

QUESTION 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.

QUESTION 2

Signs and symptoms of an allergy attack include which of the following?

- A. Wheezing on inspiration
- B. Increased respiratory rate
- C. Circumoral cyanosis
- D. Prolonged expiration

Answer: D

Explanation:

(A) Wheezing occurs during expiration when air movement is impaired because of constricted edematous bronchial lumen. (B) Respirations are difficult, but the rate is frequently normal. (C) The circumoral area is usually pale. Cyanosis is not an early sign of hypoxia. (D) Expiration is prolonged because the alveoli are greatly distended and air trapping occurs.

QUESTION 3

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

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

Answer: B

Explanation:

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

QUESTION 4

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.

QUESTION 5

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

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

Answer: C

Explanation:

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

QUESTION 6

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.

QUESTION 7

A client with bipolar disorder taking lithium tells the nurse that he has ringing in his ears, blurred vision, and diarrhea

A. The nurse notices a slight tremor in his left hand and a slurring pattern to his speech. Which of the following actions by the nurse is appropriate?

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

Answer: C

Explanation:

- (A) These symptoms are indicative of lithium toxicity. A stat dose of lithium could be fatal.
 - (B) These are toxic effects of lithium therapy. (C) The client is exhibiting symptoms of lithium toxicity, which may be validated by lab studies. (D) There is no known lithium antidote.
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QUESTION 8

A diagnosis of hepatitis C is confirmed by a male client's physician. The nurse should be knowledgeable of the differences between hepatitis A, B, and C. Which of the following are characteristics of hepatitis C?

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

Answer: C

Explanation:

- (A) Hepatitis C and B may result in chronic liver disease. Hepatitis A has a low potential for chronic liver disease. (B) Hepatitis C and B have insidious onsets. Hepatitis A has an abrupt onset. (C) Incubation periods are as follows: hepatitis C is 2–26 weeks, hepatitis B is 6–20 weeks, and hepatitis A is 2–6 weeks. (D) Only hepatitis B has an effective vaccine.
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QUESTION 9

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.
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QUESTION 10

Which of the following activities would be most appropriate during occupational therapy for a client with bipolar disorder?

- A. Playing cards with other clients
- B. Working crossword puzzles
- C. Playing tennis with a staff member
- D. Sewing beads on a leather belt

Answer: C

Explanation:

(A) This activity is too competitive, and the manic client might become abusive toward the other clients. (B) During mania, the client's attention span is too short to accomplish this task. (C) This activity uses gross motor skills, eases tension, and expands excess energy. A staff member is better equipped to interact therapeutically with clients. (D) This activity requires the use of fine motor skills and is very tedious.

QUESTION 11

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

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

Answer: C

Explanation:

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

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

QUESTION 12

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.

QUESTION 13

When evaluating a client with symptoms of shock, it is important for the nurse to differentiate between neurogenic and hypovolemic shock. The symptoms of neurogenic shock differ from hypovolemic shock in that:

- A. In neurogenic shock, the skin is warm and dry
- B. In hypovolemic shock, there is a bradycardia
- C. In hypovolemic shock, capillary refill is less than 2 seconds
- D. In neurogenic shock, there is delayed capillary refill

Answer: A

Explanation:

(A) Neurogenic shock is caused by injury to the cervical region, which leads to loss of sympathetic control. This loss leads to vasodilation of the vascular beds, bradycardia resulting from the lack of sympathetic balance to parasympathetic stimuli from the vagus nerve, and the loss of the ability to sweat below the level of injury. In neurogenic shock, the client is hypotensive but bradycardiac with warm, dry skin. (B) In hypovolemic shock, the client is hypotensive and tachycardiac with cool skin. (C) In hypovolemic shock, the capillary refill would be >5 seconds. (D) In neurogenic shock, there is no capillary delay, the vascular beds are dilated, and peripheral flow is good.

QUESTION 14

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

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

Answer: B

Explanation:

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

QUESTION 15

A schizophrenic client has made sexual overtures toward her physician on numerous occasions. During lunch, the client tells the nurse, “My doctor is in love with me and wants to marry me.” This client is using which of the following defense mechanisms?

- A. Displacement
- B. Projection
- C. Reaction formation
- D. Suppression

Answer: B

Explanation:

(A) Displacement involves transferring feelings to a more acceptable object. (B) Projection involves attributing one's thoughts or feelings to another person. (C) Reaction formation involves transforming an unacceptable impulse into the opposite behavior. (D) Suppression involves the intentional exclusion of unpleasant thoughts or experiences.

QUESTION 16

When teaching a sex education class, the nurse identifies the most common STDs in the United States as:

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

Answer: A

Explanation:

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

QUESTION 17

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.

QUESTION 18

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.

QUESTION 19

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

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

Answer: D

Explanation:

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

QUESTION 20

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.

QUESTION 21

An 8-year-old child comes to the physician's office complaining of swelling and pain in the knees. His mother says, "The swelling occurred for no reason, and it keeps getting worse."

The initial diagnosis is Lyme disease. When talking to the mother and child, questions related to which of the following would be important to include in the initial history?

- A. A decreased urinary output and flank pain
- B. A fever of over 103F occurring over the last 2–3 weeks
- C. Rashes covering the palms of the hands and the soles of the feet
- D. Headaches, malaise, or sore throat

Answer: D

Explanation:

(A) Urinary tract symptoms are not commonly associated with Lyme disease. (B) A fever of 103F is not characteristic of Lyme disease. (C) The rash that is associated with Lyme disease does not appear on the palms of the hands and the soles of the feet. (D) Classic symptoms of Lyme disease include headache, malaise, fatigue, anorexia, stiff neck, generalized lymphadenopathy, splenomegaly, conjunctivitis, sore throat, abdominal pain, and cough.

QUESTION 22

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

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

Answer: A

Explanation:

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

QUESTION 23

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.

QUESTION 24

Three weeks following discharge, a male client is readmitted to the psychiatric unit for depression. His wife stated that he had threatened to kill himself with a handgun. As the nurse admits him to the unit, he says, "I wish I were dead because I am worthless to everyone; I guess I am just no good." Which response by the nurse is most appropriate at this time?

- A. "I don't think you are worthless. I'm glad to see you, and we will help you."
- B. "Don't you think this is a sign of your illness?"
- C. "I know with your wife and new baby that you do have a lot to live for."
- D. "You've been feeling sad and alone for some time now?"

Answer: D

Explanation:

- (A) This response does not acknowledge the client's feelings.
 - (B) This is a closed question and does not encourage communication.
 - (C) This response negates the client's feelings and does not require a response from the client. (D) This acknowledges the client's implied thoughts and feelings and encourages a response.
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QUESTION 25

Which of the following should be included in discharge teaching for a client with hepatitis C?

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

Answer: C

Explanation:

- (A) Aspirin is hepatotoxic, may increase bleeding, and should be avoided. (B) Blood should not be donated by a client who has had hepatitis C because of the possibility of transmission of disease. (C) Alcohol is detoxified in the liver. (D) Hepatitis C is not spread through the oral route.
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QUESTION 26

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

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

Answer: B

Explanation:

- (A) In the past, neutralizing solutions were recommended, but presently there is concern that these solutions

extend the depth of burn are

A. (B) The use of large amounts of water to flush the area is recommended for chemical burns. (C) Calcium chloride is not recommended therapy and would likely worsen the problem. (D) Lanolin is of no benefit in the initial treatment of a chemical injury and may actually extend a thermal injury.

QUESTION 27

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

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

Answer: D

Explanation:

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

QUESTION 28

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.

QUESTION 29

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.

QUESTION 30

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?

QUESTION 31

The child with iron poisoning is given IV deferoxamine mesylate (Desferal). Following administration, the child suffers hypotension, facial flushing, and urticari

- A. 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.

QUESTION 32

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

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

Answer: A

Explanation:

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

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

QUESTION 33

A client has been diagnosed as being preeclamptic. The physician orders magnesium sulfate. Magnesium sulfate (MgSO₄) is used in the management of preeclampsia for:

- A. Prevention of seizures
- B. Prevention of uterine contractions
- C. Sedation
- D. Fetal lung protection

Answer: A

Explanation:

(A) MgSO₄ is classified as an anticonvulsant drug. In preeclampsia management, MgSO₄ is used for prevention of seizures. (B) MgSO₄ has been used to inhibit hyperactive labor, but results are questionable. (C) Negative side effects such as respiratory depression should not be confused with generalized sedation. (D) MgSO₄ does not affect lung maturity. The infant should be assessed for neuromuscular and respiratory depression.

QUESTION 34

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.

QUESTION 35

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

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

Answer: D

Explanation:

(A) Sodium enters the edema fluid in the burned area, lowering the sodium content of the vascular fluid. Hyponatremia may continue for days to several weeks because of sodium loss to edema, sodium shifting into the cells, and later, diuresis. (B) Hypocalcemia occurs because of calcium loss to edema fluid at the burned site (third space fluid). (C) Protein loss occurs at the burn site owing to increased capillary permeability. Serum protein levels remain low until healing occurs. (D) Hematocrit level is elevated owing to hemoconcentration from hypovolemia.

A. Anemia is present in the postburn stage owing to blood loss and hemolysis, but it cannot be assessed until the client is adequately hydrated.

QUESTION 36

What is the most effective method to identify early breast cancer lumps?

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

Answer: D

Explanation:

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

QUESTION 37

A client with a C-3–4 fracture has just arrived in the emergency room. The primary nursing intervention is:

- A. Stabilization of the cervical spine
- B. Airway assessment and stabilization
- C. Confirmation of spinal cord injury
- D. Normalization of intravascular volume

Answer: B

Explanation:

(A) If cervical spine injury is suspected, the airway should be maintained using the jaw thrust method that also protects the cervical spine. (B) Primary intervention is protection of the airway and adequate ventilation. (C, D) All other interventions are secondary to adequate ventilation.

QUESTION 38

To ensure proper client education, the nurse should teach the client taking SL nitroglycerin to expect which of the following responses with administration?

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

Answer: A

Explanation:

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

QUESTION 39

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.

QUESTION 40

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.

QUESTION 41

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.

QUESTION 42

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.

QUESTION 43

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.

QUESTION 44

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.

QUESTION 45

Which of the following risk factors associated with breast cancer would a nurse consider most significant in a client's history?

- A. Menarche after age 13
- B. Nulliparity
- C. Maternal family history of breast cancer
- D. Early menopause

Answer: C

Explanation:

(A) Women who begin menarche late (after 13 years old) have a lower risk of developing breast cancer than women who have begun earlier. Average age for menarche is 12.5 years. (B) Women who have never been pregnant have an increased risk for breast cancer, but a positive family history poses an even greater risk. (C) A positive family history puts a woman at an increased risk of developing breast cancer. It is recommended that mammography screening begin 5 years before the age at which an immediate female relative was diagnosed with breast cancer. (D) Early menopause decreases the risk of developing breast cancer.

QUESTION 46

A client returns for her 6-month prenatal checkup and has gained 10 lb in 2 months. The results of her physical

examination are normal. How does the nurse interpret the effectiveness of the instruction about diet and weight control?

- A. She is compliant with her diet as previously taught.
- B. She needs further instruction and reinforcement.
- C. She needs to increase her caloric intake.
- D. She needs to be placed on a restrictive diet immediately.

Answer: B

Explanation:

(A) She is probably not compliant with her diet and exercise program. Recommended weight gain during second and third trimesters is approximately 12 lb. (B) Because of her excessive weight gain of 10 lb in 2 months, she needs re-evaluation of her eating habits and reinforcement of proper dietary habits for pregnancy. A 2200-calorie diet is recommended for most pregnant women with a weight gain of 27–30 lb over the 9-month period. With rapid and excessive weight gain, PIH should also be suspected. (C) She does not need to increase her caloric intake, but she does need to re-evaluate dietary habits. Ten pounds in 2 months is excessive weight gain during pregnancy, and health teaching is warranted. (D) Restrictive dieting is not recommended during pregnancy.

QUESTION 47

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.

QUESTION 48

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

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

Answer: D

Explanation:

(A) Norepinephrine's side effects are primarily related to safe, effective care environment and include decreased peripheral perfusion and bradycardia

A. (B) Dobutamine's side effects include increased heart rate and blood pressure, ventricular ectopy, nausea,

and headache. (C) Propranolol's side effects include elevated blood urea nitrogen, serum transaminase, alkaline phosphatase, and lactic dehydrogenase. (D) Epinephrine increases serum glucose levels by increasing glycogenolysis and inhibiting insulin release. Prolonged use can elevate serum lactate levels, leading to metabolic acidosis, increased urinary catecholamines, false elevation of blood urea nitrogen, and decreased coagulation time.

QUESTION 49

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

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

Answer: D

Explanation:

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

QUESTION 50

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

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

Answer: C

Explanation:

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

QUESTION 51

Which of the following statements relevant to a suicidal client is correct?

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

Answer: A

Explanation:

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

QUESTION 52

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

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

Answer: B

Explanation:

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

QUESTION 53

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

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

Answer: B

Explanation:

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

QUESTION 54

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.

QUESTION 55

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.

QUESTION 56

A client with emphysema is placed on diuretics. In order to avoid potassium depletion as a side effect of the drug therapy, which of the following foods should be included in his diet?

- A. Celery
- B. Potatoes
- C. Tomatoes
- D. Liver

Answer: B

Explanation:

(A) Celery is high in sodium. (B) Potatoes are high in potassium. (C) Tomatoes are high in sodium. (D) Liver is high in iron.

QUESTION 57

Which of the following signs and symptoms indicates a tension pneumothorax as compared to an open pneumothorax?

- A. Ventilation-perfusion (V./Q.) mismatch
- B. Hypoxemia and respiratory acidosis
- C. Mediastinal tissue and organ shifting
- D. Decreased tidal volume and tachypnea

Answer: C

Explanation:

(A, B, D) These occur in both tension pneumothorax and open pneumothorax. (C) The tension pneumothorax acts like a one-way valve so that the pneumothorax increases with each breath. Eventually, it occupies enough space to shift mediastinal tissue toward the unaffected side away from the midline. Tracheal deviation, movement of point of maximum impulse, and decreased cardiac output will occur. The other three options will occur in both types of pneumothorax.

QUESTION 58

A 38-year-old pregnant woman visits her nurse practitioner for her regular prenatal checkup. She is 30 weeks' gestation. The nurse should be alert to which condition related to her age?

- A. Iron-deficiency anemia
- B. Sexually transmitted disease (STD)
- C. Intrauterine growth retardation
- D. Pregnancy-induced hypertension (PIH)

Answer: D

Explanation:

(A) Iron-deficiency anemia can occur throughout pregnancy and is not age related. (B) STDs can occur prior to or during pregnancy and are not age related. (C) Intrauterine growth retardation is an abnormal process where fetal development and maturation are delayed. It is not age related. (D) Physical risks for the pregnant client older than 35 include increased risk for PIH, cesarean delivery, fetal and neonatal mortality, and trisomy.

QUESTION 59

A type I diabetic client is diagnosed with cellulitis in his right lower extremity. The nurse would expect which of the following to be present in relation to his blood sugar level?

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

Answer: C

Explanation:

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

QUESTION 60

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.

QUESTION 61

The cardiac client who exhibits the symptoms of disorientation, lethargy, and seizures may be exhibiting a toxic reaction to:

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

Answer: B

Explanation:

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

QUESTION 62

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.

QUESTION 63

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.

QUESTION 64

Discharge teaching was effective if the parents of a child with atopic dermatitis could state the importance of:

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

Answer: D

Explanation:

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

QUESTION 65

Which of the following would differentiate acute from chronic respiratory acidosis in the assessment of the trauma client?

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

Answer: C

Explanation:

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

QUESTION 66

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

- A. Phentolamine (Regitine)
- B. Epinephrine

- C. Phenylephrine (Neo-Synephrine)
- D. Sodium bicarbonate

Answer: A

Explanation:

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

QUESTION 67

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

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

Answer: C

Explanation:

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

QUESTION 68

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

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

Answer: C

Explanation:

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

QUESTION 69

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.

QUESTION 70

Priapism may be a sign of:

- A. Altered neurological function
- B. Imminent death
- C. Urinary incontinence
- D. Reproductive dysfunction

Answer: A

Explanation:

(A) Priapism in the trauma client is due to the neurological dysfunction seen in spinal cord injury. Priapism is an abnormal erection of the penis; it may be accompanied by pain and tenderness. This may disappear as spinal cord edema is relieved. (B) Priapism is not associated with death. (C) Urinary retention, rather than incontinence, may occur. (D) Reproductive dysfunction may be a secondary problem.

QUESTION 71

When assessing fetal heart rate status during labor, the monitor displays late decelerations with tachycardia and decreasing variability. What action should the nurse take?

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

Answer: D

Explanation:

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

QUESTION 72

The most commonly known vectors of Lyme disease are:

- A. Mites
- B. Fleas

- C. Ticks
- D. Mosquitoes

Answer: C

Explanation:

(A) Mites are not the common vector of Lyme disease. (B) Fleas are not the common vector of Lyme disease. (C) Ticks are the common vector of Lyme disease. (D) Mosquitoes are not the common vector of Lyme disease.

QUESTION 73

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.

QUESTION 74

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.

QUESTION 75

Which of the following would the nurse expect to find following respiratory assessment of a client with advanced emphysema?

- A. Distant breath sounds
- B. Increased heart sounds
- C. Decreased anteroposterior chest diameter
- D. Collapsed neck veins

Answer: A

Explanation:

(A) Distant breath sounds are found in clients with emphysema owing to increased anteroposterior chest diameter, overdistention, and air trapping. (B) Decreased heart sounds are present because of the increased anteroposterior chest diameter. (C) A barrel-shaped chest is characteristic of emphysema.

A. (D) Increased distention of neck veins is found owing to right-sided heart failure, which may be present in advanced emphysema.

QUESTION 76

Which of the following would have the physiological effect of decreasing intracranial pressure (ICP)?

- A. Increased core body temperature
- B. Decreased serum osmolality
- C. Administration of hypo-osmolar fluids
- D. Decreased PaCO₂

Answer: D

Explanation:

(A) An increase in core body temperature increases metabolism and results in an increase in ICP. (B) Decreased serum osmolality indicates a fluid overload and may result in an increase in ICP. (C) Hypo-osmolar fluids are generally voided in the neurologically compromised. Using IV fluids such as D5W results in the dextrose being metabolized, releasing free water that is absorbed by the brain cells, leading to cerebral edema.

A. (D) Hypercapnia and hypoventilation, which cause retention of CO₂ and lead to respiratory acidosis, both increase ICP. CO₂ is the most potent vasodilator known.

QUESTION 77

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

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

Answer: C

Explanation:

(A) Diluted fruit juices are not recommended for rehydration because they tend to aggravate the diarrhea.

A. (B) Diluted soft drinks have a high-carbohydrate content, which aggravates the diarrhea.

A. (C) Soy-based, lactose-free formula reduces stool output and duration of diarrhea in most infants. (D) Regular formulas contain lactose, which can increase diarrhea.

QUESTION 78

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

- A. High protein and low carbohydrate
- B. Low calorie and low protein

- C. High carbohydrate and high calorie
- D. Low carbohydrate and high calorie

Answer: C

Explanation:

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

QUESTION 79

A long-term goal for the nurse in planning care for a depressed, suicidal client would be to:

- A. Provide him with a safe and structured environment.
- B. Assist him to develop more effective coping mechanisms.
- C. Have him sign a “no-suicide” contract.
- D. Isolate him from stressful situations that may precipitate a depressive episode.

Answer: B

Explanation:

(A) This statement represents a short-term goal. (B) Long-term therapy should be directed toward assisting the client to cope effectively with stress. (C) Suicide contracts represent short-term interventions. (D) This statement represents an unrealistic goal. Stressful situations cannot be avoided in reality.

QUESTION 80

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.

QUESTION 81

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

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

D. The nurse should administer an alcohol backrub at bedtime.

Answer: A

Explanation:

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

QUESTION 82

When inspecting a cardiovascular client, the nurse notes that he needs to sit upright to breathe. This behavior is most indicative of:

- A. Pericarditis
- B. Anxiety
- C. Congestive heart failure
- D. Angina

Answer: C

Explanation:

(A) Pericarditis can cause dyspnea but primarily causes chest pain. (B) Anxiety can cause dyspnea resulting in SOB, yet it is not typically influenced by degree of head elevation. (C) The inability to oxygenate well without being upright is most indicative of congestive heart failure, due to alveolar drowning. (D) Angina causes primarily chest pain; any SOB associated with angina is not influenced by body position.

QUESTION 83

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

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

Answer: B

Explanation:

(A) Exercise should not be performed before meals because the blood sugar is usually lower just prior to eating; therefore, there is an increased risk for hypoglycemia

A. (B) Exercise lowers blood sugar levels; therefore, a snack may be needed to maintain the appropriate glucose level. (C) Exercise lowers blood sugar levels. (D) Exercise lowers blood sugar levels. If the blood glucose level is 100 mg or below at the start of exercise, the potential for hypoglycemia is greater.

QUESTION 84

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.

QUESTION 85

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.

QUESTION 86

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 β -blocking agents, which can increase airway resistance and cause bronchospasms.