several days should be reported promptly. The client should be evaluated for fluid volume excess. (C) Elevating the client??s head prevents reflux and thus formula from entering the airway. (D) Bacteria proliferate rapidly in enteral formulas and can cause gastroenteritis and even sepsis.

NEW QUESTION 144

- (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 148

- (Topic 2)

A mother came to the pediatric clinic with her 17- month-old child. The mother would like to begin toilet training. What should the nurse teach her about implementing toilet training?

- A. Take two or three favorite toys with the child.
- B. Have a child-sized toilet seat or training potty on hand.
- C. Explain to the child she is going to ??void?? and ??defecate.??
- D. Show disapproval if she does not void or defecate.

Answer: B

Explanation:

(A) Giving her toys will distract her and interfere with toilet training because of inappropriate reinforcement. (B) A child-sized toilet seat or training potty gives a child a feeling of security. (C) She should use words that are age appropriate for the child. (D) Children should be praised for cooperative behavior and/or successful evacuation.

NEW QUESTION 151

- (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 153

- (Topic 2)

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

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

Answer: B

Explanation:

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

NEW QUESTION 155

- (Topic 2)

A 6-month-old infant has developmental delays. His weight falls below the 5th percentile when plotted on a growth chart. A diagnosis of failure to thrive is made. What behaviors might indicate the possibility of maternal deprivation?

- A. Responsive to touch, wants to be held
- B. Uncomforted by touch, refuses bottle
- C. Maintains eye-to-eye contact
- D. Finicky eater, easily pacified, cuddly

Answer: B

Explanation:

(A) Normal infant attachment behaviors include responding to touch and wanting to be held. (B) Maternal deprivation behaviors include poor feeding, stiffening and refusal to eat, and inconsistencies in responsiveness. (C) Attachment behavior includes maintaining eye contact. (D) Maternal deprivation behaviors include displeasure with touch and physical contact.

NEW QUESTION 156

- (Topic 2)

A pregnant client is at the clinic for a third trimester prenatal visit. During this examination, it has been determined that her fetus is in a vertex presentation with the occiput located in her right anterior quadrant. On her chart this would be noted as:

- A. Right occipitoposterior
- B. Right occipitoanterior
- C. Right sacroanterior
- D. LOA

Answer: B

Explanation:

(A) The fetus in the right occipitoposterior position would be presenting with the occiput in the maternal right posterior quadrant. (B) Fetal position is defined by the location of the fetal presenting part in the four quadrants of the maternal pelvis. The right occipitoanterior is a fetus presenting with the occiput in mother's right anterior quadrant. (C) The fetus in right sacroanterior position would be presenting a sacrum, not an occiput. (D) The fetus in left occipitoanterior position would be presenting with the occiput in the mother's left anterior quadrant.

NEW QUESTION 161

- (Topic 2)

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

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

Answer: C

Explanation:

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

NEW QUESTION 163

- (Topic 2)

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

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

Answer: C

Explanation:

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

NEW QUESTION 168

- (Topic 2)

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

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

Answer: D

Explanation:

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

NEW QUESTION 171

- (Topic 2)

A male client is scheduled for a liver biopsy. In preparing him for this test, the nurse should:

- A. Explain that he will be kept NPO for 24 hours before the exam
- B. Practice with him so he will be able to hold his breath for 1 minute
- C. Explain that he will be receiving a laxative to prevent a distended bowel from applying pressure on the liver
- D. Explain that his vital signs will be checked frequently after the test

Answer: D

Explanation:

(A) There is no NPO restriction prior to a liver biopsy. (B) The client would need to hold his breath for 5–10 seconds. (C) There is no pretest laxative given. (D) Following the test, the client is watched for hemorrhage and shock.

NEW QUESTION 176

- (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 180

- (Topic 2)

Nursing interventions designed to decrease the risk of infection in a client with an indwelling catheter include:

- A. Cleanse area around the meatus twice a day
- B. Empty the catheter drainage bag at least daily
- C. Change the catheter tubing and bag every 48 hours
- D. Maintain fluid intake of 1200–1500 mL every day

Answer: A

Explanation:

(A) Catheter site care is to be done at least twice daily to prevent pathogen growth at the catheter insertion site. (B) Catheter drainage bags are usually emptied every 8 hours to prevent urine stasis and pathogen growth. (C) Tubing and collection bags are not changed this often, because research studies have not demonstrated the efficacy of this practice.

(D) Fluid intake needs to be in the 2000–2500 mL range if possible to help irrigate the bladder and prevent infection.

NEW QUESTION 181

- (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 184

- (Topic 2)

A male client is started on IV anticoagulant therapy with heparin. Which of the following laboratory studies will be ordered to monitor the therapeutic effects of heparin?

- A. Partial thromboplastin time
- B. Hemoglobin
- C. Red blood cell (RBC) count
- D. Prothrombin time

Answer: A

Explanation:

(A) Partial thromboplastin time is used to monitor the effects of heparin, and dosage is adjusted depending on test results. It is a screening test used to detect deficiencies in all plasma clotting factors except factors VII and XIII and platelets. (B) Hemoglobin is the main component of RBCs. Its main function is to carry O₂ from the lungs to the body tissues and to transport CO₂ back to the lungs. (C) RBC count is the determination of the number of RBCs found in each cubic millimeter of whole blood. (D) PT is used to monitor the effects of oral anticoagulants, e.g., coumarin-type anticoagulants.

NEW QUESTION 186

- (Topic 2)

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

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

Answer: D

Explanation:

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

NEW QUESTION 191

- (Topic 2)

A nasogastric (NG) tube inserted preoperatively is attached to low, intermittent suction. 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 192

- (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 197

- (Topic 2)

A client in active labor asks the nurse for coaching with her breathing during contractions. The client has attended Lamaze birth preparation classes. Which of the following is the best response by the nurse?

- A. ??Keep breathing with your abdominal muscles as long as you can.??
- B. ??Make sure you take a deep cleansing breath as the contractions start, focus on an object, and breathe about 16–20 times a minute with shallow chest breaths.??
- C. ??Find a comfortable position before you start a contractio
- D. Once the contraction has started, take slow breaths using your abdominal muscles.??
- E. ??If a woman in labor listens to her body and takes rapid, deep breaths, she will be able to deal with her contractions quite well.??

Answer: B

Explanation:

(A) Lamaze childbirth preparation teaches the use of chest, not abdominal, breathing. (B) In Lamaze preparation, every patterned breath is preceded by a cleansing breath; as labor progresses, shallow, paced breathing is found to be effective. (C) It is important to assume a comfortable position in labor, but the Lamazeprepared laboring woman is taught to breathe with her chest, not abdominal, muscles. (D) When deep chest breathing patterns are used in Lamaze preparation, they are slowly paced at a rate of 6–9 breaths/min.

NEW QUESTION 198

- (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 202

- (Topic 2)

A 7-year-old child is brought to the ER at midnight by his mother after symptoms appeared abruptly. The nurse??s initial assessment reveals a temperature of 104.5F (40.3C), difficulty swallowing, drooling, absence of a spontaneous cough, and agitation. These symptoms are indicative of which one of the following?

- A. Acute tracheitis
- B. Acute spasmodic croup
- C. Acute epiglottitis
- D. Acute laryngotracheobronchitis

Answer: C

Explanation:

(A) Clinical manifestations of acute tracheitis include a 2–3 day history of URI, croupy cough, stridor, purulent secretions, high fever. (B) Clinical manifestations of spasmodic croup include a history of URI, croupy cough, stridor, dyspnea, low-grade fever, and a slow progression. The age group most affected is 3 months to 3 years. (C) Three clinical observations have been found to be predictive of epiglottitis: the presence of drooling, absence of spontaneous cough, and agitation. Epiglottitis has a rapid onset that is accompanied by high fever and dysphagia. (D) Clinical manifestations of acute laryngotracheobronchitis (LTB) include slow onset with a history of URI, low-grade fever, stridor, brassy cough, and irritability.

NEW QUESTION 204

- (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 207

- (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 208

- (Topic 2)

The nurse is preparing a 6-year-old child for an IV insertion. Which one of the following statements by the nurse is appropriate when preparing a child for a potentially painful procedure?

- A. ??Some say this feels like a pinch or a bug bit
- B. You tell me what it feels like.??
- C. ??This is going to hurt a lot; close your eyes and hold my hand.??
- D. ??This is a terrible procedure, so don't look.??
- E. ??This will hurt only a little; try to be a big boy.??

Answer: A

Explanation:

(A) Educating the child about the pain may lessen anxiety. The child should be prepared for a potentially painful procedure but avoid suggesting pain. The nurse should allow the child his own sensory perception and evaluation of the procedure. (B) The nurse should avoid absolute descriptive statements and allow the child his own perception of the procedure. (C) The nurse should avoid evaluative statements or descriptions and give the child control in describing his reactions. (D) False statements regarding a painful procedure will cause a loss of trust between the child and the nurse.

NEW QUESTION 209

- (Topic 2)

The nurse teaches a male client ways to reduce the risks associated with furosemide therapy. Which of the following indicates that he understands this teaching?

- A. ??I'll be sure to rise slowly and sit for a few minutes after lying down.??
- B. ??I'll be sure to walk at least 2–3 blocks every day.??
- C. ??I'll be sure to restrict my fluid intake to four or five glasses a day.??
- D. ??I'll be sure not to take any more aspirin while I am on this drug.??

Answer: A

Explanation:

(A) This response will help to prevent the occurrence of postural hypotension, a common side effect of this drug and a common reason for falls. (B) Although walking is an excellent exercise, it is not specific to the reduction of risks associated with diuretic therapy. (C) Clients on diuretic therapy are generally taught to ensure that their fluid intake is at least 2000–3000 mL daily, unless contraindicated. (D) Aspirin is a safe drug to take along with furosemide.

NEW QUESTION 214

- (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 219

- (Topic 2)

Other drugs may be ordered to manage a client's ulcerative colitis. Which of the following medications, if ordered, would the nurse question?

- A. Methylprednisolone sodium succinate (Solu-Medrol)
- B. Loperamide (Imodium)
- C. Psyllium
- D. 6-Mercaptopurine

Answer: D

Explanation:

(A) Methylprednisolone sodium succinate is used for its anti-inflammatory effects. (B) Loperamide would be used to control diarrhea. (C) Psyllium may improve consistency of stools by providing bulk. (D) An immunosuppressant such as 6-mercaptopurine is used for chronic unrelenting Crohn's disease.

NEW QUESTION 220

- (Topic 2)

A client is being discharged on warfarin (Coumadin), an oral anticoagulant. The nurse instructs him about using this drug. Which following response by the client indicates the need for further teaching?

- A. I should shave with my electric razor while on Coumadin.
- B. I will inform my dentist that I am on anticoagulant therapy before receiving dental work.
- C. I will continue with my usual dosage of aspirin for my arthritis when I return home.
- D. I will wear an ID bracelet stating that I am on anticoagulants.

Answer: C

Explanation:

(A) Using an electric razor prevents the risk of cuts while shaving. (B) Any physician or dentist should be informed of anticoagulant therapy because of the risk of bleeding due to a prolonged PT. (C) The client should be instructed to consult with his physician. Aspirin is avoided because it potentiates the effects of oral anticoagulants by interfering with platelet aggregation. (D) Identification bracelets are necessary to direct treatment, especially in an emergency situation.

NEW QUESTION 222

- (Topic 2)

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

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

Answer: B

Explanation:

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

NEW QUESTION 225

- (Topic 3)

A 55-year-old man has recently been diagnosed with hypertension. His physician orders a low-sodium diet for him. When he asks, "What does salt have to do with high blood pressure?" the nurse's initial response would be:

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

Answer: B

Explanation:

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

NEW QUESTION 228

- (Topic 3)

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

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

Answer: C

Explanation:

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

NEW QUESTION 230

- (Topic 3)

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

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

D. Pulmonary emboli

Answer: C

Explanation:

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

NEW QUESTION 234

- (Topic 3)

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

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

Answer: A

Explanation:

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

NEW QUESTION 238

- (Topic 3)

What is the appropriate nursing action for a child with increased intracranial pressure?

- A. Head of bed elevated 45 degrees with child's head maintained in a neutral position
- B. Child lying flat
- C. Head turned to side
- D. Frequent visitation for stimulation

Answer: A

Explanation:

(A) Elevation of head of bed and neutral head position promote drainage of cerebrospinal fluid. (B) Flat position increases intracranial pressure and impedes cerebrospinal fluid drainage. (C) Head turned to either side impedes cerebrospinal fluid drainage. (D) Child should be in a calm, quiet environment with minimal stimulation.

NEW QUESTION 243

- (Topic 3)

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

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

Answer: C

Explanation:

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

NEW QUESTION 248

- (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 251

- (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 255

- (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 259

- (Topic 3)

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

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

Answer: C

Explanation:

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

NEW QUESTION 262

- (Topic 3)

While the RN is assessing a mother's perineum on her 2nd postpartum day after having a vaginal delivery, the RN notes a large ecchymotic area located to the left of the mother's perineum. Which one of the following interventions should the RN initiate at this time?

- A. Have the client expose the area to air.
- B. Apply ice to the perineum.
- C. Encourage the client to take warm sitz baths.
- D. Inform the physician.

Answer: C

Explanation:

(A) The area is bruised and painful. This action would do nothing to help with the healing process of the perineum or to provide comfort. (B) Ice is effective immediately after birth to reduce edema and discomfort, but not on the 2nd postpartum day. (C) Sitz baths are useful if the perineum has been traumatized, because the moist heat increases circulation to the area to promote healing, relaxes tissue, and decreases edema. (D) The physician is not notified of bruising, but if a hematoma is present, then the physician is notified.

NEW QUESTION 266

- (Topic 3)

A client has consented to have a central venous catheter placed. The best position in which to place the client is the Trendelenburg position. The reason is that the Trendelenburg position:

- A. Allows the physician to visualize the subclavian vein
- B. Reduces the possibility of air embolism
- C. Reduces the possibility of hematoma formation
- D. Makes the procedure more comfortable for the client

Answer: B

Explanation:

(A) The subclavian vein is not visible during central line insertion regardless of the client's position. (B) The Trendelenburg position reduces the possibility of air embolism because it places slight positive pressure on the central veins. It also distends the veins, and distention facilitates insertion. (C) This response is untrue; it has no effect on hematoma formation. (D) This position is not necessarily more comfortable for the client, and many clients, especially those who may be short of breath, may find the position uncomfortable and difficult to maintain.

NEW QUESTION 271

- (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 272

- (Topic 3)

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

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

Answer: B

Explanation:

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

NEW QUESTION 275

- (Topic 3)

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

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

Answer: A

Explanation:

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

NEW QUESTION 277

- (Topic 3)

A young boy tells the nurse, "I don't like my Dad to kiss or hug my Mom. I love my Mom and want to marry her." The nurse recognizes this stage of growth and development as:

- A. Electra complex
- B. Oedipus complex
- C. Superego
- D. Ego

Answer: B

Explanation:

(A) The Electra complex is the erotic attachment of the female child to the father. (B) The Oedipus complex is characterized by jealousy toward the parent of the same sex and erotic attachment to the parent of the opposite sex. (C) The superego as described by Freud is the part of personality that is associated with internalized parental and societal control. (D) The ego as described by Freud is the part of personality that is associated with reality assessment.

NEW QUESTION 282

- (Topic 3)

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

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

Answer: A

Explanation:

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

NEW QUESTION 286

- (Topic 3)

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

- A. Reverse Trendelenburg
- B. Fowler's
- C. Trendelenburg
- D. Sims

Answer: C

Explanation:

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

NEW QUESTION 289

- (Topic 3)

A 24-year-old client presents to the emergency department protesting "I am God." The nurse identifies this as a:

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

Answer: A

Explanation:

(A) 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 292

- (Topic 3)

A 67-year-old client will be undergoing a coronary arteriography in the morning. Client teaching about postprocedure nursing care should include that:

- A. Bed rest with bathroom privileges will be ordered
- B. He will be kept NPO for 8–12 hours
- C. Some oozing of blood at the arterial puncture site is normal
- D. The leg used for arterial puncture should be kept straight for 8–12 hours

Answer: D

Explanation:

(A) Bed rest will be ordered for 8–12 hours postprocedure. Flexing of the leg at the arterial puncture site will occur if the client gets out of bed, and this is contraindicated after arteriography. (B) The client will be able to eat as soon as he is alert enough to swallow safely and that will depend on what medications are used for sedation during the procedure. (C) Oozing at the arterial puncture site is not normal and should be closely evaluated. (D) The leg where the arterial puncture occurred must be kept straight for 8–12 hours to minimize the risk of bleeding.

NEW QUESTION 295

- (Topic 3)

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

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

Answer: D

Explanation:

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

NEW QUESTION 299

- (Topic 3)

A 1000-mL dose of lactated Ringer's solution is to be infused in 8 hours. The drop factor for the tubing is 10 gtt/mL. How many drops per minute should the nurse administer?

- A. 125 gtt/min
- B. 48 gtt/min
- C. 20 gtt/min
- D. 21 gtt/min

Answer: D

Explanation:

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) This answer has not been rounded off to an even number. (D) 20.8, or 21 gtt/min.

NEW QUESTION 302

- (Topic 3)

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

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

Answer: B

Explanation:

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

NEW QUESTION 305

- (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 PCO₂ level is decreased, and the HCO₃ level 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 PCO₂ level is elevated, and the HCO₃ level is elevated. The client's primary alteration is an inability to remove CO₂ from the lungs, so over time, the kidneys increase reabsorption of HCO₃ to buffer the CO₂. (C) In compensated respiratory alkalosis, the pH level is normal, the PCO₂ level is decreased, and the HCO₃ level is decreased. The client's primary alteration is hyperventilation, which decreases PCO₂. The client compensates by increasing the excretion of HCO₃ from the body. (D) In uncompensated respiratory acidosis, the pH level is decreased, the PCO₂ level is increased, and the HCO₃ level is normal. The client's primary alteration is an inability to remove CO₂ from the lungs. The kidneys have not compensated by increasing HCO₃ reabsorption.

NEW QUESTION 306

- (Topic 3)

The nurse is assessing and getting a history from a client treated for depression with a monoamine oxidase (MAO) antidepressant. The most serious side effect associated with this antidepressant and the ingestion of tyramine in aged foods may be:

- A. Hypertensive crisis
- B. Severe rash
- C. Severe hypotension
- D. Severe diarrhea

Answer: A

Explanation:

(A) The most serious adverse reactions of MAO inhibitors involve blood pressure and ingestion of tyramine-containing foods, which may provoke a hypertensive crisis. (B) MAO inhibitors cause adverse reactions affecting the central nervous system and serious adverse reactions involving blood pressure. (C) MAO inhibits false neurotransmitters (phenylalanines) and may produce hypotensive reactions from gradual accumulation of these neurotransmitters. (D) The most serious adverse reactions of MAO inhibitors involve blood pressure.

NEW QUESTION 308

- (Topic 3)

A 3-month-old infant has had a unilateral cleft lip repair. He has resumed feedings of oral formula. The nurse should feed the infant with:

- A. Gavage tube
- B. Nipple and bottle
- C. A straw and cup
- D. Syringe

Answer: D

Explanation:

(A) A gavage tube may damage suture line. It is the most invasive and should be the last measure. (B) A nipple and bottle require sucking, which may damage sutures. (C) A 3-month-old infant is not able to drink from a straw. (D) A syringe allows for the formula to be placed to the side and back of the mouth. This minimizes the amount of sucking needed.

NEW QUESTION 309

- (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 313

- (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 314

- (Topic 3)

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

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

Answer: D

Explanation:

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

NEW QUESTION 317

- (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 320

- (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 324

- (Topic 3)

A pregnant client experiences spontaneous rupture of membranes. The first nursing action is to:

- A. Assess the client's respirations
- B. Notify the physician
- C. Auscultate fetal heart rate
- D. Transfer to delivery suite

Answer: C

Explanation:

(A) Immediately following membrane rupture, the fetus is at risk for complications, not necessarily the mother. (B) The physician is notified after the nurse completes an assessment of the mother's and fetus's conditions. (C) Rupture of membranes facilitates fetal descent. A potential complication is cord prolapse, which is assessed by auscultating fetal heart rate. (D) Rupture of membranes does not necessarily indicate readiness to deliver.

NEW QUESTION 325

- (Topic 3)

A 13-year-old hemophiliac is hospitalized for hemarthrosis of his right knee. To relieve the pain, the nurse should:

- A. Place on bed rest; elevate and splint the right knee
- B. Apply moist heat to the right knee
- C. Administer aspirin for pain
- D. Encourage active range of motion to right knee

Answer: A

Explanation:

(A) Immobilization, splinting, and bed rest will reduce the bleeding. Once bleeding is reduced or stopped, the pain will subside. (B) Moist heat causes vasodilation and bleeding. Ice or cold compresses should be applied. (C) Aspirin decreases platelet aggregation, which causes bleeding. (D) Active range of motion aggravates bleeding and damages the synovial sac during bleeding episodes.

NEW QUESTION 329

- (Topic 3)

A cardinal symptom of the schizophrenic client is hallucinations. A nurse identifies this as a problem in the category of:

- A. Impaired communication
- B. Sensory-perceptual alterations
- C. Altered thought processes
- D. Impaired social interaction

Answer: B

Explanation:

(A) Impaired communication refers to decreased ability or inability to use or understand language in an interaction. (B) In sensory-perceptual alterations an individual has distorted, impaired, or exaggerated responses to incoming stimuli (i.e., a hallucination, which is a false sensory perception that is not associated with real external stimuli). (C) An altered thought processes problem statement is used when an individual experiences a disruption in cognitive operations and activities (i.e., delusions, loose associations, ideas of reference). (D) In impaired social interaction, the individual participates too little or too much in social interactions.

NEW QUESTION 331

- (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 335

- (Topic 3)

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

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

Answer: A

Explanation:

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

NEW QUESTION 337

- (Topic 3)

A female client who has chronic obstructive pulmonary disease (COPD) has presented in the emergency department with cough productive of yellow sputum and increasing shortness of breath. On room air, her blood gases are as follows: pH 7.30 mm Hg, PCO₂ 60 mm Hg, PO₂ 55 mm Hg, HCO₃ 32 mEq/L. These arterial blood gases reflect:

- A. Compensated respiratory acidosis
- B. Normal blood gases
- C. Uncompensated metabolic acidosis
- D. Uncompensated respiratory acidosis

Answer: D

Explanation:

(A) In compensated respiratory acidosis, the pH level is normal, the PCO₂ level is elevated, and the HCO₃ level is elevated. The client's primary alteration is an inability to remove CO₂ from the lungs, so over time, the kidneys increase reabsorption of HCO₃ to buffer the CO₂. (B) Normal ranges for arterial blood gases for adults and children are as follows: pH 7.35–7.45, PO₂ 80–100 mm Hg, PCO₂ 35–45 mm Hg, HCO₃ 21–28 mEq/L. (C) In uncompensated metabolic acidosis the pH level is decreased, the PCO₂ level is normal, and the HCO₃ level is decreased. The client's primary alteration is an inability to remove excess acid via the kidneys. The lungs are unable to clear the increased acid. (D) In uncompensated respiratory acidosis, the pH level is decreased, the PCO₂ level is increased, and the HCO₃ level is normal. In a person with long-standing COPD, the HCO₃ level will rise gradually over time to compensate for the gradually increasing PCO₂, and the person's pH level will be normal. When a person with COPD becomes acutely ill, the kidneys do not have time to increase the reabsorption of HCO₃, so the person's pH level will reflect acidosis even though the HCO₃ is elevated.

NEW QUESTION 338

- (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 339

- (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 341

- (Topic 3)

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

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

Answer: D

Explanation:

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

NEW QUESTION 343

- (Topic 3)

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

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

Answer: B

Explanation:

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

NEW QUESTION 344

- (Topic 3)

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

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

Answer: A

Explanation:

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

NEW QUESTION 348

- (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 349

- (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 351

- (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 356

- (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 trauma causes 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 x-ray 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 360

- (Topic 3)

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

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

Answer: A

Explanation:

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

NEW QUESTION 364

- (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 366

- (Topic 4)

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

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

Answer: B

Explanation:

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

NEW QUESTION 367

- (Topic 4)

On an assessment of a client's mouth, the nurse notices white patches on the buccal mucosa. The nurse tries to obtain a sample for a culture, but the lesion cannot be rubbed off. The nurse would suspect that this lesion is:

- A. Xerostomia
- B. Candidiasis
- C. Leukoplakia
- D. Stomatitis

Answer: C

Explanation:

(A) Xerostomia is dry mouth. (B) Candidiasis can be rubbed off, but it will bleed. (C) Leukoplakia cannot be rubbed off. (D) Stomatitis is caused by candidiasis and gram-negative bacteria.

NEW QUESTION 371

- (Topic 4)

A 58-year-old client on a general surgery unit is scheduled for transurethral resection of the prostate (TURP) in 2 hours. The nurse explains to the client that this procedure means:

- A. Removal of the prostate tissue by way of a lower abdominal midline incision through the bladder and into the prostate gland
- B. Removal of prostate tissue by a resectoscope that is inserted through the penile urethra
- C. Removal of the prostate tissue by an open surgical approach through an incision between the ischial tuberosities, the scrotum, and the rectum
- D. Removal of prostate tissue by an open surgical approach through a low horizontal incision, bypassing the bladder, to the prostate gland

Answer: B

Explanation:

(A) This describes a suprapubic (transvesical) prostatectomy procedure. (B) This is the correct description of a TURP procedure. (C) This describes a perineal prostatectomy procedure. (D) This describes a retropubic (extravesical) prostatectomy procedure.

NEW QUESTION 375

- (Topic 4)

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

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

Answer: C

Explanation:

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

NEW QUESTION 377

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