HESI Computerized Adaptive Testing (CAT) Test Bank With Rationales.

HESI Computerized Adaptive Testing(CAT) Test Bank

Question 1

A nurse is counseling the spouse of a client who has a history of alcohol abuse. What doesthe nurse explain is the main reason for drinking alcohol in people with a long history of alcohol abuse?

A. They are dependent on it.
B. They lack the motivation to stop.
C. They use it for coping.
D. They enjoy the associated socialization. ✓ Ans- a

Alcohol causes both physical and psychological dependence; the individual needs the alcohol to function. Alcoholism is a disorder that entails physical and psychological dependence. Because alcohol is so physiologically addictive, the client's body craves the alcohol, so most clients lack the motivation to stop because they will go into withdrawal. Clients who abuse alcohol have numbed their ability to utilize other coping mechanisms, soalcohol is used as an excuse for coping. People with alcoholism usually drink alone or feel alone in a crowd; socialization is not the prime reason for their drinking.

Question 2

How do adolescents establish family identity during psychosocial development? Select allthat apply.

A. By acting independently to make his or her own decisions
B. By evaluating his or her own health with a feeling of well-being
C. By fostering his or her own development within a balanced family structure
D. By building close peer relationships to achieve acceptance in the society
E. By achieving marked physical changes ✓ Ans- ac

An adolescent establishes family identity by acting independently for taking important decisions about self. They also need to foster their development along with maintaining a balanced family structure. Health identity is associated with the evaluation of one's own health with a feeling of well-being. By building close peer relationships, an adolescent develops a sense of belonging, approval, and the opportunity to learn acceptable behavior. These actions establish an adolescent's group identity. The sound and healthy growth of the adolescent, with marked physical changes, helps to build an adolescent's sexual identity.

Question 3

A clinic nurse observes a b-year-old client sitting alone, rocking and staring at a small, shiny top that she is spinning. Later the father relates his concerns, stating, "She pushes me away. She doesn't speak, and she only shows feelings when I take her top away. Is it something I've done?" What is the most therapeutic initial response by the nurse?

A. Asking the father about his relationship with his wife
B. Asking the father how he held the child when she was an infant
C. Telling the father that it is nothing he has done and sharing the nurse's observations of the child
D. Telling the father not to be concerned and stressing that the child will outgrow this developmental phase ✓ Ans- c

The nurse provides support in a nonjudgmental way by sharing information and observations about the child. This child exhibits symptoms of autism, which is not attributable to the actions of the parents. Asking the father about his relationship with his wife or how he held the child when she was an infant indirectly indicates that the parent may be at fault; it negates the father's need for support and increases his sense of guilt.
Telling the father not to be concerned and stressing that the child will outgrow this developmental phase is false reassurance that does not provide support; the father recognizes that something is wrong.

Question 4

What is most appropriate for a nurse to say when interviewing a newly admitted depressed client whose thoughts are focused on feelings of worthlessness and failure?

A. "Tell me how you feel about yourself."
B. "Tell me what has been bothering you."
C. "Why do you feel so bad about yourself?"

D. "What can we do to help you while you're here?" ✓ Ans- a

Because major depression is a result of the client's feelings of self-rejection, it is important for the nurse to have the client initially identify these feelings before developing a plan of care. Later discussion should be focused on other topics to prevent reinforcement of negative thoughts and feelings. "Tell me what has been bothering you" is asking the client to draw a conclusion; the client may be unable to do so at this time. Also, depression may be related not to external events but instead to a client's psychobiology. Asking why does not let a client explore feelings; it usually elicits an "I don't know" response. "What can we do to help you while you're here?" is beyond the scope of the client's abilities at this time.

Question 5

A client is admitted to the mental health unit with the diagnosis of major depressive disorder. Which statement alerts the nurse to the possibility of a suicide attempt?

A. ”I don't feel too good today."
B. "I feel much better; today is a lovely day."
C. "I feel a little better, but it probably won't last." d

D. "I'm really tired today, so I'll take things a little slower." ✓ Ans- b

A rapid mood upswing and psychomotor change may signal that the client has made a decision and has developed a plan for suicide. "I don't feel too good today"; "I feel a little better, but it probably won't last"; and "I'm really tired today, so I'll take things a little slower" are all typical of the depressed client; none of these statements signals a change in mood.

Question 6

During a group discussion it is learned that a group member hid suicidal urges and committed suicide several days ago. What should the nurse leading the group be prepared to manage?

A. Guilt of the co-leaders for failing to anticipate and prevent the suicide
B. Guilt of group members because they could not prevent another's suicide
C. Lack of concern over the suicide expressed by several of the members in the group
D. Fear by some members that their own suicidal urges may go unnoticed and that they may go unprotected ✓ Ans- d

Ambivalence about life and death, plus the introspection commonly found in clients with emotional problems, can lead to increased anxiety and fear among the group members. These feelings must be handled within the support and supervisory systems for the staff; the group members are the primary concern. Guilt that the group's leaders or members might feel because they could not

prevent another's suicide will probably be a secondary concern of the group leader. Lack of concern over the suicide expressed by several of the members in the group is not a primary concern, but this should be explored later to determine the reason for such apparent indifference, which may be a mask to cover true feelings.

Question 7

Which screening report will help the nurse determine skeletal growth in a child?

A. Electroencephalogram reports
B. Radiographs of the hand and wrist
C. Magnetic resonance imaging (MRI)
D. Denver Developmental Screening Test ✓ Ans- b

Skeletal growth in a child can be determined from the ossification centers. At e to f months of age, the capitate and hamate bones in the wrist are the earliest centers. Therefore radiographs of the hand and wrist will help determine skeletal growth in the child.
Electroencephalogram reports will help assess a child's brain activity. MRI is used to scan the internal structures of a client. The Denver Developmental Screening Test is used to understand developmental issues of a child.

Question 8

A client describes his delusions in minute detail to the nurse. How should the nurse respond?

A. Changing the topic to reality-based events
B. Continuing to discuss the delusion with the client
C. Getting the client involved in a social project with peers
D. Disputing the perceptions with the use of logical thinking ✓ Ans- a

Decreasing time spent on delusions prevents reinforcement of psychotic thinking. Discussing reality-based events improves contact with reality. Encouraging discussion will give validity to the delusion. The client will have difficulty getting involved in a social activity; the activity will not stop the delusion. Challenging the client may increase anxiety.

Question 9

A nurse working on a mental health unit is caring for several clients who are at risk for suicide. Which client is at the greatest risk for successful suicide?

E. Young adult who is acutely psychotic

F. Adolescent who was recently sexually abused

G. Older single man just found to have pancreatic cancer

H. Middle-age woman experiencing dysfunctional grieving ✓ Ans- c

Older single men with chronic health problems are at the highest risk of suicide. This is because men have fewer social supports than women do. (Men are less social then women in general.) Less social support at times of stress can increase the risk of suicide. Also, chronic health problems can lead to learned helplessness, which can lead to depression.
People who are acutely psychotic as a group are at higher risk for suicide, but they do not have the suicide rate of older single adult men with chronic health problems. An adolescent who was recently sexually abused, although severely traumatized, does not have the risk of suicide of an older single man with chronic health problems. Dysfunctional grieving is prolonged grieving that is characterized by greater disability and dysfunctional patterns of behavior. Although people with complicated dysfunctional grieving may be at risk for self- directed violence, they do not have the suicide risk of older single men with chronic health problems.

Question 10

Which stages would the nurse explain that a toddler goes through, according to Freud'stheory? Select all that apply.

A. Oral
B. Anal
C. Phallic
D. Genital
E. Latency ✓ Ans- ab

According to Freud's theory, a toddler goes through the oral and anal stages. The phallic stage is seen in children between the ages of c to f years. The genital stage is seen during puberty through adulthood. The latency stage is seen in children ages f to ab years of age.

Question 12

A client is found to have a borderline personality disorder. What behavior does the nurseconsider is most typical of these clients?

A. Inept
B. Eccentric
C. Impulsive
D. Dependent ✓ Ans- c

Impulsive, potentially self-damaging behaviors are typical of clients with this personalitydisorder. Inept behavior, by itself, is not typical of clients with any specific personality disorder. Eccentric behavior is more typical of the client with a schizotypal personality disorder. Dependent behavior is more typical of the client with a dependent personality disorder.

Question 13

An older adult, accompanied by family members, is admitted to a long-term care facilitywith symptoms of dementia. What initial statement by the nurse during the admission procedure would be most helpful to this client?

A. "You're a little disoriented now, but don't worry. You'll be all right in a few days."
B. "Don't be afraid. I'm your nurse, and everyone here in the hospital is here to help you."
C. "I'm the nurse on duty today. You're in the hospital. Your family can stay with you for a while."
D. "Let me introduce you to the staff here first. In a little while I'll get you acquainted with ourunit routine." ✓ Ans- b

Familiarity with the environment and a self-introduction may help promote security and feelings of trust. Telling the client "You're a little disoriented now, but don't worry. You'll be all right in a few days" denies the client's feelings and provides false reassurance. A self-introducing one's self followed by telling the client that of being in the hospital and that thefamily may stay for a while denies the client's feelings but does provide self-introduction and orientation regarding the client's location. A person under stress cannot assimilate much information; verbiage could lead to more confusion.

Question 14

Which identity may fail to develop if the adolescent fails to feel a sense of belonging andacceptance?

A. Sexual identity
B. Group identity
C. Family identity
D. Health identity ✓ Ans- b

Failure to feel acceptance and belonging results in failure to establish a group identity. A lack of physical evidence of maturity can predispose the adolescent to fail to establish a sexual identity. Adolescents depend on these physical cues because they want assurance ofmaleness or femaleness and do not wish to be different from their peers. If an adolescent fails to foster independence and balance in the family structure, it may hamper family identity. Healthy adolescents evaluate their own health on the basis of feelings of well- being, ability to function normally, and absence of symptoms.

Question 15

In her eighth month of pregnancy, a bd-year-old client is brought to the hospital by the police, who were called when she barricaded herself in a ladies' restroom of a restaurant. During admission the client shouts, "Don't come near me! My stomach is filled with bombs, and I'll blow up this place if anyone comes near me." What does the nurse conclude that theclient is exhibiting?

A. Ideas of reference
B. Loose associations
C. Delusional thinking
D. Tactile hallucinations ✓ Ans- c

Delusions are false fixed beliefs that have a minimal basis in reality. This is a somatic delusion. Ideas of reference are false beliefs that every statement or action of others relatesto the individual. Loose associations are verbalizations that sound disjointed to the listener.Tactile hallucinations are false sensory perceptions of touch without external stimuli.

Question 16

Which should the nurse encourage for a school-age client diagnosed with a chronic illnessto enhance a sense of accomplishment?

A. Wearing make-up
B. Making up missed work
C. Participating in sports activities
D. Participating in creative activities ✓ Ans- b

Making up missed work is an activity the nurse can encourage to enhance a sense of accomplishment for a school-age client who is diagnosed with a chronic illness. Wearingmake-up is often encouraged for an adolescent client. Participation in sports activities enhances the development of peer relationship in the school-age child. Participating in creative activities allows the school-age child to learn through concrete operations.

Question 17

A nurse is caring for a client exhibiting compulsive behaviors. The nurse concludes that thecompulsive behavior usually incorporates the use of which defense mechanism?

A. Projection
B. Regression
C. Displacement
D. Rationalization ✓ Ans- c

Displacement is the unconscious redirection of an emotion from a threatening

source to a nonthreatening source. Projection is the attribution of one's unacceptable feelings and thoughts to someone else. Regression is the return to an earlier, more comfortable level ofbehavior; it is a retreat from the present. Rationalization is the attempt to make unacceptable behavior or feelings acceptable by justifying the reasons for them.

Question 18

A client is admitted for a biopsy of a tumor in her left breast. The client states, "I know it can't be cancer, because it doesn't hurt." What is the nurse's most therapeutic response?

A. ”Let’s hope that it isn't malignant."
B. ”What do you know about breast cancer?"
C. "Most lumps in the breast are not malignant.”
D. "Has your primary healthcare provider told you that it wasn't cancer?" ✓ Ans- b

Asking what the client knows about breast cancer allows the nurse to assess the client's understanding of breast cancer and to clarify any misconceptions. Saying that they should hope that the growth isn't malignant avoids an opportunity to teach, and it is a type of falsereassurance. The statement may actually increase feelings of hopelessness if the lesion is determined to be malignant. Although correct, stating that most lesions are benign provides a false sense of security and avoids an opportunity to teach. Asking whether the primary healthcare provider has told the client that it wasn't cancer focuses on what the primary healthcare provider said rather than on what the client knows and may limitfurther communication of feelings and beliefs.

Question 19

A nurse in the emergency department is assessing a client who has been physically andsexually assaulted. What is the nurse's priority during assessment?

A. The family's feelings about the attack
B. The client's feelings of social isolation
C. The client's ability to cope with the situation
D. Disturbance in the client's thought processes ✓ Ans- c

The situation is so traumatic that the individual may be unable to use past coping behaviorsto comprehend what has occurred. Assessing emotions that occur in response to news of the attack will occur later. The client should be the focus of care at this time. Social isolationis not an immediate concern. Coping

skills, not thought processes, are challenged at this time.

Question 20

A client is admitted to the psychiatric unit with the diagnosis of obsessive-compulsive disorder. The client washes her hands more than b0 times a day, and they are raw and bloody. What defense mechanism does the nurse conclude that the client is using to ease anxiety?

A. Undoing
B. Projection
C. Introjection
D. Displacement ✓ Ans- a

Undoing is an act that partially negates a previous one; the client is using this defense mechanism to atone for unacceptable acts or wishes. The client is not attributing self- thoughts or impulses to another person or group, which is called projection. The client is not absorbing into the self a hated or loved object (introjection). Displacement is the transferring of feelings from one person, object, or experience onto another, less threatening person, object, or experience.

Question 21

The parents tell the nurse that their preschooler often awakes from sleep screaming in the middle of the night. The preschooler is not easily comforted and screams if the parents try to restrain the child. What does the nurse instruct the parents?

A. "Always read a story to the child before bedtime."
B. "Intervene only if necessary to protect the child from injury."
C. "Discuss counseling options with the primary health care provider."
D. "Try to wake the child and ask the child to describe the dream." ✓ Ans- b

Waking up screaming from sleep at night indicates sleep terrors. The nurse should advise the parents to observe the child and intervene only if there is a risk for injury. Reading a story before bedtime helps to calm the child before sleeping, but it does not ensure that the child will not have a sleep terror. There is no need for professional counseling, because sleep terrors are a common phenomenon in preschool-age children. The child is not aware of anybody's presence during a sleep terror, so it is not appropriate to wake up the child; this may cause the child to scream and thrash more.

Question 22

A client who was forced into early retirement is found to have severe depression. The client says, "I feel useless, and I've got nothing to do." What is the best initial response by the nurse?

A. "Tell me more about feeling useless."
B. "Volunteering can help you fill your time."
C. "Your illness is adding to your current feelings."
D. "Let's talk about what you'd like to be doing right now." ✓ Ans- a

An open-ended response encourages further discussion and allows exploration of feelings. Telling the client that volunteering will help pass the time ignores the client's feelings. The depression is not adding to the feelings; the feelings are causing the depression. Asking the client to talk about what the client would rather be doing ignores the client's feelings.

Question 23

What characteristic is most essential for the nurse caring for a client undergoing mental health care?

A. Empathy
B. Sympathy
C. Organization

D. Authoritarianism ✓ Ans- a

Empathy—understanding and to some extent sharing the emotions of another — encourages the expression of feelings. Empathy is an essential tool in caring for emotionally ill clients. Sympathy, or feeling sorry for someone, may further decrease the client's feelings of self-worth. Although organization may help the client accept limits andorganize activities, it is not as important as empathy. An authoritarian approach will emphasize the client's weak ego and lack of self-esteem.

Question 24

When visiting hours are over, a nurse approaches a client with paranoid schizophrenia, who shouts, "You're the one that made my lover leave me." What conclusion does the nursemake about the client?

A. The patient is disoriented.
B. The patient is actively hallucinating.
C. The patient feels a sense of vulnerability.
D. The patient needs to have limits set after calming down. ✓ Ans- c

The client's low self-esteem precipitates doubt of the lover's feelings, creating a sense of vulnerability. This statement reflects the client's low self-esteem, which is projected onto the nurse as part of the delusion. The client's statements do not reflect disorientation but instead reflect false beliefs, which are common in clients with paranoid schizophrenia. Theclient's statements do not represent hallucinations because they are not false sensory perceptions. Setting limits after the fact is not effective in any situation; limits must be set when the problem occurs.

Question 24

During a survey, the community nurse meets a client who has not visited a gynecologist after the birth of her second child. The client says that her mother or sister never had annual gynecologic examinations. Which factor is influencing the client's health practice?

A. Spiritual belief
B. Family practices
C. Emotional factors
D. Cultural background ✓ Ans- b

Family practices influence the client's perception of the seriousness of diseases. The client does not feel the need to seek preventive care measures because no family member practices preventive care. The client is not

influenced by spiritual beliefs in this instance. An individual's spiritual beliefs and religious practices may restrict the use of certain formsof medical treatment. Emotional factors such as stress, depression, or fear may influence anindividual's health practice; however, this client does not show signs of being affected by emotional factors. The client is said to be influenced by cultural background if he or she follows certain beliefs about the causes of illness and uses customary practices to restore health.

Question 25

A client tells the nurse, "A man is speaking to me from the corner of the room. Can you hearhim?" How should the nurse respond?

A. ”What's he saying to you? Does it make any sense?"
B. "Yes, I hear him, but I can't understand what he's saying."
C. "I don't hear him. There's no one in the corner of the room."
D. "No, I don't hear him, but is it making you uncomfortable to hear him?" ✓ Ans- d

The statement "No, I don't hear him, but is it making you uncomfortable to hear him?" points out reality, identifies potential feelings, and prevents the nurse from supporting the hallucination. Asking what the man is saying to the client and whether it makes any sense isnontherapeutic because it supports and focuses on the hallucination. "Yes, I hear him, but I can't understand what he is saying" is nontherapeutic because it supports and focuses on the hallucination; also, it is not truthful. Although denying hearing the voice and pointing out that there is no one else in the room points out reality, this statement does not focus on the client's feelings.

Question 26

What is the priority nursing objective of the therapeutic psychiatric environment for aconfused client?

A. Helping the client relate to others
B. Making the hospital atmosphere more homelike
C. Helping the client become accepted in a controlled setting
D. Maintaining the highest level of safe, independent function ✓ Ans- d

The therapeutic milieu is directed toward helping the client develop effective ways of functioning safely and independently. Helping the client relate to others is one small part ofthe overall objectives. The therapeutic milieu allows some items from home to make the client less anxious; however, the objective is not to duplicate a home situation. Helping the client become accepted in a controlled setting is a worthwhile objective but not as important as working toward the maximal degree of safe, independent function.

Question 27

Before an amniocentesis, both parents express anxiety about the fetus's safety during thetest. Which nursing intervention is most appropriate in promoting the parents' ability to cope?

A. Initiating a parent-primary healthcare provider conference
B. Reassuring them that the procedure is safe
C. Explaining the procedure, step by step
D. Arranging for the father to be present during the test ✓ Ans- c

Giving the parents information about what to expect during the procedure will help allay their fears and encourage their cooperation. The nurse should be able to provide information and interpretation of procedures for clients; a delay in answering questions may increase a client's concerns. Amniocentesis is a low-risk procedure; however, some complications may occur. If the father is uninformed, viewing the procedure may increasehis anxiety, even though his presence may be comforting to the mother.

Question 28

A young client who has just lost her first job comes to the mental health clinic very upset and says, "I just start crying without any reason and without any warning." How should thenurse respond initially?

A. "Do you know what makes you cry?"
B. "Most of us need to cry from time to time."
C. "Crying unexpectedly can be very upsetting."
D. "Are you having any other problems at this time?" ✓ Ans- c

The response "Crying unexpectedly can be very upsetting" identifies the client's feelings. Asking, "Do you know what makes you cry?" is an unrealistic question; the cause of anxietymay not be known. "Most of us need to cry from time to time" moves the focus away from the client. "Are you having any other problems at this time?" disregards the client'scomment; it is a direct question that may impede communication.

Question 29

A client is admitted to the hospital with the diagnosis of severe anxiety. What should thenurse's plan of care for a client with an anxiety disorder include?

A. Promoting the suppression of anger by the client
B. Supporting the verbalization of feelings by the client
C. Encouraging the client to limit anxiety-related behaviors
D. Restricting the involvement of the client's family during the acute phase ✓ Ans- b

Freedom to ventilate feelings serves as a safety valve to reduce anxiety. The suppression ofanger may increase the client's anxiety. Encouraging the client to limit anxiety-related behaviors is not therapeutic; it may increase the anxiety that the client is feeling.

Restricting the involvement of the client's family during the acute phase may or may not behelpful; the client's family may provide support to the client.

Question 30

Windows in the recreation room of the adolescent psychiatric unit have been broken on numerous occasions. After a group discussion one of the adolescents confides that anotheradolescent client broke them. What should the nurse do when using an assertive intervention instead of aggressive confrontation?

A. Confront the adolescent openly in the group, using a controlled voice and maintaining direct eye contact.
B. Knock on the door of the adolescent's room and ask whether the adolescent would comeout to talk about the situation.
C. Approach the adolescent when the client is alone and, after making direct eye contact, inquire about the involvement in these incidents.
D. Use a trusting approach toward the adolescent and imply that the staff doubts the adolescent's involvement but requests a denial for the record. ✓ Ans- c

A private confrontation with presentation of reported facts allows verification; a calm, direct manner is most assertive. Confronting the adolescent openly in the group, using a controlled voice and maintaining direct eye contact, is aggressive confrontation, not assertive intervention. Knocking on the door of the adolescent's room and asking whether the adolescent would come out to talk about the situation places control in the hands of the client rather than the nurse, and this may lead to aggressive confrontation. Using a trustingapproach toward the adolescent and implying that the staff doubts the adolescent's involvement but requests a denial for the record is not assertive intervention; it is manipulation and is not truthful.

Question 31

A 6-year-old child with autism is nonverbal and makes limited eye contact. What should thenurse do initially to promote social interaction?

A. Encourage the child to sing songs with the nurse.
B. Engage in parallel play while sitting next to the child.
C. Provide opportunities for the child to play with other children.
D. Use therapeutic holding when the child does not respond to verbal interactions. ✓ Ans- b Entering the child's world in a nonthreatening way helps promote trust and eventual interaction with the nurse. Using therapeutic holding may be necessary when a child initiates self-mutilating behaviors. Singing songs with the child participating or providingopportunities for the child to play with other children is unrealistic at this

time; playing with others is a long-term objective.

Question 32

What is an important aspect of nursing care for a client exhibiting psychotic patterns ofthinking and behavior?

A. Helping keep the client oriented to reality
B. Involving the client in activities throughout the day
C. Helping the client understand that it is harmful to withdraw from situations
D. Encouraging the client to discuss why interacting with other people is being avoided ✓ Ans- a

Keeping the withdrawn client oriented to reality prevents further withdrawal into a privateworld. A gradual involvement in selected activities is best. Helping the client understand that it is harmful to withdraw from situations is futile at this time. The psychotic client is unable to tell anyone the reason for avoiding interaction with others.

Question 33

A nurse is volunteering on the community crisis hotline. What is the final objective of thecounseling process?

A. Reducing anxiety
B. Exploring feelings
C. Developing constructive coping skills
D. Accomplishing the debriefing process ✓ Ans- c

Past coping behaviors have been inadequate in resolving the current crisis; new coping skills are needed to manage anxiety-producing conflicts. Reduction of anxiety is an earlyobjective. Exploration of feelings is an immediate objective. Accomplishment of the debriefing process is an early objective.

Question 34

An infant is born with a bilateral cleft palate. Plans are made to begin reconstruction immediately. What nursing intervention should be included to promote parent-infantattachment?

A. Demonstrating positive acceptance of the infant
B. Placing the infant in a nursery away from view of the general public
C. Explaining to the parents that the infant will look normal after the surgery
D. Encouraging the parents to limit contact with the infant until after the surgery ✓ Ans- a

By demonstrating acceptance of the infant, without regard for the defect, the nurse acts as arole model for the parents, thereby encouraging their acceptance. Infants with cleft palates can remain in the newborn nursery; they

should not be hidden. Telling the parents that the child will look normal after surgery is false reassurance; it does not promote parent-infant attachment behaviors. Encouraging the parents to limit contact will delay attachment; the parents should be encouraged to have frequent contact with their infant.

Question 35

A nurse is working with a client experiencing a major depressive episode. What is a long-term outcome for this client?

A. Talking openly about the depressed feelings
B. Identifying and using new defense mechanisms
C. Discussing the unconscious source of the anger
D. Verbalizing realistic perceptions of self and others ✓ Ans- d

A major part of depression involves an inability to accept the self as is, which leads to making demands on others to meet unrealistic needs. Talking about the client's depressedfeelings is a short-term goal; looking at what is causing those feelings is a long-term goal. Developing new defense mechanisms is not the priority, because they tend to help the client avoid reality. Discussing the unconscious source of the anger is not important or crucial to the client's recovery.

Question 36

The nurse finds a client with schizophrenia lying under a bench in the hall. The client says, "God told me to lie here." What is the best response by the nurse?

A. ”I didn't hear anyone talking; come with me to your room."
B. "What you heard was in your head; it was your imagination."
C. "Come to the dayroom and watch television; you'll feel better."
D. "God wouldn't tell you to lie there in the hall. God wants you to behave reasonably." ✓ Ans-a

The nurse is focusing on reality and trying to distract and refocus the client's attention. "What you heard was in your head; it was your imagination" is too blunt and belittling; thisapproach rarely is effective. "Come to the dayroom and watch television; you'll feel better" is false reassurance; the nurse does not know that the client will feel better. "God wouldn't tell you to lie in the hall; God wants you to behave reasonably" may be interpreted as belittling or an attempt to convince the client that the behavior is irrational, which is usually ineffective.

Question 37

A nurse is obtaining a health history from a client who is known to be verbally abusive. Theclient tells the nurse, "You're ugly, and you're probably stupid, too. Why am I stuck with you as my nurse?" What is the best response by the nurse?

A. ”It doesn't matter what you think, because I know I'm a capable nurse."
B. "Tell me more about why my caring for you today is so upsetting to you."
C. "If you like, I will arrange to switch assignments so you can have another nurse."
D. "You are talking inappropriately, so I'm going to leave and will come back when you stopbeing verbally abusive." ✓ Ans- d

The response "You are talking inappropriately, so I'm going to leave and will come backwhen you stop being verbally abusive" provides specific realistic feedback without rejecting the client. The reply "It doesn't matter what you think, because I know I'm a capable nurse" is defensive and insulting to the client. The reply "Tell me more about whymy caring for you today is so upsetting to you" will most likely encourage more inappropriate communication. The client's behavior is the issue, and switching assignments does not address this. The client may view a change of nurse as rejection.

Question 38

A nurse anticipates that most clients with phobias will use which defense mechanisms?

A. Dissociation and denial
B. Introjection and sublimation
C. Projection and displacementd
D. Substitution and reaction formation ✓ Ans- c

Clients with phobias cope with anxiety by placing it on specific persons, objects, or situations through displacement, projection, or both. The person with a phobia recognizes and admits the exaggerated fear as a real part of the self and does not deny it. Neither introjection, whereby a person internalizes and incorporates the traits of another, nor sublimation, whereby socially acceptable behavior is substituted for unacceptable instincts,is related to phobic activity. A less valued object is not substituted for one more highly valued (substitution), nor are the expressed feelings opposite of the experienced feelings offear (reaction formation).

Question 39

A depressed client cries when the family does not visit. What is the most therapeuticresponse by the nurse?

A. ”It's difficult to realize that no one cares about you."

B. "Your family didn't visit, and now you're feeling rejected."
C. "It's terrible to have such negative thoughts about yourself."
D. "Your family members work—that's why they don't visit you." ✓ Ans- b

The statement "Your family didn't visit, and now you're feeling rejected" accurately reflects the client's emotions and may encourage exploration of feelings. The nurse does not know that no one cares about the client, and the statement may increase the client's unhappiness. The client is upset about the lack of visitors; discussing negative self-thoughts changes the subject. The defensive statement "Your family members work—that's why they don't visit you" may worsen the client's self-derogatory feelings.

Question 40

A nurse is caring for a client with the diagnosis of bulimia nervosa. What does the nurse understand to be the function of food for individuals with bulimia?

A. Gain attention
B. Control others
C. Avoid growing up
D. Meet emotional needs ✓ Ans- d

Clients with bulimia [a] [b] eat to blunt emotional pain because they frequently feel unloved, inadequate, or unworthy; purging is precipitated to relieve feelings of guilt for bingeing or out of fear of obesity. The bingeing and purging are usually done alone and in secret. Clients with bulimia often feel out of control and perform their behaviors in secret. A protest against growing up is one of the psychodynamic theories regarding anorexia nervosa, not to bulimia nervosa.

Question 41

A ef-year-old man is admitted to the inpatient unit after family members report that he seems to be experiencing auditory hallucinations. The man has a history of schizophrenia and has had several previous admissions. Which statement indicates to the nurse that the client is experiencing auditory hallucinations?

A. "Get these horrible snakes out of my room!"
B. "I am not the devil! Stop calling me those names!"
C. "The food on this plate has poison in it, so take it away—I won't eat it."
D. "I did see an alien spaceship last night outside in my yard, and I've felt worse ever since." ✓

Ans- b

The client is responding to messages that he is hearing, which are auditory hallucinations. The responses regarding the snakes and the spaceship are

examples of visual hallucinations because they describe what the client sees. The accusation of poisoning is the statement of a client who is suspicious and paranoid but not hallucinating.

Question 42

What statements about culturally congruent care by the student nurse are correct? Select all that apply.

A. ”It is the main goal of transcultural nursing.”
B. "It is provided through cultural competence."
C. "It is provided in accordance with set criteria."
D. "It is bound to the professional health care system."
E. "It depends on the patterns and needs of an individual." ✓ Ans- abe

Culturally congruent care is tailored to the needs of people themselves, not delivered in accordance with predetermined criteria. This care may be different from the values and meanings of the professional health care system. The main goal of transcultural nursing is to provide culturally congruent care. Cultural competence is applied to ensure the delivery of this care. Culturally congruent care is provided in accordance with people's life patterns, values, and beliefs.

Question 43

A hospitalized psychiatric client with the diagnosis of histrionic personality disorder demands a sleeping pill before going to bed. After being refused the sleeping pill, the client throws a book at the nurse. What does the nurse recognize this behavior to be?

A. Exploitive
B. Acting out
C. Manipulative
D. Reaction formation ✓ Ans- b

Acting out is the process of expressing feelings behaviorally. The action is not exploitive, because no evidence is provided to demonstrate that anyone has been used to get what the client wants. The action is not manipulative, because no evidence is provided to demonstrate that anyone has been influenced against his or her wishes. The action is not disguising unacceptable feelings by expressing opposite emotions (reaction formation).

Question 44

A woman who is frequently physically abused tells the nurse in the emergency department that it is her fault that her husband beats her. What is the most therapeutic response by the nurse?

A. ”Maybe it was your husband's fault, too."

B. "I can't agree with that—no one should be beaten."
C. "Tell me why you believe that you deserve to be beaten."
D. "You say that it was your fault—help me understand that." ✓ Ans- d

Paraphrasing and clarifying are interviewing techniques that promote communication between the nurse and client and help the client hear and explore her words and gain insight into her behavior. "Maybe it was your husband's fault, too" is a declarative statement that is closed, will limit dialog, and is not therapeutic. When the nurse voices her opinion saying, "I can't agree with that—no one should be beaten", the nurse is shutting off communication with the client. Nurses are to be nonjudgmental and not offer an opinion, and should ask open-ended questions to facilitate communication with the client. Asking a "why" question is generally not therapeutic because most clients cannot respond to these questions with logical explanations.

Question 45

After counseling an older widowed client, a nurse concludes that the grieving process has been successfully completed when the client does what?

A. Is able to plan to start new relationships
B. Talks about the deceased spouse at great length
C. Ignores the deceased spouse's less-than-perfect qualities
D. Decides to leave the deceased spouse's study as it was before the death ✓ Ans- a

A healthy resolution helps the person move away from the old, safe, familiar relationship to establish new ones. Talking about the deceased spouse at great length is termed obsessional review; the mourner can talk of nothing else but the deceased and events surrounding the death. A reduction in obsessional review is a healthy sign. With a positive outcome to the grieving process, the mourner is able to see and accept the dead person's negative and positive qualities. Leaving the deceased spouse's study as it was before the death is an example of mummification, a pathological outcome to the grieving process.

Question 46

The mental health nurse is facilitating a therapy group. How can the nurse further develop trust among the members of the group?

A. By discussing the importance of their trusting one another
B. By revealing some personal data as an example of trusting behavior
C. By having group members reveal some personal information about themselves
D. By reminding group members about the need for confidentiality within the group ✓ Ans- d

Members must feel comfortable discussing things in the group; there must be an understanding that what is discussed in the group will remain in the group. Talking about trust does little to foster it. Revealing personal data about one's self or having

group members reveal information will not establish trust and may increase anxiety because the members may feel that their turn for exposure will come whether they want it or not.

Question 47

According to Kübler-Ross, during which stage of grieving are individuals with seriushealth problems most likely to seek other medical opinions?

A. Anger
B. Denial
C. Bargaining
D. Depression ✓ Ans- b

Denial includes feelings that the healthcare provider has made a mistake, so the client seeks additional opinions. Anger follows denial; behavior will be hostile and critical. Bargaining occurs after anger; the client verbally or secretly may promise something in return for wellness or a prolonged life. Depression occurs after bargaining; the client feelssadness and despair and may be withdrawn.

Question 48

Which parental statement indicates the need for further education regarding thepsychosocial development that occurs during infancy?

A. ”My older kids are so excited that our a0-month-old can play hide-and-seek with them."
B. "Peek-a-boo is an appropriate activity to initiate with my baby around 9 months of age."
C. "I just bought my f-month-old some new rattles to play with because they are easy to grasp.”
D. "It is important that my baby develops trust so we always respond when he cries for us atnight." ✓ Ans- a

Play is an important aspect of an infant's psychosocial development. While more complex interactive games, such as hide-and-seek involving objects is expected by a-year of age, thisstatement would require additional education regarding age-appropriate play for the infant. Peek-a-boo and rattles are both appropriate play for the infant. Responding promptly to an infant's cry will establish trust.

Question 49

A hospice nurse is caring for a dying client and the client's family members during the developing awareness stage of grief. What is the most important

thing about the family thatthe nurse should assess before providing care?

A. Cohesiveness
B. Educational level
C. Cultural background
D. Socioeconomic status ✓ Ans- c

During the developing awareness stage of grief the degree of anguish experienced or expressed is influenced by the cultural background of the individual and family. Although cohesiveness does enter into the grief process, it is not as important in the developing awareness stage as cultural background is. Educational level has no relationship to the grieving process. Socioeconomic status is not a defining factor in how a family will respondto the loss of a loved one.

Question 50

A client's severe anxiety and panic are often considered "contagious." What action shouldbe taken when a nurse's personal feelings of anxiety are increasing?

A. Refocusing the conversation to more pleasant topics
B. Saying to the client, "Calm down. You're making me anxious, too."
C. Saying, "Another staff member is coming in. I'll leave and come back later."
D. Remaining quiet so personal feelings of anxiety do not become apparent to the client ✓

Ans- c

The nurse who is anxious should leave the situation after ensuring continuity of care; the client will be aware of the nurse's anxiety, and the nurse's presence will be nonproductiveand nontherapeutic. The client will probably sense the nurse's anxiety through nonverbalchannels, if not through verbal responses. Refocusing and asking the client to calm down both meet the nurse's need; this response may make the client feel guilty that something was said that upset the nurse. The client will be aware of the nurse's anxiety, which will increase the client's own anxiety.

Question 51

A client undergoes dilation and curettage (D & C) after an early miscarriage (spontaneousabortion). The nurse finds her crying later in the day. What is the most appropriate statement by the nurse at this time?

A. ”This must be a very difficult experience for you to deal with."
B. "You'll have other children to take the place of the one you lost."
C. "Of course you're sad now, but at least you know you can get pregnant."

D. "I know how you feel, but when a woman miscarries, it's usually for the best." ✓ Ans- a Saying that this must be a difficult experience acknowledges the validity of the client's griefand provides the client an opportunity to talk if she wishes. Other children cannot and should not be substituted for a lost fetus. Getting pregnant is not the issue; this statement belittles the lost fetus. The nurse cannot know how the client feels. Stating that a miscarriage is for the best is patronizing and diminishes the significance of the lost fetus.

Question 52

A ae-year-old client tearfully states that her father has been sexually abusing her for thepast 8 years. What statement should the nurse initially respond with?

A. ”Which type of incidents preceded the abuse?"
B. "Sharing this information is a positive step in getting help."
C. "I have to report this to child protective services right now."
D. "What kinds of things does he do to you when he abuses you?" ✓ Ans- b "Sharing this information is a positive step in getting help" is an emotionally supportive response; it demonstrates that sharing this information is acceptable and provides hope that the client will get help. The client needs support, and asking what incidents preceded the abuse may precipitate or increase feelings of guilt. Telling the client that the abuse mustbe reported immediately to child protective services is not a priority at this time and may interfere with future sharing; the client needs immediate emotional support. Asking what the father did as part of the abuse implies that the client does not know what she is talking about; the client needs support, whether the abuse is real or imagined.

Question 53

During the course of treatment a toddler is to receive an intramuscular injection. What is the priority nursing intervention that should be included in the plan of care to comfort thechild?

A. Distracting the toddler's attention with a toy car
B. Telling the parents exactly what will be done to the toddler
C. Giving the toddler the choice of having the injection now or later
D. Involving the parents in comforting the toddler after the injection ✓ Ans- d The parents are the most significant people in the young child's life, and their involvement in comforting the child is the most supportive intervention for the toddler. Distraction doesnot provide an outlet for the toddler's feelings. Explaining the procedure to the parents does not comfort the child. Offering choices for the toddler is incorrect because this type of choice is not a viable option; the medication must be administered as prescribed.

Question 54

A preterm newborn is admitted to the neonatal intensive care unit (NICU). Which concern is most commonly expressed by NICU parents?

A. Fear of handling the infant
B. Delayed ability to bond with the infant
C. Prolonged hospital stay needed by the infant
D. Inability to provide breast milk for the infant ✓ Ans- a

Because these infants are so tiny and frail, parents most commonly fear handling or touching them; they should be encouraged to do so by the NICU staff. The primary concern is the infant's fragility, not bonding; however, bonding should be encouraged. Although there may be concerns about a long hospital stay, they are not commonly expressed by mothers. The primary concern is the infant's fragility, not breast-feeding. Breasts may be pumped and breast milk given in gavage feedings.

Question 55

A father asks a nurse for strategies to convince his e-year-old to wear a helmet while bicycling. What should the nurse suggest to the father?

A. ”You should forbid your child from riding a bicycle."
B. "You should wear your helmet while riding your bicycle."
C. "You should limit your child's bicycling to a defined area."
D. "You should tell your child about the risks associated with not wearing a helmet." ✓ Ans- b

The nurse should suggest the father to wear a helmet when he rides his bicycle. This sets a positive example for the child to wear his or her helmet. Restricting the child will interfere with the cognitive development. Limiting the child's bicycling to a defined area may lead to conflicts between the father and the child. Telling the child about the risks of not wearing a helmet may interfere with the child's willingness to ride.

Question 56

After a difficult labor a client gives birth to a 9-lb (4 kg) boy who expires shortly afterward. That evening the client tearfully describes to the nurse her projected image of her son and what his future might have been. What is the nurse's most therapeutic response?

A. ”I guess you wanted a son very much."
B. "It must be difficult to think of him now."
C. "I'm sure he would have been a wonderful child."
D. "If you dwell on this now, your grief will be harder to bear." ✓ Ans- b

Stating that it must be difficult to think of him now demonstrates empathy; the

nurse is attempting to show understanding of the client's feelings. Stating that the patient must have wanted a son very much is nontherapeutic; the nurse has no way of knowing this. Stating the certainty that the infant would have been a wonderful child switches the focusaway from the client, whose needs should be met at this time. Stating that dwelling on thedeath will make her grief harder to bear denies the client's feelings and implies that the client should curb painful emotions.

Question 57

At a am a b8-month-old toddler is admitted to the pediatric unit with suspected meningitis.At c am, after the child is settled in, the mother tells the nurse, "I have to leave now, but whenever I try to go my child gets upset and then I start to cry." What is the best action by the nurse?

A. Walking the mother to the elevator
B. Encouraging the mother to spend the night
C. Staying with the child while the mother leaves
D. Telling the mother to wait until the child falls asleep ✓ Ans- c

Staying with the child enables the mother to leave and reassures her and the child that someone will be with and comfort the child. The mother has indicated that she is upset when the child is upset; walking the mother to the elevator meets neither the mother's nor the child's needs. The mother has said she must leave; trying to persuade her to stay willmake her feel guilty about having to leave. Telling the mother to leave after the child is asleep is a dishonest solution; the child should be aware that the mother is leaving and reassured in terms that a toddler will understand that she will return.

Question 58

Which intervention does the nurse implement to develop a caring relationship with theclient's family?

A. Deciding healthcare options for the client
B. Identifying the client's family members and their roles
C. Declining to inform the client's family after performing a procedure
D. Refraining from discussing the client's health with the family ✓ Ans- b

The family is an important resource in client care. Therefore, the nurse must first identify the client's family members and their roles in the client's life. This action helps the nurse todetermine his or her contribution towards the client's healthcare. The nurse should not decide healthcare options for the client. The nurse should inform the client and family about a procedure and take permission before implementing the procedure. The nurse ensures the client's well-being by accepting the client as an active partner in healthcare.

Question 59

A client is admitted to a psychiatric hospital with the diagnosis of schizoid personality disorder. Which initial nursing intervention is a priority for this client?

A. Helping the client enter into group recreational activities
B. Convincing the client that the hospital staff is trying to help
C. Helping the client learn to trust the staff through selected experiences
D. Limiting the client's contact with others while in the hospital ✓ Ans- c

Demonstrating that the staff can be trusted is a vital initial step in the therapy program. The client is not ready to enter group activities yet and will not be until trust is established. Even proof will not convince the client with a schizoid personality that feelings of distrust are false. Arranging the client's contact with others is not realistic even if it is possible; limiting contact with other clients will not enhance trust.

Question 60

During the first session of a therapy group, one of the clients asks, "What's supposed to happen in this group?" What is the most appropriate response by the nurse facilitator?

A. "First I'd like for you to tell me what you want to happen."
B. "This is your group, and your participation will largely determine what happens."
C. "The purpose of this group is to examine the way each of you interacts with the others."
D. "You and the others are supposed to discuss any reality-based concerns you have about your illness." ✓ Ans- a

To achieve the greatest therapeutic value from a group session, the members must be involved in deciding what will be discussed. By telling the clients that this is their group, the nurse facilitator abdicates the leadership role and places responsibility for the success of the group entirely on its members. The responses "The purpose of this group is to examine the way each of you interacts with the others" and "You and the others are supposed to discuss any reality-based concerns you have about your illness" present a structured view of the purpose of a therapy group; the members must be involved in selection of the topics to be discussed.

Question 61

A client with mild preeclampsia is instructed to rest at home. She asks the nurse, "What do you mean by rest?" What is the most appropriate response?

A. ”Tell me what you consider rest."
B. "Take three or four naps a day."
C. "Stay off your feet as much as possible."
D. "Would you like to know what I think it means?" ✓ Ans- a

Responding by asking what the client considers rest reflects the client's statement andpermits clarification, which will yield information that can be used in planning.

Recommending three or four naps each day is too specific an interpretation of a rest requirement; there is more to maintaining rest than naps. There is also more to maintaining rest than staying off one's feet; this response is a vague interpretation of a rest requirement. What the nurse thinks rest means does not provide a clear picture of what theclient interprets as rest.

Question 62

A client reports fever, headache, extreme tiredness, dry cough, sore throat, runny nose,muscle aches, nausea, vomiting, and diarrhea. Which organism is responsible for this condition?

A. Influenza virus
B. Toxoplasma gondii
C. Human herpes virus-8
D. Cryptosporidium muris ✓ Ans- a

Fever, headache, extreme tiredness, dry cough, sore throat, runny nose, muscle aches, nausea, vomiting, and diarrhea are symptoms of influenza. Influenza is caused by the Influenza virus. Toxoplasma gondii causes fever, altered mental status, headache, and seizures. Human herpes virus-8 causes vascular lesions on the skin. Cryptosporidium muriscauses watery diarrhea and weight loss.

Question 63

A nurse is caring for a client with hyperthyroidism. Which laboratory test will be mostbeneficial in monitoring the effectiveness of drug therapy?

A. Free thyroxine (FTd)
B. Thyroxine (Td), total
C. Free triiodothyronine (FTc)
D. Triiodothyronine (Tc), total ✓ Ans- b

The thyroxine (Td) total study is the best method of monitoring thyroid therapy. A free thyroxine (FTd) study measures the active component of total Td; this test is an indicator of thyroid function. Free triiodothyronine (FTc) measures the active component of triiodothyronine (Tc) total. Total Tc helps to diagnose hyperthyroidism when Td levels arenormal.

Question 64

A client's relative asks the nurse what a cataract is. Which explanation should the nurseprovide?

A. An opacity of the lens
B. A thin film over the cornea
C. A crystallization of the pupil
D. An increase in the density of the conjunctiva ✓ Ans- a

A cataract [a] [b] is a clouding (opacity) of the crystalline lens or its capsule. A thin filmover the cornea, a crystallization of the pupil, and an increase in the density of the conjunctiva are not the pathophysiology related to cataracts.

Question 65

When assessing an 8e-year-old client's vital signs, the nurse anticipates a number of changes in cardiac output that result from the aging process. Which finding is consistentwith a pathologic condition rather than the aging process?

A. A pulse rate irregularity
B. Equal apical and radial pulse rates
C. A pulse rate of f0 beats per minute
D. An apical rate obtainable at the fifth intercostal space and midclavicular line ✓ Ans- a

Dysrhythmias are abnormal and are associated with acute or chronic pathologic conditions.An equal apical and radial pulse is expected; the radial pulse reflects ventricular contractions. The expected range in adults is f0 to a00 beats per minute. An apical rate obtainable at the fifth intercostal space and midclavicular line are the anatomical landmarks for locating the apex of the heart; they are unaffected by aging.

Question 66

A nurse notices a firm, edematous, irregularly shaped skin lesion on a client who reports aninsect bite. Which skin lesion is this?

A. Wheal
B. Plaque
C. Vesicle
D. Pustule ✓ Ans- a

A wheal is a firm, edematous, irregularly shaped skin lesion, formed as an inflammatoryresponse to an allergen or insect bite. A plaque is a circumscribed, elevated, superficial lesion, like psoriasis. A vesicle is a circumscribed, superficial collection of serous fluid. Apustule is an elevated, superficial lesion filled with purulent fluid.

Question 67

A pregnant woman who is in the third trimester arrives in the emergency department withvaginal bleeding. She states that she snorted cocaine approximately b hours ago. Which complication does the nurse suspect as the cause of the bleeding?

A. Placenta previa
B. Tubal pregnancy
C. Abruptio placentae
D. Spontaneous abortion ✓ Ans- c

Abruptio placentae is associated with cocaine use; it occurs in the third trimester. Placentaprevia is seen in the third trimester; however, it is not associated with cocaine use. A tubalpregnancy is identified in the first trimester. Spontaneous abortion occurs in the first two trimesters.

Question 68

The nurse is assessing a term newborn. Which sign should the nurse report to the pediatricprimary healthcare provider?

A. Temperature of 97.7° F (36.5° C)
B. Pale-pink to rust-colored stain in the diaper
C. Heart rate that decreases to 115 beats/min
D. Breathing pattern with recurrent sternal retractions ✓ Ans- d

A breathing pattern with recurrent sternal retractions is indicative of respiratory distress;the expected pattern is abdominal with synchronous chest movement. A temperature of 97.7° F (36.5° C) is within the expected range of 97.f° F (36.4° C) to 99° F (37.2° C) for a newborn. Pale-pink to rust-colored staining in the diaper is caused by uric acid crystals from the immature kidneys; it is a common occurrence. A decrease in heart rate to 115 beats/min is within the expected range of aa0 to 160 beats/min for a newborn.

Question 69

Which type of burn/injury may cause a client to have a cervical spine injury?

A. Electrical burns
B. Chemical burns
C. Inhalation injury
D. Cold thermal injury ✓ Ans- a

Electrical burns may cause injuries to the cervical spine because intense electrical currentscan fracture long bones and vertebrae. Chemical burns may cause eye and tissue damage. Inhalation injuries may damage the respiratory

tract. Cold thermal injuries may cause tissue damage.

Question 70

A client is noted to have thickened toenails that overhang the toes. The registered nurse suspects a fungal infection and instructs the student nurse to examine the fungal infection to confirm the diagnosis. Which action of the student nurse needs correction?

A. Cutting the client's fingernails straight across
B. Using the client's fingernails for assessing capillary refill
C. Using the nail appearance alone for assessing fungal infection
D. Assessing skin next to the nail to determine whether the thick nail is irritating the skin ✓

Ans- c

The nurse should not consider the nail appearance alone for assessing a fungal infection but should assess the toenails and the underlying skin to confirm the diagnosis. The nurse should cut the thickened toenails straight across to prevent discomfort. Fingernails are used for assessing capillary refill. The nurse should assess the skin next to the nail to determine the irritation caused by the thickened nail.

Question 71

A primary healthcare provider diagnoses late-stage (tertiary) syphilis in a client. Which statement made by the client supports this diagnosis?

A. ”I noticed a wart on my penis."
B. "I have sores all over my mouth."
C. "I've been having a sore throat lately."
D. "I'm having trouble keeping my balance." ✓ Ans- d

Neurotoxicity, as manifested by ataxia (balance problems), is evidence of tertiary syphilis, which may involve the central nervous system (CNS) or cardiovascular system. A wart on the penis occurs in the secondary stage of syphilis. Sores all over the mouth occur in the first and secondary stage of syphilis. Sore throat with flulike symptoms occurs in the secondary stage of syphilis.

Question 72

A nurse assesses a newly admitted client with a diagnosis of pulmonary tuberculosis (TB). Which clinical findings support this diagnosis? Select all that apply.

A. Fatigue
B. Polyphagia